Approved: 03/15/93
Date

MINUTES OF THE HOUSE COMMITTEE ON APPROPRIATIONS.

The meeting was called to order by Chairman Rochelle Chronister at 12:10 p.m. on March 03, 1993 in Room 514-S of the Capitol.

All members were present except: Rep. Wanda Fuller (excused absence)

Committee staff present: Debra Duncan, Legislative Research Department
Timothy Colton, Legislative Research Department
Alan Conroy, Legislative Research Department
Kathy Porter, Legislative Research Department
Jim Wilson, Revisor of Statutes
Jerry Cole, Committee Secretary
Sharon Schwartz, Administrative Assistant

Conferees appearing before the committee:

Others attending: See attached list

Attachments 1, 2 and 3 were provided to the committee members upon the call to order.

The committee was meeting to continue subcommittee recommendations for **HB 2047.** Rep. Lowther presented the subcommittee report for the FY 94 Topeka State Hospital on adjournment of the prior day's meeting. Rep. Helgerson made a motion, as an addition to the report, requesting Department of Social and Rehabilitative Services (SRS) to submit additional agency information to the subcommittee for appropriations during omnibus consideration. Rep. Heinemann seconded the motion and it carried. Rep. Teagarden made a motion, as an addition to the report, for the introduction of a bill moving patients from catchment area to catchment area be referred to the subcommittee for study. Rep. Helgerson seconded the motion and it carried. Rep. Lowther moved the adoption of the subcommittee report for the FY 94 Topeka State Hospital budget as it was amended by the committee. Rep. Heinemann seconded the motion and it carried.

Rep. Mead moved bill introduction with regard to KanWork. Rep. Helgerson seconded the motion which then carried. Rep. Mead made another motion for bill introduction on a moratorium for nursing homes. Rep. Glasscock seconded the motion and the motion carried.

Rep. Heinemann made a motion to adopt the subcommittee reports for FY 93 and FY 94 Kansas Neurological Institute budgets. (See Attachment 4). Rep. Lowther seconded the motion and it carried. Rep. Heinemann moved adoption of the subcommittee reports for FY 93 and FY 94 Parsons State Hospital budgets. (See Attachment 5). Rep. Dean seconded the motion which then carried. Rep. Heinemann moved to adopt the subcommittee recommendations for the FY 93 and FY 94 Winfield State Hospital and Training Center budgets. (See Attachment 6). Rep. Lowther seconded the motion and it carried. Rep. Dean made a motion to adopt the subcommittee report for the FY 93 SRS Community Mental Retardation Services budget. (See Attachment 7). Rep. Lowther seconded the motion and it carried. The subcommittee presented their report for the FY 94 SRS-Community Mental Retardation (MR) Services budget. (See Attachment 7). Rep. Bradley made a motion to adopt the mental retardation subcommittee reports and to postpone discussion of closure of a MR hospital until more community caseload information could be gathered. Rep. Teagarden seconded the motion. Rep. Blumenthal stated that he thought Rep. Bradley's motion was premature without even hearing the majority and minority subcommittee reports on the closure considerations. Rep. Bradley, with the consent of Rep. Teagarden, withdrew his motion. Rep. Lowther moved to adopt the subcommittee report for the FY 94 SRS Community MR Services budget. Rep. Dean seconded the motion and it carried. Rep. Lowther moved to pass and favorably recommend **HB 2047** as it was amended by the committee. Rep. Heinemann seconded the motion and it carried.

Rep. Helgerson moved to pass and favorably recommend **HB 2087** from the committee. Rep. Mead seconded his motion and it carried.

Rep. Kline moved to pass and favorably recommend **HB 2122** as it was amended by the committee. Rep. Teagarden seconded the motion and it carried.

Chairman Chronister then turned the committee's attention to the question of MR hospital closure under the Developmental Disability Reform Act. Rep.'s Heinemann, Dean and Lowther presented the Majority Report. (See Attachment 8). Rep. Gross presented the Report of the Minority. (See Attachment 9). Chairman Chronister then recessed the committee until adjournment of the House.

The committee reconvened at 4:19 p.m. Attachments 10, 11, 12, 13 and 14 were given to committee members throughout discussion on the issue. Rep. Lowther moved adoption of the Majority report for the Developmental Disabilities Reform Act and was seconded by Rep. Dean. Rep. Gross made a substitute motion for adoption of the Minority report and his motion was seconded by Rep. Everhart. The minority report failed on a vote of 10-12. Rep. Blumenthal made a substitute motion appointing an independent commission for studying the closure and the motion was seconded by Rep. Everhart. (See Attachment 15). Rep. Glasscock concurred with Rep. Blumenthal and discussed appointing an independent panel for studying the closure, but added stipulations to the appointment. In agreement with Rep. Everhart, Rep. Blumenthal withdrew his motion. Rep. Glasscock made a second substitute motion to appoint an outside expert to study the issue of an MR hospital closure and for the expert to make his recommendation by January 1994. Outlined in Rep. Glasscock's plan was that the expert specify which hospital should be closed and when, obligating SRS to close the hospital that was recommended and that a date be prescribed for said closure. Rep. Helgerson seconded his motion. Rep. Glasscock's motion failed on a vote of 11-11. Chairman Chronister then returned to the motion made by Rep. Lowther for adoption of the Majority report. Adoption of the Majority report, targeting the Kansas Neurological Institute for closure, was adopted 13-8.

Rep. Teagarden moved a bill introduction for legislation specifying that Osawatomie Hospital transfer land to Miami county for the construction of a new hospital. The motion was seconded by Rep. Heinemann and carried. Chairman Chronister adjourned the meeting at 6:33 p.m.

The next meeting is scheduled for March 09, 1993.

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE: MAR. 03, 1993

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
ETHEL MAY MILLER	3934 SW WANAMAKER	ARC - Parent
Katie Pyle	3700 SW Huntoon	AARP - CCTF
Kathy Sexton	Topeka	DOB
Randy Rowton	"	SRS / MHRS
Ned Mathingly	Winfield	Citizen
Richard E Cotton	Winfield	City
Rodger Stoffer	winfield	Citizen
Leslie Votaw-Braley	Topeka	KNI
CECIL T. WASHINGTON III	TOPEKA	KNI
Willie Mentor	Wichita	Sedg. Co.
SOLEDAD WATKINS	TOPEKA	K-N-I.
LaWanda Roach	Topeka	KNI
Sylvia Coulter	TOPEKA	KNI
[illegible]	Topeka	KNI
Marvena Barksdale	2043 SE Turnpike	KNI
Robert Huckstep II	1924 SE 30th Topeka	KNI
Pat Chandler	3002 Wisconsin	K.N.I
Becky Wall	1900 SE 24th Street	KNI
Elizabeth B. Johnson	Wichita	City
GARRY HECKEN	CITY OF TOPEKA	
Alene Jensen	Topeka	A.D.A.P.T.
Tim Hoyt	"	SRS
Linda Lopez	Topeka	KNI
Gerri Johnson	Topeka	KNI
Stephanie Brockman	Topeka	KNI

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE: ______

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Danny T. Sanders	Topeka	KNI
Betty J. Wendt	Topeka	KNI
Jan Smith	Topeka	KNI
Christi Young	Topeka	Topeka Chamber of Commerce
Brenda Malone	Topeka	KNI
Leon Fundenberger	Topeka	KNI
Mary Young	Topeka	KNI
[illegible] Meseke	Topeka	KNI
Connie Stewart	Hoyt	KNI FSA
[illegible] Hartness	Auburn	KNI
Jim Hartness	Auburn	KNI Supporter
Chuck Welch	Topeka	KNI
Cheryl A. Larson	Lawrence	KNI
Roslynn Crouch	Topeka	KNI
[illegible]	Topeka	KNI
JIM HELTON	CARBONDALE	KNI
Anna LaRue	Tecumseh	Parent
Wilbur LaRue	Tecumseh	Parent
DAWN PAYNE	TOPEKA	KNI
Carol Dickens	Topeka	KNI
Kerri Elert	Topeka	KAPE
Susan Ewing	Topeka	KNI
Katherine Janich	Topeka	KNI
Betty K. Meyers	Topeka	Mental Health Assn in KS
[illegible]	Wichita	[illegible] Research Fd. of Ks

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE:

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Mary Ellen Conlee	Wichita	Wichita Hospitals
Robin Nichols	Wichita	Wichita Public Schools
Dick Pilsaver	Wichita	Coleman
[illegible] Cooper	Topeka	KNI
Jessie Mae Thompson	Topeka	KNI
VIRGINIA GREEN	Topeka	KNI
Ray Brown	Topeka	KNI (PARENT)
RECESS	RECESS	RECESS
Debra Clemens	Topeka	KNI
Josie Torrez	Topeka	Families Together
* IF YOU'VE SIGNED THIS LIST PRIOR, YOUR	PRESENCE UPON RECONVENING	IS ASSUMED. NO
NEED TO SIGN AGAIN.	THANKS. JSC	
Michael Donnelly	Topeka	Topeka Independent Living
[illegible]	Manhattan	KAPS
Christy Young	Topeka	Topeka Chamber of Comm
Jo Bentgen	Topeka	KARF
PAOLO POLITI	TOPEKA	KARF
Dave Slater	Winfield	Winfield Courier
Martha Holzgesmith	Topeka	KARF
Don Jordan	Topeka	MHRS-SRS
ED HELBERT	TOPEKA	KNI
Bob Wootton	Topeka	Legis.
Marvena Barksdale	Topeka	KNI
Marilyn Wilson	Topeka	KNI
Leslie [illegible]-Bealy	Topeka	KNI

GUEST LIST

COMMITTEE: HOUSE APPROPRIATIONS DATE:

NAME (PLEASE PRINT)	ADDRESS	COMPANY/ORGANIZATION
Lynn Carter	3201 SW Randolph # C	K.N.I
Elizabeth B. Johnson	Wichita	City
Pete McGill	Topeka	Pete McGill & Assoc.
Becky Nall	Topeka	KNI
Robert L. Clark	Pittsburg	CASS LTD
Kathy Sexton	Topeka	DOB
[illegible]	Topeka	KNI
Heatha Hadley	1192 Boswell	KNI
Doug Tate	3021 Randolph #203 Topeka, KS	KNI
Rene Gardner		Governor's Office
Greg Tugman	Topeka	Div. of the Budget
Gina McDonald	Topeka	KAC/C
Johnny Scroggins	3730 Truman Topeka 66604	City of Topeka Blue Boulevard
Roy L. Abbott	2337 Monroe Topeka 66605	KNI
Lisa Pasley	Topeka	AKC Kansas
Donna L. Whiteman	Topeka	SRS
JENE VICKREY	6740 W 263rd Louisburg	St. Representative 6th Dist

Jerry

Catherine L. Holthaus LBSW
Rt. 3 Box 135
Seneca, Kansas 66538
February 24,1993

HB 2246

Dear Representative Chronister;

I'd like to thank you and the committee for letting me speak at the Appropriations Committee hearing on Tuesday. One representative asked me how come I didn't identify my "group". I want to point out that I was not representing any group, but only expressed my own thoughts and concerns. If we were supposed to be speaking for a "group", then I apologize for speaking out of place. For the convenience of the committee, I will restate my credentials and my concerns.

I have a dual degree in Family and Child Development\ and Social Work and graduate hours in Early Childhood Education, Media, and Prevention, as well as 60 hours every 2 years, of continuing education in all aspects of Social Services. I established the agency for Kansas Children's Service League in Emporia, and developed the Foster Care and Respite Care programs for them. While living in Seneca I have worked for SRS, Kanza Mental Center, and NEK Health Department (all at the same time), with my duties being to provide prevention services to schools, counseling to pregnant teens, family services to families in need, and developing and servicing Employee Assistance Programs. I now am self employed providing Prevention Services to schools and counseling to a volunteer support group.

My thoughts as expressed February 23 are:

1. Assuming that a Family Resource Center would be established in a school in a rural community where grades K-8 or K-12 attend, the possibility of a child growing up "institutionalized" spending 18 years in the same building is very real. It is well documented that the best place for a child to grow up is her own home, 2nd best is a relative's home, 3rd is a daycare home, and the least desirable place for a child to be is in an institution type setting.

2. In our community, the source of income for many women is providing licensed daycare in their home. Because the daycare provided by the FRC would most likely be less expensive, this could put these women out of business.

3. Because so many services would be provided within the FRC, there is great potential for confidentiality to be lost. As a Social Worker, this has always been one of the most important aspects of service to families and children. Along that same line, there is great potential for communication to break down between parent, FRC, and the child. In most agencies (especially state agencies), the paperwork time can exceed the service time, and often things don't get communicated simply because there is so much red tape, and not enough time. The more services that are provided, the more potential there is for this to happen.

4. As a Social Worker, my goal is to make things better for families and children. If "Social Work" is really working...If I am really doing my job well, then eventaully I will work myself out of a job. Since I've been a Social Worker, social services have increased and more and more money has been put into social services, while at the same time the social fabric of our country has decreased, and there are more social problems than ever before. I'm just wondering...maybe we are doing something wrong. I sincerely believe that if I do a good, then I should be working myself out of a job, ironic as that may sound. I believe that my job is to help families, and children become independent and successful human beings, not become addicted to state aid.

My intention is not to criticize any agency or individual. These are just some issues that I feel should be addressed by the committee, as it is always appropriate to consider the pros and cons of any idea or program. Although I had no plans to speak, I felt it my duty to provide an experienced worker's perspective to the committee. I thank you for the opportunity to express my thoughts.

Sincerely,

Catherine L. Holthaus

Catherine L. Holthaus LBSW

913-336-3199

ATTACHMENT 1

STATE OF KANSAS

RICHARD R. ROCK
SENATOR, 32ND DISTRICT
COWLEY AND SUMNER COUNTIES
STATE CAPITOL BUILDING
ROOM 401-S
TOPEKA, KANSAS 66612-1504
(913) 296-7381
P.O. BOX 618
ARKANSAS CITY, KANSAS 67005
(316) 442-8370

TOPEKA

SENATE CHAMBER

OFFICE OF ASSISTANT MINORITY LEADER

COMMITTEE ASSIGNMENTS
RANKING MINORITY MEMBER: WAYS AND MEANS
MEMBER: INTERSTATE COOPERATION
JUDICIARY
TRANSPORTATION AND UTILITIES

March 3, 1993

MEMBERS, HOUSE APPROPRIATIONS COMMITTEE:

I apologize for adding to the weight of material you have become heir to, but feel that I must make a brief response to the latest T.I.L.R.C. effort.

During the mid 80's there were problems at both KNI and Winfield hospitals which resulted in the superintendents of those facilities being replaced by those currently in charge. Each of those institutions had accreditation problems for the next few years.

HCFA compliance is the only objective, outside source yardstick that is available to measure relative care and, under that standard, Winfield does very well. Since 1988, WSH has not been found out of HCFA compliance on any "Condition of Participation" while KNI has 5 times.

Fact is, this is history unrelated to current status. Both institutions have made remarkable improvement. Each is currently among the highest rated in the U.S.

I have attached, hereto, an interesting statistic that has relevance to HCFA and the fact of compliance. I am saddened at this ongoing effort by T.I.L.R.C. to denigrate a competing facility. These are both excellent hospitals. I suggest that the committee consider past efforts from this source and the obvious fact that comparable disciplinary actions by other institutions are not here reported.

Sincerely,

Senator Dick Rock

ATTACHMENT 2

We have been talking so much about the cost of each facility that the revenue collections have been ignored. Fifty-eight cents of each dollar spent is reimbursed by the Federal Government to the State of Kansas. A good economist would apply the multiplier effect for this revenue and be able to show an excellent effect on the Kansas economy.

Another comparison between the facilities is to look at the fee collections:

	FY92	ADC
WSH Fees	1,194,846	350
PSH Fees	793,432	268.2
KNI Fees	869,198	329

In FY92, the following amounts were collected at each facility *per resident:*

WSH	3,413.85
PSH	2,958.36
KNI	2,641.94

WSH collects $772 more per resident per year that KNI does. WSH has a 6% higher ADC than does KNI; and has a 27% higher collection rate.

3-3-93

Committee Members — In response to Mr. Donnelly's continued assault on W.S.H. & T.C. I provide the following FACTUAL INFORMATION.

The Kansas Civil Service Board has provided the following statistics comparing the number of appeals filed by employees at Winfield State Hospital (WSH) and at Kansas Neurological Institute (KNI) for fiscal years 1990, 1991, and 1992.

	WSH	KNI
FY 1990	7	1
FY 1991	1	5
FY 1992	1	9

The preceding numbers show that when an "apple to apple" comparison is made on any issue, Winfield's operation and efficiency is quality.

Thank You,

Rep. Randy Rock
79th Legis. Dist.

March 3, 1993

To the Members of the House Appropriations Committee:

My talents do not run in the political arena, so please understand I don't write any better than I speak. My thoughts and feelings are based on my years of experience working with multipli-disabled individuals. I'm not a professional, just a Mental Retardation Technician with a lot of concerns for my clients.

I'd be lying if I said I wasn't concerned about my job. My "work career" runs the gamut, many into traditionally male roles. In spite of my age, I could find another job eventually. This issue shouldn't be a "job issue." When Parsons, KNI and Winfield were opened, the state didn't open them to provide jobs, but to provide care, education, training and protection for the disabled clients. The employment was an added plus. In the two decades I've been associated sporadically with KNI, the emphasis was always on the best interest of the client, not staff or professionals. There was stress put on respecting clients, preserving their worth and dignity, and improving and maintaining their quality of life. Think about it! Having people care! What a wonderful comparison to living in someone's attic, back room and basement. These were some of the places and treatment developmentally disabled people were subjected to prior to the institutions availability. Now our world is opening up and changing. Acceptance has improved immensely. The institutions for that reason are downsizing.

My main concern is the people I work with. My heart goes out to the people who work at Winfield, but I have seen many changes at KNI who, from what I understand, had a smaller budget. What happened at Winfield? Why should my people be forced out to the middle of nowhere in second-rate surroundings with unmotivated staff? Sounds a bit political to me. No one is considering the client. What about their rights that I have been trained to respect and preserve?

I am a 39-year-old mother of 4. Two of my children still live with me. I, like the employees at Winfield, will be out of a job. Its hard for someone my age to start over again. The added hardship is I have a disabled child too; my son is mentally ill. Without insurance it will be difficult to have him treated at a quality institution. I choose to work for SRS; not live off it. Welfare does not become me, and I hate living off someone else's paycheck. So, as you can see, I have a personal stake in this too.

My greatest concern is my clients. One lady I work with is like a member of my family. When I began working with her, she was 18, and I was 19. "Sissy" and I have a special relationship. I carry a picture of us together in my wallet. My kids call her "Aunt Sissy" and ask about her often. When allowed, they visit her. It's rare when her parents don't show up for a nightly visit. They are as active and concerned in the life of their daughter as I am with mine--probably more so. If Sissy moved to Winfield, they probably would too. Actually, I'd probably sneak her off to my house first!

This is just one story of many at KNI regarding clients and staff. We love our "kids." (You'll have to pardon that word. The majority of clients were children when I first worked there.)

My pleading and sympathy goes to those who must make the decision. I know some of you may not be reelected if KNI stays open. You may even loose your job. But I'd hate to be the person who votes to close KNI. I wouldn't be able to sleep. . .

Sincerely,

Terry McCoy-Shepherd
MENTAL RETARDATION TECHNICIAN
KANSAS NEUROLOGICAL INSTITUTION

ATTACHMENT 3

1993 H.B. 2047

Section 3 -- Kansas Neurological Institute

Section 6 -- Parsons State Hospital

Section 9 -- Winfield State Hospital

Representative James Lowther
Subcommittee Chair

Representative George Dean

Representative Delbert Gross

Representative David Heinemann

Attachment 4

SUBCOMMITTEE REPORT

Agency: Kansas Neurological Institute **Bill No.** 2087 **Bill Sec.** 18

Analyst: Colton **Analysis Pg. No.** 606 **Budget Page No.** 380

Expenditure Summary	Agency Est. FY 93	Governor's Rec. FY 93	Subcommittee Adjustments
State Operations:			
State General Fund	$ 10,968,504	$ 10,938,296	$ --
Title XIX	12,760,952	12,790,056	--
General Fees Fund	714,699	714,699	--
Other Funds	234,938	243,135	--
Subtotal	$ 24,679,093	$ 24,686,186	$ --
Other Assistance (SGF)	--	--	--
Subtotal--Operating	$ 24,679,093	$ 24,686,186	$ --
Capital Improvements:			
State Institutions Bldg. Fund	171,295	171,295	--
TOTAL EXPENDITURES	$ 24,850,388	$ 24,857,481	$ --
Average Daily Census	296	296	--
FTE Positions	852.5	852.5	--

Agency Estimate/Governor's Recommendation

The agency requests FY 1993 operating expenditures of $24,679,093. Of the estimate, $10,968,504 is from the State General Fund and $13,800,589 is from special revenue funds. The estimated expenditures from the State General Fund are $24,446 less than the amount approved by the 1992 Legislature as adjusted by the State Finance Council. The difference can be attributed to the agency's expenditure of FY 1992 moneys reappropriated to FY 1993. Estimated expenditures from special revenue funds are in the amount approved by the 1992 Legislature.

The agency estimate would fund expenditures for salaries and wages in the amount of $20,855,379; expenditures for contractual services in the amount of $1,648,866; expenditures for commodities in the amount of $2,034,122; and capital outlay expenditures in the amount of $140,726. The agency estimates a 7 percent turnover rate for FY 1993.

The Governor recommends FY 1993 funding for KNI in the amount of $24,686,186. This is $7,093 more than the agency requested. The difference is due to the fact that the Governor recommends an FY 1993 salary-turnover rate (6.75 percent) that is slightly lower than the rate estimated by the agency (7 percent).

House Subcommittee Recommendation

Concur.

93-5260

ATTACHMENT 4-2

SUBCOMMITTEE REPORT

Agency: Kansas Neurological Institute **Bill No.** 2047 **Bill Sec.** 3

Analyst: Colton **Analysis Pg. No.** 606 **Budget Page No.** 380

Expenditure Summary	Agency Req. FY 94	Governor's Rec. FY 94	Subcommittee Adjustments
State Operations:			
State General Fund	$ 10,736,029	$ 9,927,229	$ --
Title XIX	13,895,073	13,461,794	--
General Fees Fund	960,872	927,988	--
Other Funds	234,938	238,645	--
Subtotal	$ 25,826,912	$ 24,555,656	$
Other Assistance (SGF)	--	--	--
Subtotal--Operating	$ 25,826,912	$ 24,555,656	$ --
Capital Improvements:			
State Institutions Bldg. Fund	--	--	--
TOTAL EXPENDITURES	$ 25,826,912	$ 24,555,656	$ --
Average Daily Census	282	265	--
FTE Positions	815.5	815.5	--

Agency Request/Governor's Recommendation

The agency requests FY 1994 expenditures of $25,826,912, of which $10,736,029 is from the State General Fund and $15,090,883 is from special revenue funds. Proposed State General Fund expenditures are down from estimated FY 1993 expenditures by 2.1 percent, while proposed expenditures from all funds exceed estimated FY 1993 expenditures by 4.7 percent.

The agency request would fund 815.5 FTE positions, a reduction of 37.0 FTE from the agency's FY 1993 estimate. The positions will have been eliminated during the course of FY 1993, but the agency's FTE position limitation was kept at 852.5 during FY 1993 in order to give the agency greater flexibility in making the reductions. There are two new initiatives in KNI's FY 1994 budget request. The first new initiative is the **establishment of a day-care center for on-campus care of KNI employees' children**; the cost of this initiative would be $139,229. The other requested new initiative is the **creation of a LAN (Local Area Network) computer system**; funding in the amount of $71,443 is requested for the LAN.

The Governor recommends FY 1994 operating expenditures in the amount of $24,555,656 for the Kansas Neurological Institute. The recommendation is $382,256 less than the agency requested. The recommendation would fund 815.5 FTE positions (as requested by the agency), but provides about $100,000 less in overtime funding than was requested by the agency. The recommendation does include funding for a 2.5-percent unclassified-merit or classified step-movement increase, annualization of a 1-percent cost-of-living increase approved for half of FY 1993 by the 1992 Legislature and longevity bonuses for eligible employees. The recommendation calls for an FY 1994

turnover rate of 6.25 percent. The Governor's recommendations do not fund either of the new initiatives requested by the agency.

House Subcommittee Recommendation

Concur.

SUBCOMMITTEE REPORT

Agency: Parsons State Hospital and Training Center **Bill No.** 2087 **Bill Sec.** 19

Analyst: Colton **Analysis Pg. No.** 636 **Budget Page No.** 462

Expenditure Summary	Agency Est. FY 93	Gov. Rec. FY 93	Subcommittee Adjustments
State Operations:			
State General Fund	$ 6,751,423	$ 6,754,770	$ 8,580
Title XIX	10,536,044	10,550,070	14,002
General Fees Fund	579,840	573,691	--
Other Funds	104,548	104,548	--
Subtotal	$ 17,971,855	$ 17,983,079	$ 22,582
Other Assistance (SGF)	1,000	1,000	--
Subtotal -- Operating	$ 17,972,855	$ 17,984,079	$ 22,582
State Institutions Bldg. Fund	--	362,398	--
TOTAL EXPENDITURES	$ 17,972,855	$ 18,346,477	$ 22,582
Average Daily Census	256	256	--
FTE Positions	563.0	562.0	1.0

Agency's FY 1993 Estimate

The agency estimates FY 1993 operating expenditures of $17,972,855. This is $69,704 more than was approved by the 1992 Legislature as adjusted by the State Finance Council. The difference can be attributed to the inclusion of $69,704 in Oil Overcharge--Second Stage Refund Program Fund moneys in its estimate; the expenditures authorized by the 1992 Legislature did not contemplate the use of such funds. According to the agency, the money was received during FY 1992 and was intended for interactive television equipment that would allow the Hospital to participate in an interactive video network linking Kansas Regents institutions (Parsons State Hospital is affiliated with the University of Kansas Bureau of Child Research, which has departments at Parsons, Kansas City, and Lawrence).

During FY 1993, Parsons State Hospital and Training Center will lose 26.0 FTE positions. However, in order to give the institution greater flexibility in making the reductions, this is not reflected in the FY 1993 position limitation, but rather, in the FY 1994 figure.

Governor's FY 1993 Recommendation

The Governor recommends FY 1993 operating expenditures of $17,984,079 at Parsons State Hospital and Training Center. This is $80,928 more than the 1992 Legislature approved for the agency, and $11,224 more than the agency request. The difference is due to two things: a) the Governor's recommendation to include $69,704 in Oil Overcharge -- Second Stage Refund Program

ATTACHMENT 5

funding, as requested by the agency; and b) the Governor's addition of funding to reduce salary turnover from the six percent requested by the agency to 5.7 percent.

The Governor recommends abolishing a 1.0 FTE clerical position in FY 1993, putting the recommended FY 1993 FTE position limitation at the institution at 562.0 FTE positions. The Governor concurs with the agency's other proposed position eliminations.

House Subcommittee Recommendation

The Subcommittee concurs with the Governor, with the following change:

1. Restore 1.0 FTE Bookkeeper position and funding in the amount of $22,582 ($8,580 from the State General Fund and $14,002 in Title XIX funding).

SUBCOMMITTEE REPORT

Agency: Parsons State Hospital and Training Center **Bill No.** 2047 **Bill Sec.** 6

Analyst: Colton **Analysis Pg. No.** 636 **Budget Page No.** 462

Expenditure	Agency Req. FY 94	Governor's Rec. FY 94	Subcommittee Adjustments
State Operations:			
State General Fund	$ 6,760,706	$ 6,232,837	$ 8,580
Title XIX	11,174,079	10,836,578	14,002
General Fees Fund	985,673	963,265	--
Other Funds	34,844	34,844	--
Subtotal	$ 18,955,302	$ 18,067,524	$ 22,582
Other Assistance (SGF)	1,000	1,000	--
Subtotal--Operating	$ 18,956,302	$ 18,068,524	$ 22,582
Capital Improvements:			
State Institutions Bldg. Fund	--	--	--
TOTAL EXPENDITURES	$ 18,956,302	$ 18,068,524	$ 22,582
Average Daily Census	242	235	--
FTE Positions	537.0	534.0	1.0

Agency Request/Governor's Recommendation

The agency requests FY 1994 operating expenditures in the amount of $18,956,302. Of the request, $6,761,706 is from the State General Fund, and $12,194,596 is from special revenue funds. Proposed State General Fund expenditures are up from the agency's FY 1993 estimate by 0.1 percent, and proposed expenditures from all funds are increased from the FY 1993 estimate by 5.5 percent. There is one new initiative for which the agency requests funding in FY 1994: the creation of a LAN (Local Area Network) computer system. The agency requests funding in the amount of $95,000 for the LAN. Such networks have been included in the budget requests of all the mental retardation institutions. The agency maintains that such a network would allow the easier transfer of clinical data, increased efficiency among administrative and support services, and would allow agency staff to spend more time in direct service to clients rather than in doing paperwork. The agency's request would fund 537.0 FTE positions, or 26.0 FTE positions less than in FY 1993. The request would also provide for a salary turnover rate of 3.62 percent.

The Governor recommends FY 1994 operating expenditures of $18,068,524 at Parsons State Hospital and Training Center. Proposed funding from the State General Fund is down by 7.7 percent from the FY 1993 recommendation, while proposed funding from all funds is up by one-half of one percent. The Governor's recommendation calls for an average daily census of 235 clients,

which is seven less than proposed by the agency in its FY 1994 request. The Governor's FY 1994 recommendation would fund 534.0 FTE positions, or 3.0 FTE positions less than requested by the agency. The Governor recommends the FY 1994 deletion of 2.0 more FTE positions than proposed by the agency; the positions recommended for abolition are clerical positions. The Governor's recommendation calls for a salary-turnover rate of 5.3 percent, where the agency requested a rate of 3.62 percent. The Governor's recommendation provides funding for classified step-movement or unclassified-merit increases, annualization of a one-percent cost-of-living adjustment approved by the 1992 Legislature for half of FY 1993 and longevity bonuses for eligible employees.

House Subcommittee Recommendation

The Subcommittee concurs with the Governor, with the following changes and comments:

1. Restore 1.0 FTE Bookkeeper position and funding in the amount of $22,582 ($8,580 from the State General Fund and $14,002 in Title XIX funding).

2. The Subcommittee notes that the agency requested $95,000 in FY 1994 for a local-area computer network (LAN). Funding for the project was not recommended by the Governor. The agency maintains that such a network would allow easier transfer of clinical data, increased efficiency in the provision administrative and support services and would allow agency staff to spend more time in direct service to clients, rather than in doing paperwork. The Subcommittee toured Parsons State Hospital, and had an opportunity to look at much of the agency's computer equipment, some of which is on the verge of obsolescence. The Subcommittee encourages the agency to present a proposal for this project to the Joint Committee on Computers and Telecommunications, and, should that Committee recommend the project, present the project to the 1994 Legislature for reconsideration.

SUBCOMMITTEE REPORT

Agency: Winfield State Hospital and Training Center **Bill No.** -- **Bill Sec.** --

Analyst: Colton **Analysis Pg. No.** 663 **Budget Page No.** 634

Expenditure	Agency Est. FY 93	Governor's Rec. FY 93	Subcommittee Adjustments
State Operations:			
State General Fund	$ 13,722,261	$ 13,542,707	$ --
Title XIX	14,675,729	14,407,696	--
General Fees Fund	944,275	944,275	--
Other Funds	55,875	55,971	--
Subtotal	$ 29,398,140	$ 28,950,649	$ --
Other Assistance (All Funds)	--	--	--
Subtotal--Operating	$ 29,398,140	$ 28,950,649	$ --
Capital Improvements:			
State Institutions Bldg. Fund	434,831	434,832	--
TOTAL EXPENDITURES	$ 29,832,971	$ 29,385,481	$ --
Average Daily Census	318	320	--
FTE Positions	872.5	872.5	--

Agency Estimate/Governor's Recommendation

The agency estimates FY 1993 operating expenditures of $29,398,140. Of the estimate, $13,722,261 is from the State General Fund and $15,675,879 is from special revenue funds. The estimated expenditures are equal to those approved by the 1992 Legislature, except for the inclusion of $22,609 in Foster Grandparent (Federal) Funds, carried over from FY 1992. The agency estimate would fund expenditures for salaries and wages in the amount of $24,140,544; expenditures for contractual services in the amount of $3,324,963; expenditures for commodities in the amount of $1,744,662; and capital outlay in the amount of $174,034. The agency estimates an FY 1993 turnover rate of 7.2 percent.

The Governor recommends operating expenditures in FY 1993 of $28,950,649 for Winfield State Hospital and Training Center. The Governor's recommendation effectuates reductions both from the agency's FY 1993 estimate and from expenditures approved by the 1992 Kansas Legislature. According to the Governor, reductions were effected in funding for overtime, temporary staffing, fees--professional services and miscellaneous other operating expenditures, although funding was added to reduce salary turnover, for staff health insurance and for other salary adjustments. The Governor concurs with the agency request for the inclusion, in FY 1993, of Foster Grandparent (Federal) funds that were carried over from FY 1992.

House Subcommittee Recommendation

The House Subcommittee concurs with the Governor's recommendations.

93-5265

ATTACHMENT 6

SUBCOMMITTEE REPORT

Agency: Winfield State Hospital and Training Center **Bill No.** 2047 **Bill Sec.** 9

Analyst: Colton **Analysis Pg. No.** 663 **Budget Page No.** 634

Expenditure	Agency Req. FY 94	Governor's Rec. FY 94	Subcommittee Adjustments
State Operations:			
State General Fund	$ 13,538,396	$ 12,538,562	$ --
Title XIX	16,478,739	15,259,475	--
General Fees Fund	1,047,487	963,610	--
Other Funds	33,266	33,266	--
Subtotal	$ 31,097,888	$ 28,794,913	$ --
Other Assistance (All Funds)	3,500	--	--
Subtotal--Operating	$ 31,101,388	$ 28,794,913	$ --
Capital Improvements:			
State Institutions Bldg. Fund	29,400	--	--
TOTAL EXPENDITURES	$ 31,130,788	$ 28,794,913	$ --
Average Daily Census	304	287	--
FTE Positions	948.5	862.5	--

Agency Request/Governor's Recommendation

The agency requests FY 1994 operating expenditures of $31,101,388. Of the requested operating funds, $13,541,896 is from the State General Fund and $17,559,492 is from special revenue funds. Requested expenditures from the State General Fund are down by 1.3 percent below the FY 1993 estimate, while proposed expenditures from all funds are increased by 5.8 percent.

The agency request would fund 948.5 FTE positions, an increase of 76.0 FTE positions from the FY 1993 estimate. (**Staff Note**: Winfield State Hospital is the only MR institution to propose new positions for FY 1994. KNI and Parsons have proposed reductions in FTE positions in accordance with the SRS/MHRS downsizing plan, which is summed up in the separate Legislative Research Department systemwide memorandum on Kansas' mental retardation institutions. The SRS plan called for a reduction in FTE positions at Winfield in FY 1994, to 862.5 FTE positions.)

Requested salary expenditures ($25,434,770) in the agency's FY 1994 budget request exceed those in the FY 1993 estimate by 5.4 percent. Included in the request is a 2.5 percent classified step-movement or unclassified merit increase, annualization of the mid-year one percent base salary increase approved in the current year, as well as longevity bonuses for eligible employees. The agency requests a turnover rate of 7.2 percent, the same as in FY 1993. The agency requests expenditures for contractual services and commodities in the amount of $5,286,385 in FY 1994, an increase of 4.3 percent over the FY 1993 estimate of $5,069,625. The agency has called attention to its **request for $43,200 for braces and upper-extremity orthotic devices**; the agency reports that prices for such items have risen by 500 percent, and that the purchase of such items is no longer reimbursed

by Medicaid. The agency requests capital outlay funding of $376,823. (**Staff Note**: $47,200 is requested for equipment for the agency's local-area computer network (LAN). The agency requested funding for such a network in its FY 1993 budget document, but the funding was neither recommended by the Governor nor approved by the 1992 Legislature. The agency was apparently able to finance the LAN through savings in other areas of its budget.)

The Governor recommends FY 1994 expenditures for Winfield State Hospital and Training Center in the amount of $29,794,913, of which $12,538,562 is from the State General Fund and $16,256,351 is from special revenue funds. The recommendation is $2,313,475 less than what the agency requested. Funding from the State General Fund is reduced by 7.4 percent, with respect to the FY 1993 recommendation, while recommended spending from all funds falls by one-half of one percent. The FY 1994 recommendation contemplates an FY 1994 FTE position limitation of 862.5 FTE positions and a continued reduction in average daily census. The Governor does not recommend the new initiatives requested by the agency.

House Subcommittee Recommendation

The House Subcommittee concurs with the Governor's recommendations, with the following comment:

1. The Subcommittee learned that while KNI has 6.5 trainee positions, and Parsons State Hospital 13.5, Winfield State Hospital has, at the moment, 71 trainee positions (the Governor's recommended budget calls for 63 trainees). While the Subcommittee recognizes that Winfield does have a number of medically-challenged clients, the Subcommittee does not believe that this fact alone justifies the $4,239,257 difference in recommended expenditures between Winfield and KNI.

Institution	FY 1994 Recommended Expenditures
Winfield	$ 28,794,913
KNI	24,555,656
Difference	$ 4,239,257

The Subcommittee believes that this is especially true in light of the fact that Winfield has only 21 more clients than KNI, and a significant number of people at KNI are also medically challenged. The Subcommittee considers it exaggerated that Winfield State Hospital has over 10 times the number of trainees as KNI, and urges the agency to study how efficiencies can be effected, and staffing levels brought more into line with the other institutions. The Subcommittee expects for changes to be made in this regard, and cautions the agency that the matter will be studied again by next year's Legislature.

93-5269

1993 H.B. 2047

Section 2

Department of Social and Rehabilitation Services
Community Mental Retardation Issues

Representative James E. Lowther
Subcommittee Chair

Representative George R. Dean

Representative Delbert L. Gross

Representative David J. Heinemann

Attachment 7

SUBCOMMITTEE REPORT

Agency: SRS -- *Community Mental Retardation Services* **Bill No.** 2087 **Bill Sec.** 17

Analyst: Howard **Analysis Pg. No.** 585 **Budget Page No.** 546

Expenditure Summary	Agency Est. FY 93	Gov. Rec. FY 93	Subcommittee Adjustments
All Funds:			
State Operations	$ 216,457,566	$ 204,764,429	$ --
Local Aid	56,060,011	56,060,011	100,000
Other Assistance	926,858,413	924,491,432	(974,511)
Subtotal -- Operating	$ 1,199,375,990	$ 1,185,315,872	$ (874,511)
Capital Improvements	6,597,638	6,718,657	--
TOTAL	$ 1,205,973,628	$ 1,192,034,529	$ (874,511)
State General Fund:			
State Operations	$ 86,768,271	$ 80,655,985	$ --
Local Aid	47,938,715	43,450,485	--
Other Assistance	248,642,451	251,911,782	(405,007)
Subtotal -- Operating	$ 383,349,437	$ 376,018,252	$ (405,007)
TOTAL	339,263	339,263	--
	$ 383,688,700	$ 376,357,515	$ (405,007)
FTE Positions	3,955.7	3,917.0	--

Agency Estimate/Governor's Recommendation

The Division of Mental Health and Retardation Services estimates expenditures of $33,633,663 for community mental retardation services in the Division of Mental Health and Retardation Services in FY 1993, including $24.1 million from the State General Fund. In addition, the agency estimates expenditures of $25.1 million in the medical assistance budget for the HCBS-MR waiver, and expenditures of $37.1 million for the ICF-MR program. The estimate for the HCBS-MR waiver is a reduction of $1.5 million from the approved amount reflected slower than budgeted movement from the state hospitals.

The Governor concurs with the agency estimate of funding in the Division of Mental Health and Retardation Services. The Governor recommends $21.1 million for the HCBS-MR waiver in FY 1993, a reduction of $5.5 million from the approved amount. The Governor's recommendation is intended to reflect the rate of actual client placement from the state hospitals. The Governor concurs with the request for ICF-MR funding in FY 1993.

ATTACHMENT 7-2

House Subcommittee Recommendations

The House Subcommittee concurs with the recommendations of the Governor with the following adjustments:

1. Delete $405,007 from the State General Fund ($974,511 All Funds) in the Home and Community Based Services program for the mentally retarded (HCBS-MR). The recommendation reflects savings associated with slower than anticipated client movement from state hospitals to the community.

2. Add $100,000 from the SRS Contingency Fund in FY 1993 for one-time placement costs associated with the movement of clients from state hospitals to the community. The Subcommittee heard testimony that one-time placement costs range from $2,000 to $5,000 per client for purchases such as furniture and appliances. The recommendation is based on average one-time costs of $3,250. The Subcommittee recommends that expenditures on behalf of any single client be limited to a maximum of $5,000.

SUBCOMMITTEE REPORT

Agency: SRS -- *Community Mental Retardation Services* **Bill No.** 2047 **Bill Sec.** 2

Analyst: Howard **Analysis Pg. No.** 585 **Budget Page No.** 546

Expenditure	Agency Req. FY 94	Governor's Rec. FY 94	House Sub. Adjustments
All Funds:			
State Operations	$ 251,376,577	$ 213,255,017	$ 154,000
Local Aid	69,610,613	61,809,212	1,625,500
Other Assistance	1,083,190,497	990,200,803	2,475,489
Subtotal -- Operating	1,404,177,687	$ 1,265,265,032	$ 4,254,989
Capital Improvements	16,657,656	4,002,648	--
TOTAL	$ 1,420,835,343	$ 1,269,267,680	$ 4,254,989
State General Fund:			
State Operations	$ 104,010,489	$ 86,898,538	$ 61,543
Local Aid	66,002,398	49,174,617	--
Other Assistance	341,901,740	282,497,384	1,594,993
Subtotal -- Operating	511,914,627	$ 418,570,539	$ 1,656,536
Capital Improvements	6,957,759	73,313	--
TOTAL	$ 518,872,386	$ 418,643,852	$ 1,656,536
FTE Positions	4,375.2	3,903.5	6.0

Agency Request/Governor's Recommendation

The Division of Mental Health and Retardation Services requests expenditures of $44,181,208 for community mental retardation services in the Division of Mental Health and Retardation Services in FY 1994, including $34.7 million from the State General Fund. The request includes $3.1 million for medical and therapeutic services in the community, $2.1 million to expand the family subsidy/family support program, and $1.0 million for selected service enhancements in basic grants. In addition, the agency requests expenditures of $35.2 million in the medical assistance budget for the HCBS-MR waiver, and expenditures of $39.3 million for the ICF-MR program. The request for the HCBS-MR waiver includes funding for the movement of 84 clients from state hospitals to the community and funding to serve 235 community clients from the community waiting list.

The Governor recommends expenditures of $35.2 million for mental retardation services in the Division of Mental Health and Retardation Services in FY 1994, including $25.8 million from the State General Fund. The recommendation includes funding to serve 75 new clients from the community waiting list with federal vocational rehabilitation funding as well as funding to annualize FY 1993 placements. For the HCBS-MR waiver, the Governor recommends $28.8 million, a

reduction of $6.4 million from the agency request. The recommendation includes funding of $2.3 million for the placement of 84 clients from state hospitals to the community. No funding is recommended to serve additional community clients from the community waiting list. The Governor recommends $37.1 million for the ICF-MR program in FY 1994, the same amount as in FY 1993.

House Subcommittee Recommendation

The House Subcommittee concurs with the Governor with the following adjustments:

1. The Subcommittee believes that adequate funding of community-based services and provisions to reduce the size of the community waiting list must accompany any decision to downsize or close a state hospital. The Subcommittee reviewed the five-year plan designed to eliminate the community waiting list and provide an array of services in the community. The recommendations below reflect the Subcommittee's commitment to improving the quality and availability of community services both for clients from state hospitals as well as for clients already residing in the community. The Subcommittee believes there must be commitment to community services prior to agreement on closure of a state hospital, and that funding from the state hospital must flow to the community.

   The Subcommittee also heard testimony regarding certain "bottlenecks" in the community system which have impeded the movement of clients from state hospitals. Specifically, conferees identified the need for start-up funds for one-time purchases such as furniture and appliances. Community mental retardation centers also experience cash-flow problems through unreimbursed pre-placement expenses and delays in Medicaid reimbursement for client services after clients are placed. The Subcommittee strongly believes that the community system must be stabilized. A major shift in the way services are delivered to the MR/DD population also requires certain assurances of quality.

   In light of these considerations the Subcommittee makes the following recommendations designed to address the community waiting list, funding constraints faced by community providers of MR/DD services, and issues of quality of services in the community.

2. The Subcommittee believes strongly that at the same time hospital clients are moved to the community, efforts must be made to reduce the size of the waiting list for community services. The primary waiting list, which consists of persons who would accept community services immediately if they were available, includes 955 persons. Of that total number, 656 are living in the community without any current services, 134 are in state institutions, 72 are private ICF-MR facilities, and 93 receive some limited services. By the natural process of persons finishing special education, the waiting list for adult services grows by approximately 200 persons each year. Without adequate provisions for adult day and residential services, the gains made by clients in special education programs can be lost while they wait for these services. Therefore, the Subcommittee recommends the following:

Add $1,000,000 from the State General Fund ($2,450,000 All Funds) to serve 235 community clients off the community waiting list for six months in FY 1994 through the Home and Community Based Services (HCBS-MR) Medicaid waiver. This funding will provide for costs of ongoing day and residential services for 235 persons.

This recommendation, coupled with the Governor's recommendation to place 84 clients from state hospitals to the community in FY 1994, and her recommendation to place 75 clients from the community waiting list in vocational rehabilitation activities, means an increase in the number of clients receiving services through community providers of 394 in FY 1994. The Subcommittee strongly believes that this commitment to reducing the community waiting list must be a continuing effort viewed as an essential piece of the decision to close a state hospital.

3. To address "bottlenecks" in the community service system as a first step towards downsizing state hospitals the Subcommittee recommends the following steps to support the community infrastructure and facilitate service delivery to both state hospital clients and community clients:

   a. Add $273,000 from the SRS Contingency Fund for one-time placement costs associated with the movement of 84 clients from state hospitals to the community in FY 1994. The Subcommittee heard testimony that one-time placement costs range from $2,000 to $5,000 per client. The Subcommittee recommendation is based on an average cost of $3,250 per person. The Subcommittee recommends a proviso limiting maximum expenditures for any one client to $5,000.

   b. Add $352,500 from the SRS Contingency Fund for one-time costs associated with the provision of services to 235 new clients from the community waiting list. Since one-time costs are less for clients in the community than for state hospital clients, the recommendation assumes average expenditures of $1,500 per client for pre-placement planning and expenses, and one-time client expenses.

   c. Transfer $1.0 million from the SRS Contingency Fund to a Community Provider Guarantee Fund. This funding would allow the Kansas Development Finance Authority (KDFA) to issue approximately $5.0 million in bonds. The Guarantee Fund would be used to provide loans to community providers either as a pool or on a stand alone basis for remodeling costs, the purchase of equipment, preplacement expenses including staff time, and other one-time and start-up expenses. The Guarantee Fund could also be used for cash flow purposes but would not be used for ongoing operating expenses. The Subcommittee recommends that the interest be reinvested to provide a permanent revolving fund.

4. To ensure oversight and quality in the delivery of community services, the Subcommittee recommends the following:

   a. Add $1,000,000 from the SRS Contingency Fund for one-time funding for training services in the community. This recommendation provides one-time money for staff training for direct service staff in community mental retardation agencies. The Subcommittee realizes that training must be an ongoing initiative and was informed that subsequent to actual experience in capturing training costs and developing a database, these costs can be built into the reimbursement rates for both waiver and non-waiver clients. This recommendation assumes agencies will use a training curriculum developed and field tested by the Kansas University Affiliated Program, and assumes the equivalent of one full-time training coordinator for approximately 65 full-time direct care staff. The Subcommittee would note that the 1992 Legislature recommended $495,000 from the State General Fund for one-half year of training services in FY 1993. The Governor's recommendation for FY 1994 included no funding for training.

   b. Add $61,543 from the State General Fund ($154,000 All Funds) and 6.0 FTE to provide quality assurance staff in each area of the state. The Subcommittee believes it is essential to have staff to work with community programs to assure quality of programs and client services. The recommendation funds six staff positions for six months in FY 1994. The 1992 Legislature approved funding for six staff in FY 1993 to cover one-half of the state. This recommendation would provide quality assurance staff statewide by the end of FY 1994.

5. Add $1,000,000 from the State General Fund for medical and therapeutic services for clients in the community. Clients moving from state hospitals to the community lose some medical services that were available to them in the state hospital but which are not currently covered under the Medicaid program. This recommendation would expand the Medicaid waiver to provide these essential services and would also provide funding for necessary medical and therapeutic interventions for those clients not served through the waiver. The Subcommittee would note that a portion of these funds will be matched with federal Medicaid funds for eligible clients. The Subcommittee believes that these services are essential in providing a continuum of care in the community, and that clients should not lose access to certain medical services merely because they have moved to a community setting. Examples of these services include specialized durable medical equipment; frequent replacement of glasses and hearing aids; physical therapy; speech therapy; and behavioral interventions. The Subcommittee notes that the agency requested $3.1 million for medical and therapeutic services, but notes that there is no current data on what the actual cost of these services might be since they have never been available through the Medicaid program for persons in the community.

6. The Subcommittee is supportive of the concepts contained in the Developmental Disabilities Reform Act recently recommended for introduction by the House Appropriations Committee. In addition, in light of the recommendations in this report regarding support for the community system and the Subcommittee's recommendations regarding the closure of a state hospital, the Subcommittee recommends including language in H.B. 2047 directing SRS to begin the planning process towards consolidation from three to two state hospitals.

7. Delete $405,007 from the State General Fund ($974,511 All Funds) in the Home and Community Based Services program for the mentally retarded (HCBS-MR). The recommendation reflects adjustments to the FY 1994 base budget to reflect FY 1993 savings.

8. The Subcommittee recommends that community mental retardation centers, as a condition of receiving funding to serve additional clients, be required to incorporate parents, guardians and consumers into planning and ongoing care decisions.

9. The Subcommittee heard testimony regarded a proposed pilot project to be developed by the Department of Education, in cooperation with SRS, to address the educational services and supports for family and community life for children currently living in state institutions. The pilot project would be directed towards the development of child-centered plans tailored to the child's individual needs, including services and supports for an inclusive environment to meet their educational needs in their natural or surrogate families. Separate pilot projects would be developed to address children with: dual diagnosis of mental retardation and mental illness; medically fragile needs; behavioral disorders; and mental retardation/developmental disabilities. The pilot projects would include control groups of students currently in special education programs as well as pilot groups of children leaving state institutions. The pilot envisions funding through both special education and SRS community services funding, and would provide for reports back to the Legislature by February 1, 1994. The Subcommittee is cognizant of the many issues involved in serving children with special needs in the local school system and believes these pilot projects could provide important information towards developing community service models. The Subcommittee recommends that additional information be provided to the Senate Subcommittee or during the Omnibus Session regarding funding adjustments which might be necessary to accommodate these projects.

10. The Subcommittee firmly believes that reform of the MR/DD system must be a partnership that involves the state, service providers, consumers, families, advocates, and local and federal government. The Subcommittee believes that the counties must be full partners in this plan and that county participation in funding of these programs is an essential component in providing a full array of services. The Subcommittee would note that although counties may levy up to two mills for MR/DD services, most levy less than one mill. It is the Subcommittee's belief that ongoing state support for the expansion and development of community services must be accompanies by county-level commitment and financial support of community-based services.

House Appropriations Committee

Subcommittee on Mental Health and Mental Retardation Issues

Report and Recommendations on the Question of Hospital Closure

Representative James E. Lowther
Subcommittee Chair

Representative George R. Dean

Representative Delbert L. Gross

Representative David J. Heinemann

Minority Report

Representative Delbert Gross

REPORT OF THE MAJORITY

The State of Kansas currently is faced with a critical public policy choice with respect to the education, care and treatment of people with developmental disabilities. This choice involves the decision to close one of the state's three mental retardation hospitals as part of an ongoing effort to emphasize community-based services for individuals with mental retardation and developmental disabilities. The state has made important strides in the past several years in expanding and improving residential services for individuals with mental retardation and developmental disabilities (MR/DD).

The community services system has developed the capacity to serve a wider range of individuals -- including persons with disabilities who were once thought to be in need of permanent institutional care -- as the result of a continuing effort to reduce the census of Kansas' three mental retardation hospitals. Now, Kansas is rapidly reaching the point at which it makes less and less economic sense to continue to operate three hospitals for people with MR/DD.

The decision to close one of the state's MR hospitals is totally consistent with the mainstream of thinking in the developmental-disabilities field today. Twenty-four states have shut down 67 large MR facilities since 1960, and 34 are scheduled to be closed in 18 states by June 30, 1995.

In view of the changes that are taking place nationwide in how persons with disabilities are perceived, Kansas, too, is moving to discard the old myths and stereotypes. Persons with profound mental retardation are being provided individualized supports designed to make community inclusion a reality. In the context of rising costs, increased belief that persons with disabilities should be served in their own communities and the realization that the only real cost savings that can occur from reduced institutional census is through closure, we believe that the State must pursue the consolidation of MR facilities from three to two.

The issue of downsizing and closing mental retardation institutions in Kansas is not a new one. In addition to KNI, Parsons and Winfield, Kansas had a fourth mental retardation institution, Norton State Hospital, until the closing of that institution on October 1, 1988. An FY 1989 Legislative Research Department memorandum noted: "the Legislature has budgeted reductions in overall institutional populations in recent years, in an attempt to serve certain clients in a more appropriate environment in the community and to provide higher staffing ratios for the clients remaining at the institutions." The memorandum noted further that in spite of client movement into community settings, costs for operating the institutions had not decreased proportionately. The memorandum stated that "it is impossible to decrease costs proportionate to client movement unless major portions of a hospital are closed, due to the fixed nature of many costs at the institutions."

The process of reducing the number of clients with mental retardation and developmental disabilities at the state's mental retardation institutions continued in 1990, when the Kansas Legislature ordered the Department of Social and Rehabilitation Services (SRS), Division of Mental Health and Retardation Services (MHRS) to implement the movement of fifty clients from the state hospitals into community settings. The process continued in 1991, and in 1992, a subcommittee of the House Appropriations Committee, in its report on the budgets of SRS and the MR/MH institutions, suggested further reductions in census at all three mental retardation hospitals.

In response to the mandate of the 1990 Legislature and suggestions made during the 1991 Legislative Session, SRS/MHRS drew up a plan for census reduction at all three MR hospitals. The plan called for the reduction in the combined end-of-year census of all three hospitals from

approximately 965 clients in FY 1991 to approximately 828 clients in FY 1993. (The current census at all three hospitals is approximately 908 clients.)

Reductions in staff were planned at all three institutions in tandem with reductions in census. The plan called for a decrease in the number of FTE positions at all three hospitals, from 2,445.0 FTE positions in FY 1991 to 2,215.0 FTE positions in FY 1994.

The 1992 House Appropriations Subcommittee commented that it had studied the matter of client movement from institutions to community settings intensively over two legislative sessions. It concluded that, "in the case of a majority of the state's citizens with mental retardation and developmental disabilities, care in a community-based setting is preferable to residence in the mental retardation institutions." The Subcommittee added that, while it [was] cognizant of the fact that the state mental retardation hospitals offer[ed] excellent care to clients living in the institutions, it believed "that community settings offer[ed] care opportunities that are more client-centered, in which clients' families have more involvement in care decisions, and which, in the long-run, will prove much less expensive than residential care at the three mental retardation institutions."

On the subject of funding for community services, the Subcommittee noted that the Home-and Community-Based Services Medicaid (HCBS-MR) waiver would allow "a dramatic expansion of the services . . . available to clients in community-care systems." The waiver allows funding of such services at the Medicaid match rate of approximately 59 percent, which is a higher federal reimbursement rate than provided by traditional community funding sources. The Subcommittee believed that the enhanced funding [would] "allow community-care systems to provide the level of services required by patients who formerly would have required institutionalization."

The 1992 Subcommittee expressed its opinion that "the process of *downsizing* (*i.e.*, closing beds) at all three institutions contemporaneously [was] a mistake." It served, in the view of the Subcommittee, "only to create insecurity among families of clients regarding the care for their loved ones," and "create[d] a demoralizing uncertainty among employees at MR institutions with regard to the future of their jobs." The Subcommittee felt, too, that "downsizing, unless done on a dramatic scale, d[id] little to save money at the state institutions, and, in the short term, even increase[d] costs per client-day."

The 1992 Subcommittee also noted that, in the course of deliberating the MR institutions' budgets, it had heard testimony on "the progress of client movement into the community." The Subcommittee expressed its "encouragement at the success of the project to date." The Subcommittee felt that "one key element of this success [was] client-centered planning of transition from institutions into the community." Client-centered planning was practiced during the *Community Integration Demonstration Project* at Winfield State Hospital and KNI. The Subcommittee noted that, "of the clients who have moved out of those hospitals as part of the project, none have had to return to the institutions and are being successfully integrated into community-based care systems." Our Subcommittee, too, has had an opportunity to review the results of the Community Integration Demonstration Project, *i.e.*, the development of client-centered planning for movement into the community, and we are encouraged by the development this process, which aims at *putting people first*, and not buildings or programs.

The Subcommittee noted that the 1991 Interim Task Force on SRS recommended the closure of one of the state's MR hospitals.

The Subcommittee wrote that, in light of those factors, the time had come to build up the community-care system for people with mental retardation and developmental disabilities, and to consolidate the number of state MR institutions from three to two. It wrote that the process of determining which hospital to close should be driven by what is best for the system's clients and their families. The 1992 Subcommittee also developed several other factors to consider; these factors are attached to the Subcommittee report as Appendix I.

This Subcommittee agrees, with the 1992 Subcommittee, that a decision on closure must be made, and we feel that it would be a mistake to delay the closure decision any longer.

We have, however, learned that the pace of client movement is lagging considerably behind what had been projected. The bottleneck, we learned in our testimony, is due to several major factors: a) difficulties in funding start-up costs for clients making the transition into the community; b) lack of funding for training for community-care staff; and c) problems in funding medical and therapeutic costs that are not covered by the HCBS-MR waiver. Our report on community mental retardation services, therefore, recommends additional resources to address these needs, and to support the continued movement of individuals with MR/DD into appropriate community placements. Over 135 residents in the three hospitals are awaiting placement, and 635 people are on the primary waiting list for community services, as opposed to institutional placement. It is apparent that Kansans with MR/DD and their families are opting for community services, and that they shall continue to do so in the future. Our recommendation on closure is linked to the increased support that we have recommended in community funding. We feel that there cannot be one without the other.

A report was presented to the Subcommittee by the Department of Social and Rehabilitation Services that ranked the hospitals in terms of their appropriateness for closure. The report ranked Winfield State Hospital as the institution most appropriate for closure. It was followed by KNI and Parsons.

However, the Subcommittee feels that, when considering the factors listed by the 1992 Subcommittee, and taking into account the complexity and ramifications of our decision, it would be best to close Kansas Neurological Institute. Our overriding concern has been the welfare of individuals with MR/DD and their families. In addition, four other primary factors have influenced our decision:

a) the network of community services available in the Topeka area (the Subcommittee has been particularly impressed with the work of the Topeka Association of Retarded Citizens, and considers this group a model for other community-care service providers);

b) the commitment of the KNI administration and staff toward integrating their clients into the life of the community; we believe that if the transition to community-based services is to work, commitment on the part of the institution is vital;

c) the possibility of future uses for the buildings at the KNI campus; the Subcommittee urges the Joint Committee on State Building Construction to study the possibility of renovating KNI for use by other state agencies. The Subcommittee feels that this might allow the state to forego leasing a substantial amount of

office and storage space in the Topeka area, and could help to effect long-term savings for the State; and

d) the impact of closure on the community of the chosen hospital, which would, in the opinion of the Subcommittee, be proportionately smaller on Topeka than on Winfield. The Subcommittee also believes that it would be relatively easier for state workers from KNI to move into other civil service positions in the Topeka area, than it would be for workers from the Winfield area.

In dealing with the closure issue, those favoring closing Winfield State Hospital have expressed concern about the quality of care at Winfield. There have also been questions about the hospital's commitment to an inclusionary philosophy and the community placement plan. In addition, they point to the higher cost of operation at Winfield, which they believe is due to relative inefficiency of management at the institution.

The Subcommittee, while it does not necessarily disagree with these concerns, believe's that they are changeable -- that they can and should be changed. In light of these concerns, the Subcommittee strongly urges SRS to take whatever steps are necessary, including the use of an outside consultant to:

1. Ensure that the quality of care at Winfield State Hospital is on par with the other hospitals.

2. Ensure that the Winfield State Hospital is totally committed to the plan for community placement.

3. Ensure that management practices at Winfield State Hospital are changed in order to bring costs per client-day down to a level comparable to the other two hospitals.

The Subcommittee recognizes the impact that its decision will have upon the hospital's clients, their families, the hospital's employees and their families. It is, therefore, the expectation of the Subcommittee that the process of person-centered planning will continue to determine those individuals who are placed in community settings, that community placement will remain voluntary, and that it will be done only when appropriate.

The Subcommittee also recommends that measures be taken in order to ease the impact of closure on the institution's employees and their families. These could include, and would not be limited to:

- Urging the heads of all state agencies to give primary consideration to qualified employees from KNI.

- Allowing workers to use "company time" in order to attend job interviews, and paying for lodging expenses incurred on trips for job interviews.

- Establishment of an Employment Assistance Program, the aim of which would be to teach job-seeking skills, and when necessary, to help facilitate employees' entry into other career skills.

- Studying the possibility of introducing a bill, like the one pending currently in the Oklahoma Legislature that would allow displaced employees to buy additional service time towards their retirement in the state employees' retirement system; allowing KPERS vestiture after five years to workers threatened with lay-off.

- Lowering the age-plus-service formula for retirement eligibility to 70 for affected workers.

- Development of a detailed closure plan with projected staff reductions in order to allow employees to plan ahead, to prevent layoff anxiety and stop the spread of rumors.

- Budgeting money in the budget of the institution to be closed for job retraining. (A possible source is the SRS Contingency Fund.)

- Modifying job training at the institutions to provide a community focus; placement of as many clients as possible in the economic region affected by closure.

The Subcommittee recommends that the Legislature's committees on Commerce and Labor and Industry study these recommendations, develop other recommendations and, when necessary, prepare draft legislation that would implement these changes.

It is the Subcommittee's recommendation that closure take place when the combined census of all three hospitals reaches a point at which the maintenance of three institutions is no longer necessary. In any event, closure should not take place before June 30, 1997.

MINORITY REPORT

Before I begin to spell out the ways in which my opinion on the issue of hospital closure differs from that of my colleagues, I want first to point out the areas in which we are in agreement. I think that my colleagues and I, in spite of our difference of opinion on which hospital it would be most appropriate to close, all feel that we have based our decisions on what is in our hearts, and have made those decisions after deep reflection. I think that we all believe that community-based care is what the future holds for Kansas citizens with mental retardation and developmental disabilities. Like all Kansans, people with mental retardation and developmental disabilities are entitled to the same rights, dignity and respect as people without disabilities.

Like all citizens, they have the right to live, work, play, learn and receive care in the least restrictive environment possible.

Like all citizens, people with mental retardation and developmental disabilities have the right to be near their families and friends, and to live in environments that respect their privacy and their individuality.

I believe that my colleagues and I agree that the move toward deinstitutionalization has, thus far, been done on a piecemeal basis, and that, if the implementation of home- and community-based care is to be successful, a plan must be adopted that will ensure adequate funding of community services. I believe that my colleagues and I are in agreement that the State has a duty toward individuals with MR/DD, whether they are in institutions or in the community, to ensure that those individuals enjoy safe, clean and healthy environments; that services provided to those individuals meet, at least, minimum quality standards; and that the State must work in partnership with the individuals served, their families and friends, advocacy groups, service providers and local and federal governments to ensure that a comprehensive, flexible and cost-effective array of services be developed for people with MR/DD.

To that end, the Subcommittee has recommended the introduction and passage of the Developmental Disabilities Reform Act. We have also recommended substantial additions to the Governor's recommended financing for home- and community-based services for people with MR/DD. This money will go toward improving start-up services for both hospital and community clients, training for caregivers and medical-therapeutic services for community clients. Like my colleagues, I realize that this additional spending may be difficult for some members of the Committee to accept, given the State's present fiscal constraints.

However, I believe (and I think that my colleagues in the majority report agree) that the handwriting is on the wall as far as institutional care for citizens with MR/DD goes. Federal courts have found that keeping individuals with MR/DD in institutions, without providing viable and adequate care alternatives in the community, is a violation of those individuals' rights under the Fourteenth Amendment of the U.S. Constitution. A number of states, including Oklahoma, North Dakota, Alabama, Pennsylvania, New York and Tennessee have been ordered by federal courts to close institutions and develop community-based services for individuals with MR/DD.

A federal court in Oklahoma, apparently unconcerned with the financial impact on the State of Oklahoma, signed off on packages of "Cadillac services" for people with MR/DD. Those service packages were designed by a consultant, who like the court, was not overly worried about the fiscal constraints that face state legislators and administrators. The *per diem* cost of these "Cadillac services" in Oklahoma is about $267.

ATTACHMENT 9

By contrast, the *per diem* cost of services provided to people moved from Kansas institutions into the community under the Community Integration Demonstration Project was about $119.

I believe that the lesson is clear: either we act now to build up the network of community-based services for people with MR/DD, or we may, in the near future, be ordered to do so by a federal court, at a cost of tens or hundreds of millions of dollars.

Like my colleagues, I view the closure of a mental retardation institution as inevitable. I've had the opportunity to visit all three state institutions, and have been impressed with the dedication of the institutions' staffs to their clients' needs and well-being. However, less and less people want to live in institutions, and fewer and fewer families--as they become familiar with the services that can be provided in the community--want their loved ones to be institutionalized. Few people with MR/DD who graduate from the school system want to enter an institution. Unless the State acts to build up the community system, the list of people waiting for community services will continue to grow. Meanwhile, the number of people in institutions will, through natural attrition, continue to shrink. The institutions, with their large overhead, will, on a per capita basis, become more and more expensive to operate. From a fiscal perspective, it is clear (and I believe that here, too, I am in agreement with my Subcommittee colleagues) that the State should move toward closure of an institution, and invest the savings that will, in the long term, be realized in improving the community-care network.

With my fellow Subcommittee members, I feel that this has been one of the hardest, if not the hardest, decision that I've been faced with since becoming a member of the Kansas House of Representatives. I honor the thoughtfulness and the dedication that my colleagues have shown in examining this question, which, for everyone, has been an agonizing one.

* * * * *

On the question of which hospital should be targeted for closure, however, I must differ with the other members of the Subcommittee.

In reaching a decision on which hospital would be the most appropriate for closure, I feel that I have two primary duties. My first duty is to Kansas citizens with mental retardation--both those in the institutions and those in the community-services system. My second duty is to the taxpayers of Kansas.

I have looked at both Kansas Neurological Institute and Winfield State Hospital and Training Center, and, as I said before, have been impressed by the commitment and dedication that the hospitals show to their clients. However, when I ask myself--"Which hospital is the most appropriate environment for people with mental retardation and developmental disabilities?"--I have to conclude that it is KNI.

There are several reasons for this:

- KNI, of the two hospitals, has been the most innovative and forward-looking in its approach to treating those with developmental disabilities and mental retardation.

- The trend in the treatment of people with MR/DD is moving away from *separation* and toward *integration*. This is why the State is moving away from the institutional model and toward the community model. However, while building up the community-service network in Kansas, we must not forget the clients who remain in the institutions. They, too, have the right to participate in community life to the greatest degree possible. I have been impressed by the degree to which KNI has attempted to involve its institutional clients in events outside the hospital's walls. I feel that for clients remaining in an institution, KNI would be the best institution to keep open, because of its aggressive commitment to allowing its clients to participate in community life.

- I feel that, for the institutional clients, there are simply more *opportunities* for involvement in community life (sports events, concerts, recreational facilities etc.) in the Topeka area than in the Winfield area. This too, speaks for retaining KNI.

- Topeka has a more developed medical services delivery system for institutional clients with severe medical challenges. If we want to provide the best services possible not only for community clients, but for institutional clients as well, this speaks for retaining KNI.

- If we are going to keep open an institution, we have the duty to ensure that clients remaining in that institution receive top-notch care. Information presented to the Subcommittee indicates that, of the two hospitals, KNI has the least difficulty in filling medical/professional and direct-care positions. This is another reason to retain KNI.

- If we are going to retain institutional environments for the care and treatment of people with developmental disabilities, we should ensure that the institutions that are retained are the most modern and of the highest quality that we are able to provide. Winfield has the older facility. It has several multi-story buildings that pose barriers to people with limited mobility. KNI, on the other hand, is a campus composed only of one-story buildings. Barriers to people with limited mobility are fewer at KNI. In this respect, KNI, of the two hospitals, provides the *least restrictive environment*, and as such, should be the one retained.

- The Subcommittee was informed *repeatedly* during the course of hearing testimony that, of medically-challenged individuals and behaviorally-challenged individuals, the behaviorally challenged will be the most difficult to place in the community. This leads me to conclude that people with behavioral challenges may be among the last to find suitable community care settings. On October 16, 1992, at Winfield, there were about 29 clients with the psychiatric label, out of a census of 359, or about 8.1 percent of clients. On the other hand, at KNI, there were approximately 145 individuals with the psychiatric label out of a census of 330, or about 43.1 percent of all clients. This leads me to conclude that KNI's staff has the most experience in dealing with clients with behavioral disorders. As such, it will be better equipped to deal with clients who are the most likely to need institutional settings. For me, this is another reason to retain KNI.

- Those speaking against the closure of Winfield often cite Winfield's non-ambulatory and medically-challenged clients. However, KNI also has a

significant number of non-ambulatory clients (38 percent of the clientele) and individuals who require daily nursing procedures (8.6 percent). KNI's staff has experience in dealing with such clients. As I have already pointed out, services to such clients--should they continue to require institutionalization, are likely to be better in the Topeka area than in the Winfield area. Therefore, for me, this criterion has little relevance in the decision that the Committee must make.

- From the point of view of providing community services, it is, I believe, also better to retain KNI. The Subcommittee is recommending closure of an institution, among other things, on the premise that closing an institution will free up dollars so that more community services can be provided. Winfield's FY 1993 recommended budget is $28,950,649. KNI's is $24,686,186. Winfield's recommended FY 1993 budget is 17.3 percent greater than KNI's, even though Winfield's census has only 20 more clients than KNI. If we evaluate the savings that are to be generated in order to provide community services to people with MR/DD, I believe that the numbers speak for themselves, and favor the retention of KNI.

As I said before, my second duty, after my duty to do the right thing for people with MR/DD, is to the taxpayers of Kansas. If we look at the closure question in this light, the numbers, again, are as plain as day, and point to Winfield as the hospital that should be targeted for closure.

Using data provided by the hospitals, the Subcommittee was presented with budget figures for the three state institutions that reflect the services that they provide to other state agencies, and that they receive from other state agencies. KNI provides food service to Topeka State Hospital, the Topeka Correctional Facility and the SRS Comprehensive Screening Unit; it receives laundry services from Topeka State Hospital. Winfield State Hospital provides utilities to the Winfield Correctional Facility. Adjusted budget figures, staff-to-client ratios and costs per client-day are shown in the following table.

	Parsons	KNI	Winfield
Population (February 23, 1993)	266	311	331
Number of Employees (February 22, 1993)	544.0	817.2	903.5
Adjust for KNI's Food Service to TSH	--	(33)	--
Adjust for TSH's Laundry Services to KNI	--	10	--
Adjust for WSH's Utilities to WCF	--	--	--
ADJUSTED FTE POSITIONS	544	794.2	903.5
Staff-to-Client Ratio (Unadjusted)	2.05	2.63	2.73
ADJUSTED STAFF-TO-CLIENT RATIO	2.05	2.55	2.73
Gov. Rec. FY 1993 Budget	$17,984,079	$24,686,186	$28,950,649
Adjust for KNI's Food Service to TSH	--	(1,547,903)	--
Adjust for TSH's Laundry Services to KNI	--	354,812	--
Adjust for WSH's Utilities to WCF	--	--	(127,266)
Subcommittee Adjustments	22,582	--	--
ADJUSTED FY 1993 REC. BUDGET	$18,006,661	$23,493,095	$28,823,383
Cost per Client-Day (Unadjusted)	$185.23	$217.47	$239.63
ADJUSTED COST PER CLIENT-DAY	$185.46	$206.96	$238.57

Looking at the table, several things are evident.

1. Winfield's FY 1993 recommended budget, with adjustments, is $5,330,288 higher than KNI's. This is a difference of 22.7 percent. In spite of this, however, Winfield has only 20 more clients than KNI. The Department of Social and Rehabilitation Services has presented testimony, which I find credible, that KNI and Winfield serve "very similar residents." SRS has also expressed its opinion that the differences in the numbers of medically fragile clients is inadequate to explain the difference in the agencies' recommended budgets. I agree. From this standpoint, the numbers indicate that Winfield is the most appropriate institution to close.

2. In spite of the fact that the hospitals do serve a similar clientele, the adjusted staff to client ratio is 7.1 percent higher at Winfield than at KNI. This would seem to indicate that KNI (whose population of *severely and profoundly* retarded clients is very similar to Winfield's) is *providing services more efficiently* than Winfield. And yet, my colleagues have targeted KNI for closure. To me, this does not make sense.

3. Adjusted *per diem* costs per client at Winfield are 15.3 percent higher than at KNI. Once again, I submit that the differences in the number of medically-challenged individuals at the two hospitals are insufficient to explain the significant difference in the cost per client-day. If Kansas must retain institutional care settings for people with MR/DD, and it appears for the time being that we must, I believe that we should retain the one at which the best services can be provided in the most cost-effective manner. The numbers speak for themselves, and point to retaining KNI.

Numbers provided to the Subcommittee by the hospitals show that administrative costs at KNI make up about 3.3 percent of the agency's budget. At Winfield, administrative costs are about 3.4 percent. Annual administrative costs per client at KNI are about $2,663; at Winfield, $3,087. This is a *difference of 15.9 percent.* Here, too, the numbers favor KNI.

Information provided to the Subcommittee has also shown that Winfield State Hospital has *71 non-FTE trainees* at the present time (63 are recommended in the Governor's budget), while KNI has 6.5 trainees, and Parsons State Hospital 5.5. I am not satisfied that the differences in the clientele at the two hospitals are significant enough to explain why Winfield needs *over ten times the number of trainees as the other two hospitals.* Once again, I am led to conclude that in terms of relative efficiency, KNI is doing a better job.

The Subcommittee members who favor closing KNI have stated that the differences in relative efficiency between the two hospitals are changeable factors, and that SRS should take whatever measures necessary, including engaging an outside consultant, in order to bring costs per client-day at Winfield in line with the other two state hospitals. Rather than paying a consultant to make Winfield efficient, we could simply retain the better hospital -- KNI.

I represent a small city in a rural area, and know what impact the loss of a major employer can have on a town's economy. I know too, from Hays' experience, how a community can

pull together to overcome adversity, and emerge from a crisis even stronger and more prosperous. I am not recommending that Winfield, or the hospital's employees, be left out in the cold. I think that the Legislature must direct all practicable aid to Winfield in order to ease the impact of closure on the city and its residents.

However, as I said at the beginning, my duties are first, to Kansas citizens with mental retardation and developmental disabilities, and second, to the taxpayers of Kansas. Compared with the impact our decision will have on Kansas citizens with MR/DD, economics are and must remain a subordinate issue.

I know that, for the time being, it will be necessary to continue to provide institutional care alternatives as Kansas makes the switch from institutional to community care. Since we must do this, I think that we should retain the better institution. For me, the better institution is KNI. Likewise, I believe that we owe it to the taxpayers of Kansas to keep that institution that provides quality care in the most cost-effective manner possible. That institution is KNI.

To close KNI would be to close an institution that is forward-looking and innovative. It would be to close a hospital that provides quality treatment in an efficient manner. To close KNI would, for me, be unreasonable, and would go against my duties to Kansas citizens with MR/DD and the taxpayers of Kansas. For these reasons, I am unable to support the majority report. If an institution is to be targeted for closure, I believe that it should be Winfield State Hospital.

APPENDIX I

FACTORS AFFECTING THE CHOICE OF AN MR INSTITUTION FOR CLOSURE

- The impact that the hospital's closing would have on the hospital's clients and their families.
- The availability of appropriate community-care settings and supports in the service area of each institution.
- The effect of closing an institution on the institution's staff, their families, and the institution's host community.
- The efficiency of the institution's operation.
- Employee availability and labor costs.
- The ability of the institution's home community to deal with the economic consequences of closure as determined by a financial-impact study; the community's general economic health, long-term labor trends in the community and employment alternatives for workers at the institution are among the factors that should be considered in this regard. In studying this factor, the finding of the Ad Hoc Committee that two jobs would be created for every client placed into the community should be kept in mind.
- The savings to the State of Kansas that would be generated by closing the institution. (It is the understanding of the Subcommittee that savings realized from the downsizing and closing of the institution would be used to augment community-care programs for people with mental retardation and developmental disabilities.)
- The state of the institution's physical plant, and future capital costs that would be incurred by the state if the institution were kept open.

From Rep. Rock

ISSUES RELATING TO STATE HOSPITAL CLOSURE

Issue 1. Does WSH&TC provide the same quality and level of care as KNI?

Fact: Winfield State Hospital & Training Center has provided the highest level of care and has a better compliance record over the past five years in comparison to KNI.

Perhaps the best measure of quality is a review of annual surveys, as conducted by the Health Care Financing Administration (HCFA). The HCFA regulations are divided into eight Conditions of Participation, which are major conditions in the measurement of quality. In addition, there are 389 individual "tag numbers" of compliance that fall within the Conditions of Participation as subcategories. These are measures of quality in meeting specific standards of HCFA. The table is attached (Attachment 1) that clearly indicates that WSH&TC has achieved a better historical compliance rate than KNI. Since 1988, WSH has not been found out of compliance on any Conditions of Participation, while KNI has not met compliance 5 times.

Since 1988, WSH&TC has been noted in findings of non-compliance on 136 Tag Numbers, while KNI has been in non-compliance on 144 Tag Numbers. Both facilities are out on one HCFA Tag Number at this time. What can be inferred from those statistics? It is clear that both institutions had problems in certain areas, but both institutions have met the challenge in quality of care.

Perhaps a better indication of this comparison of quality of care may be a review of a letter sent to Senator Rock by three health care surveyors, dated February 18, 1993. This letter was an unsolicited response to newspaper articles that quoted community care providers during the week of testimony before the Subcommittee. The letter reads as follows:

"*Dear Senator Rock,*

We have just heard of the unfavorable review that was related to your office with regard to the provision of services to persons with retardation at Winfield State Hospital and Training Center.

This information is shocking to the three of us, as we are former surveyors with the Kansas Department of Health and Environment and have had occasion to survey this institution several times over the prior three years. You should know that at no time did

ATTACHMENT 10

we ever find the care at this hospital any different than care provided at either Kansas Neurological Institute or Parsons State Hospital & Training Center. Please understand that problems exist at all three institutions intermittently, however the care at Winfield State Hospital and Training Center has not been, during our tenure as surveyors, at the described level of clients sitting, doing nothing and listening to music being played loudly over speakers.

Thank you for your time,

Ronald B. Phifer, Former Regional Director MR/MH/DD - KDHE
Michaele Yan Hook, Former Regional Director MR/MH/DD - KDHE
Jessica L. Phifer, Former Asst. Regional Director MR/MH/DD"

Issue 2. Is there really a difference in client needs in comparing WSH and KNI? Do both use contracts for therapy services?

Fact: Both WSH&TC and KNI have historically had little success in recruiting staff therapists. KNI's patient population has significantly fewer medical needs than the population at WSH&TC (Graph 1). However even with a much smaller need for professional services KNI must still contract with an agency for its registered physical therapists. WSH&TC patient population has much greater physical and functional needs (Graph 2), and, therefore, the need for trained medical professionals is higher as well.

In a recent comparison of the residents of WSH&TC and those in KNI it was noted that 167 persons residing at Winfield were receiving direct, hands-on physical therapy services, while approximately 30 at KNI were receiving such (Graph 3). The attached chart reflects the various therapy and health service items that are being provided at WSH&TC (Attachment 2).

Issue 3. Does Winfield State Hospital & Training Center receive community support for health and medical needs of WSH residents?

Fact: Attached to this narrative are letters from several doctors, clinics, and William Newton Hospital which indicate past services provided to WSH&TC. These letters also indicate the wide variety of specialty medical services available and the desire of those persons to continue their service to WSH&TC whenever needs arise. Please review these letters marked Attachment 3.

Issue 4. Has WSH&TC taken action to ensure that quality of care is being provided to the best extent possible?

Fact: In November, 1991, staff at WSH&TC began a Quality Assurance program to track the medical and direct care services provided by staff. There have been no deficiencies or tag numbers out of compliance in medical services since the inception of this QA program. WSH is the only facility with a program of this extent, and this program ensures that quality of care is provided to the greatest extent possible.

Issue 5. Is "Winfield State Hospital is not inclusionary," or they are not making attempts to place persons in the community?

Fact: A January 8, 1993, memorandum (Attachment 4) from Russ Pittsley of Central Office refutes this issue entirely. In comparison to Parsons and KNI, WSH&TC has the fewest Essential Lifestyle Plans left to complete, and has the highest number of plans in the hands of community providers. Simply stated, WSH has been the most aggressive in their attempt to place persons in the community. To infer that WSH has not been inclusionary or is not attempting to place persons in the community is not based on the facts as presented by SRS. The following Table reflects the status of community placement plans by the three institutions:

		Step I	Step II	Step III	Step IV
WSH	Number	7	25	2	5
	Percent	18	64	5	13
KNI	Number	19	20	2	3
	Percent	43	45	5	7
PSH	Number	16	13	3	4
	Percent	44	36	8	11

Clearly, WSH&TC has been the most responsive in the placement process. WSH has the lowest number and percentage of plans to complete (Step 1), the highest number and percentage of plans in the hands of community providers (Step 2), and has the highest number and percentage of plans completed and in the scheduling of transition (Step 4). In fact, Winfield has been the most inclusionary of all three institutions.

Issue 6. Is Winfield State Hospital is more expensive and is less efficient than KNI?

Fact: Winfield does have a higher per diem than KNI, but they are not inefficient. Simply stated, it is not possible to compare the efficiency of operations by comparing the per diem cost of the three hospitals. To even attempt to use a per diem cost to measure efficiency of operations without measuring and taking into account dramatic medial and client characteristics is a serious flaw in the analysis. There is a reason that WSH has 60 nurses on staff, compared to 30 at KNI and 2 at Parsons. Simply stated, client needs will dictate the level and number of skilled care providers required -- which will dictate the per diem cost of resident and the facility. Mr. Vega presented information on Developmental Disability Profile scores of the three institutions in his testimony. The results indicate that WSH is serving the clients with the most severe health problems, having the fewest adaptive skills, and were second in overall maladaptive problems. Those client attributes indicate that WSH residents require more skilled and intensive attention by care providers, and level of care translates to dollars.

Issue 7. Efficiency of operations is actually better at WSH&TC than KNI.

Fact: The per diem cost per resident is increasing at a greater rate for KNI ($213.77 in 1992 to $228.65 in 1993) than WSH&TC ($246.37 in 1992 to $253.09 in 1993). In fact, even with the down-sizing in process, WSH has been able to lower their per diem cost to $245.12 (effective January, 1993). WSH also has the lowest use of sick leave, lowest cost of staff training, second lowest staff/resident ratio (behind PSH), and lowest percentage of medical turnover. These facts were presented in Cotton's testimony.

Issue 8. How important are the availability of supports and services offered by CMRC's? In his rebuttal testimony, Mr. Vega stated, "This is not significant for this project as each CMRC will develop individual services for each resident transferred to community services in their area."

Fact: CMRC's in different regions of the state will have different medical and professional supports and availability. Those that have lived in Western Kansas know that Mr. Vega can "wrap around" with services that are available, but much of Kansas is already medically underserved. In fact, during public testimony one of the Subcommittee members stated, "It appears that Topeka has a leg up on the rest of the state."

The attached chart (Attachment 5) illustrates the services and capacity of specific services in the 45 mile radius around the three institutions. It is extremely clear that the highest level of service and support settings are located in the KNI service area. A second chart (Attachment 6) shows the additional services that are available if the radius is expanded to 60 miles. For additional discussion on this issue, please refer to Cotton's testimony on Decision Factor 2.

Regarding Mr. Vega's statement concerning CMRC's developing individual services, it is important to note that in order for existing CMRC's to expand or new ones to open, funding is the bottom line. Up-front dollars are required to accomplish the task as set out in the SRS Report -- double funding. Some counties use mill levies to provide some funding for mental health and mental retardation facilities. As an example, Cowley County levied 1.253 mills in 1993. When you multiply the mill levy by the assessed valuation, Cowley County will provide $180,000. To make a comparison, should Shawnee County levy an equivalent 1.253 mills and multiply that by their assessed valuation

($791,728), it is not surprising to note that Shawnee County facilities would receive over $990,000. This comparison, although not statistically pure, points to the fact that rural counties are far less equipped to provide funding sources for the existing CMRC's to expand or new CMRC's to open.

HCFA ANNUAL SURVEYS
WSH/KNI COMPARISON

The following is a recap of the HCFA annual surveys beginning with 1988. The HCFA regulations are divided into eight Conditions of Participation, and 389 individual tag numbers. Conditions of Participation carry the most weight, with tag numbers next in significance.

HCFA Conditions of Participation
found Out-of-Compliance

	WSH	KNI
1988	0	3
1989	0	0
1990	0	2
1991	0	0
1992	0	0

HCFA Tag Numbers
found Out-of-Compliance

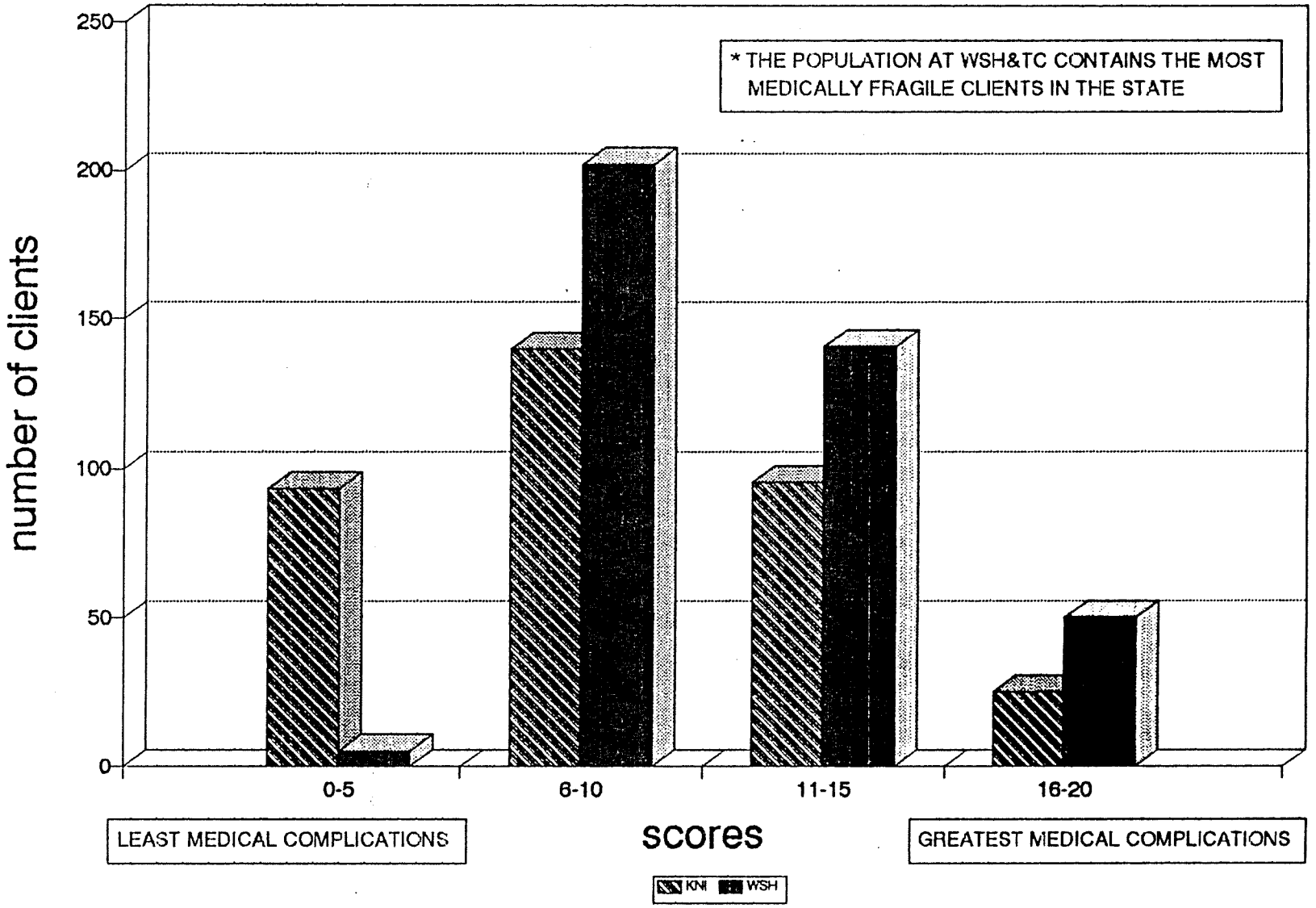
	WSH	KNI
1988	61	52
1989	41	39
1990	15	24
1991	14	15
1992	4	13

Currently both facilities are out on <u>one</u> HCFA tag #.

Attachment 1

10-7

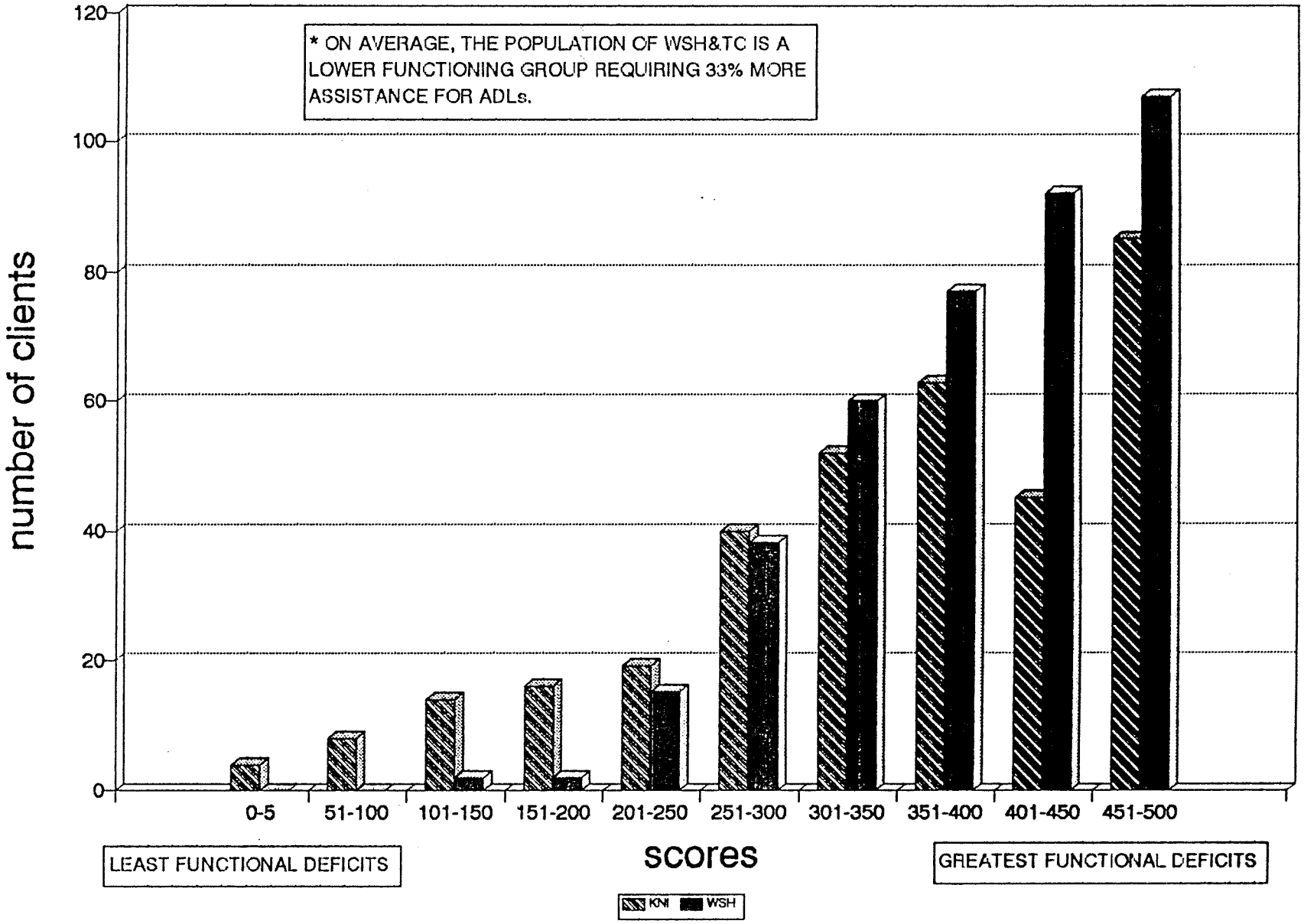
DISTRIBUTION OF DDP SCORES
HEALTH STATUS



Graph 1

8-01

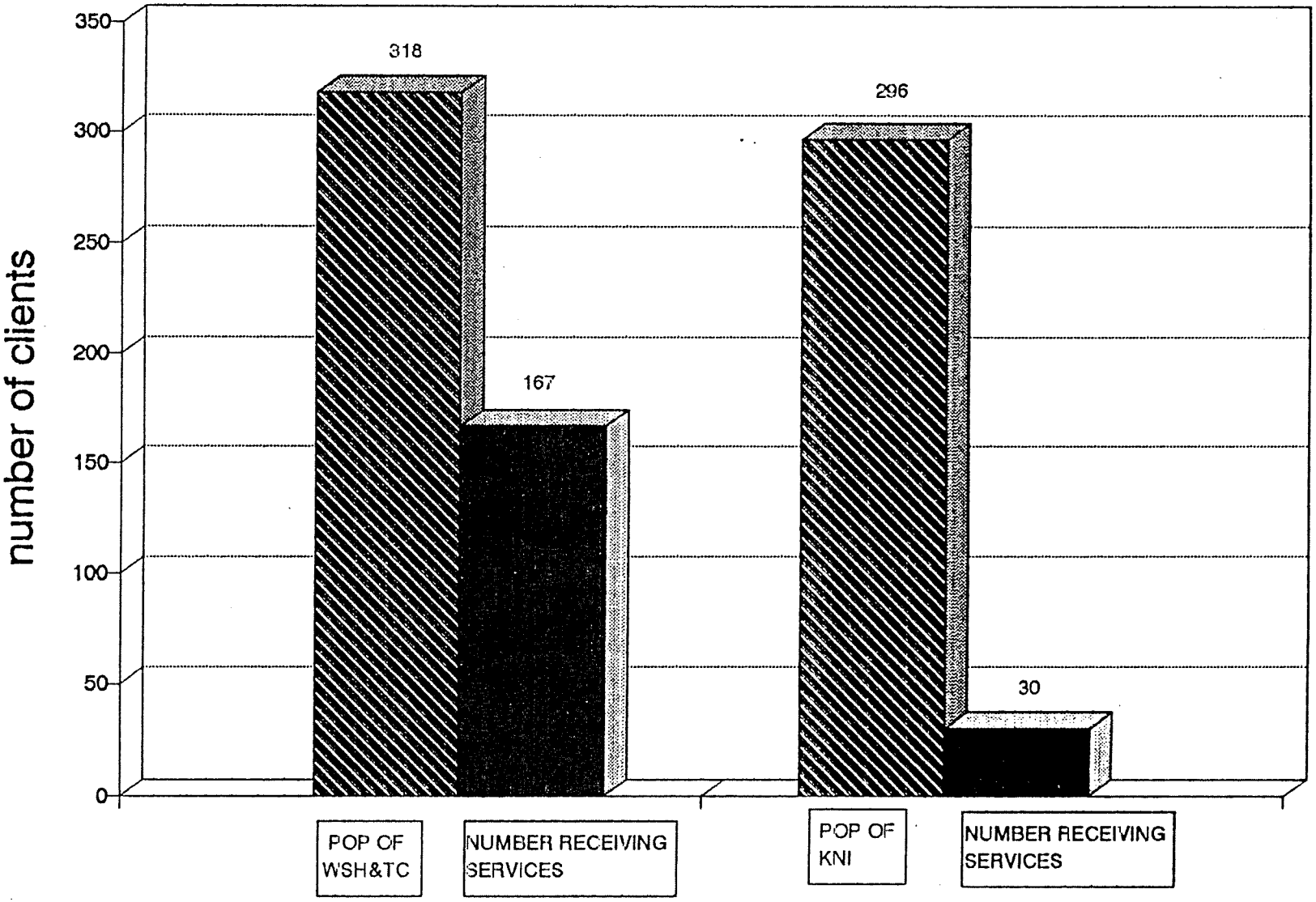
ADAPTIVE BEHAVIOR SCORES
(FUNCTIONAL ABILITIES)



Graph 2

10-9

CLIENTS RECEIVING DIRECT PHYSICAL THERAPY SERVICES



Graph 3

10-10

WINFIELD STATE HOSPITAL & TRAINING CENTER
Physical and Rehabilitative Services

84% of all clients have adaptive feeding programs and/or equipment (excluding residents with gastrostomy tubes).

236 clients require the use of a wheel chair.

84 clients require individualized physical management/positioning programs.

79 clients require the fabrication and fitting of upper extremity orthotics.

84 clients require the fabrication and fitting of lower extremity orthotics.

32 clients have custom-molded wheelchairs to address both function and skeletal deformities.

40% of all clients have custom switches adapted to their specific needs.

12 residents have been evaluated and fitted with quadruped positioners; a positioner developed by Liberty Healthcare therapists to address the unique needs of specific medical concerns.

146 clients have had videofluoroscopic swallow studies done to determine the risks involved in oral feeding. Of those identified, 46 were revealed to have aspiration difficulties.

The majority of the clients identified as having aspiration difficulties were able to be managed through positioning, diet, and by meal presentation techniques.

Currently, 74% of all clients at WSH have occupational therapy services and 40% have physical therapy services.

Attachment 2

The William Newton

MEMORIAL HOSPITAL

1300 E. FIFTH AVENUE :: WINFIELD, KANSAS 67156

316-221-2300

RICHARD H. VAUGHT
ADMINISTRATOR

February 18, 1993

The Honorable Senator Dick Rock
State Capital Building
Room 135 North
Topeka, KS 66612

Dear Senator Rock:

In its report analyzing factors considered in ascertaining which institution to close, the sub-committee refers to "..the lack of comprehensive and specialized medical services within the Winfield community." I can't image on what basis this statement was made and I wish to rectify any misconception that has resulted.

The William Newton Memorial Hospital and medical staff, which comprise the nucleus of healthcare services within the community, provide a very broad range of high quality medical services. A summary of services rendered is attached, along with a roster of our active and consulting medical staff. In addition to the comprehensive range of primary and secondary level services offered here, Winfield is fortunate to be within a forty mile proximity of the finest tertiary level medical complex in the state. Our medical staff's ties to the Wichita physician community has historically been strong and is only getting stronger today. The Snyder Clinic here in Winfield is now owned by St. Francis Regional Medical Center and the hospital is currently forging close ties with St. Francis with the common goal of continually improving healthcare services available here in Winfield. Our hospital has also recently constructed a new medical facility for the purpose of developing specialty and sub-specialty satellite clinics. We are currently providing physician services in the areas of oncology, nephrology, neurology and ophthalmology, in addition to services of an audiologist. All of our services have been and will continue to be available to Winfield State Hospital and Training Center.

Of greatest significance, our hospital has always been supportive and has worked closely with WSH&TC. We stand ready to continue this relationship in the future. Our common goal with WSH&TC is to work together to meet the medical needs of both residents and staff. This is evidenced by such endeavors as our role in helping develop an in-house respiratory care unit at WSH&TC and playing a major role in the recent development of occupational health services with the goal of reducing workman's compensation expense. The Winfield Area Emergency

Attachment 3

10-12

Medical Service has developed a very close working relationship with WSH&TC. The same is also true of our full-time hospital based radiologist, Dr. Dean Shippey.

Also of note, the appointment of a local physician, Dr. Al Bird, as Medical Director of WSH&TC has only served to further strengthen our relationship.

The bottom line is the William Newton Memorial Hospital and medical staff are providing quality, comprehensive and specialized medical services in support of the WSH&TC. We stand committed to working with WSH&TC staff and residents now and in the future.

Sincerely yours,

Jane Gary Duncan
Chairman of the Board

Richard H. Vaught
Administrator

RHV:hg

cc: The Honorable Rand Rock

10-13
3 (cont'd)

WIL AM NEWTON MEMORIAL HOSPITAL SERVICES

NURSING UNITS:
Medical/Surgical Units (85)
Skilled Nursing Unit (14)

OBSTETRICAL/NURSING:
Birthing Unit/Bed
Candle Light Dinner
Grandparent Visitation
Infant Safety Seat Program
Rooming In/Private Rooms
Sibling Visitation
Sibling Classes
Parenting Classes
Pre & Post Natal Information
Lamaze

PATHOLOGY SERVICES:
Histopathology
Cytology
Autopsy

PHARMACY:
Metabolic Support Service
Registered Pharmacist 7 Days
Unit Dose System

RADIOLOGY:
Computed Tomography (CT)
Echocardiography
Mammography (low dose)
Nuclear Medicine
Routine X-Ray
Special Procedures
Ultrasound/Sonography
Vascular Radiography
Magnetic Resonance Imaging

REHABILITATION SERVICES:
Cardiac/Pulmonary Rehab
Cognitive Rehabilitation
Electromyography (EMG)
Phase IV Exercise Program
Speech/Language Pathology
Occupational Therapy
Audiology/Hearing Services

CRITICAL CARE UNIT:
Medical/Surgical ICU
Isolation Unit
Teletrace Service

OCCUPATIONAL HEALTH SERV:
Preplacement Health Scr.
Drug Screening
Employee Assistance Program
Occupational Health Nursing
Computerized Back Testing
Carpel Tunnel Screening
Nerve Conduction Studies

OTHER SPECIAL SERVICES:
Dietetic Counseling Services
Meals On Wheels
Medical Social Services
Patient Advocacy Service

AMBULATORY CARE SERVICE:
One Day Surgery
O/P Drug I.V. Therapy
O/P Blood Transfusing
Cataract Surgery

CARDIOLOGY:
Computerized EKG Interpretation
Computerized Stress Testing
Electrocardiograms (EKG/ECG)
Electroencephalography (EEG)
Nuclear Cardiology Studies
24 Hour Holter Monitoring

LABORATORY:
Blood Bank
Chemistry
Hematology
Microbiology
Referral Lab
Transfusion Service
Special Chemistry

EMERGENCY SERVICE:
24 Hour Emergency Room
Advanced Life Support
Type II EMS
Out-Patient I.V. Therapy

HEALTH PROMOTION/HEALTHWAYS
Exercise Classes
Coronary Risk Profile
Corporate Health/Wellness Services
Fitness Assessment/Exercise
Health Risk Appraisal
Risk Reduction Programs
Smoking Cessation
Stress Management
Disease Prevention Services

ONCOLOGY SERVICES:
Cancer Center of Kansas
Satellite Office
Physician's Appointments
Blood Disorder Treatment
Chemotherapy
Radiation Scheduling
C.T. & M.R.I. Imaging
Laboratory
Hospitalization

ENDOSCOPY SERVICE:
Bronchoscopy
Esophgagastrointestinal
Colonoscopy
Sigmoidoscopy

SURGERY:
Gastrointestinal
Gynecological
Oncological
Ophthalmological
Oral Surgery
Orthopedic
Thoracic
Urological
Vascular
Laser Surgery
Laparoscopic Surgery

RESPIRATORY SERVICES:
Contract/Consult Services
Pulmonary Lab
Respiratory Care
Ventilatory Support
Home Medical Equipment

HOME HEALTH CARE:
Skilled Nursing Visits
Personal Care Service
Lifeline
Home Medical Equipment
Physical/Therpy
Occupational Therapy

EDUCATION:
Cardiac Teaching
Diabetic Teaching
Lamaze/Parenting/Sibling
Nursing "CEU" Providership
Speakers Bureau

PHYSICAL THERAPY:
Therapeutic Ultra Sound
Electrical Stimulation
Electromyography (EMG)
Neurology
Nerve Conduction
Brace Fitting
Wound Care

VOLUNTEER SERVICES:
Teen Volunteers
WNMH Auxiliary
Pink Lady/Red Coat Program
Gift Shop/Snack Bar

10-14
3 (cont'd)

WILLIAM NEWTON MEMORIAL HOSPITAL MEDICAL STAFF
1300 East 5th
Winfield, Kansas 67156

* Admitting Privileges

Aucar, Alfredo, M.D., ENT	2508 Edgemont Ark City, KS 67005	442-1710
*Bhargava, Baikunth, M.D., Urology	1317 Wheat Road Winfield, KS 67156	221-3200
*Bird, Alvin D., D.O., Family Practice	1700 East 9th Winfield, KS 67156	221-0110
Cannon, Michael W., M.D., Internal Medicine	818 N. Emporia, Suite 403 Wichita, KS 67214	262-4467
Dakhil, Shaker R., M.D., Internal Medicine	818 N. Emporia, Suite 403 Wichita, KS 67214	262-4467
*Gibson, Don, D.O., Family Practice	1700 East 9th Winfield, KS 67156	221-0110
Goodpasture, Hewitt, M.D., Internal Medicine	818 North Emporia Wichita, KS 67214	264-3505
Grene, Robert, M.D., Ophthalmology	655 N. Woodlawn Wichita, KS 67208	684-5158
Hynes, Harry, M.D., Internal Medicine	818 N. Emporia, Suite 403 Wichita, KS 67214	262-4467
*James, Richard, D.P.M., Podiatrist	1317 Wheat Road Winfield, KS 67156	221-3200
*Johnson, Theresa, M.D., Surgeon	1317 Wheat Road Winfield, KS 67156	221-3200
*Jones, Terry, M.D., Family Practice	1317 Wheat Road Winfield, KS 67156	221-3200
*Kaul, Anand, M.D., Internist	1317 Wheat Road Winfield, KS 67156	221-3200
*Nemmers, David, M.D., Internist	1317 Wheat Road Winfield, KS 67156	221-3200
*Price, Peter, M.D., Surgeon	1401 Main Winfield, KS 67156	221-3161
*Samuel, Chandy, M.D., Surgeon	1211 East 5th Winfield, KS 67156	221-6100
Samuel, Shanthi, M.D., Pathologist	1300 East 5th Winfield, KS 67156	221-2300

10-15

3 (cont'd)

WILLIAM NEWTON MEMORIAL HOSPITAL MEDICAL STAFF
1300 East 5th
Winfield, Kansas 67156

Singh, Girvar, M.D., Ophthalmology	2508 Edgemont Ark City, KS 67005	221-4300
Shippey, Dean U., M.D., Radiologist	1300 East 5th Winfield, KS 67156	221-2300
*Sturich, Jorge M., M.D., Family Practice	1211 East 5th Winfield, KS 67156	221-6100
*Turner, Wade, M.D., Internal Medicine	1317 Wheat Road Winfield, KS	221-3200
*Wells, Bruce, M.D., Family Practice	221 West 8th Winfield, KS 67156	221-3350
*Winblad, J. Kent, M.D., Obstetrician	1211 East 5th Winfield, KS 67156	221-6100
*Winblad, John, M.D., Family Practice	1211 East 5th Winfield, KS 67156	221-6100
Vaidya, Shrikrishna, M.D., Neurologist	1215 East Hartford Ponca City, OK 74601	762-7701
Zatzkin, Jay B., M.D., Internal Medicine	818 N. Emporia, Suite 403 Wichita, KS 67215	262-4467

10-16
3 (cont'd)

ACTIVE DENTAL STAFF

Barr, W. S., D.D.S., Dentistry	1421 East 1st Winfield, KS 67156	221-4806
Bradley, P. L., D.D.S., Dentistry	First National Bank Building Winfield, KS 67156	221-0260
Marcotte, Alan, D.D.S., Dentistry	222 East 9th Winfield, KS	221-7737
Parsons, D. C., D.D.S., Dentistry	123 East 10th Winfield, KS 67156	221-0730
Poltera, R. L., D.D.S., Dentistry	107 College Winfield, KS 67156	221-9580
Rupp, R. P., D.D.S., Dentistry	2107 East 12th Winfield, KS 67156	221-7230
Sawyer, S., D.D.S., Dentistry	2116 East 9th Winfield, KS 67156	221-0221
Seitz, J. D., D.D.S., Dentistry	2522 N. Summit Arkansas City, KS 67005	442-7752

10-17

3 (cont'd)

WINFIELD STATE HOSPITAL AND TRAINING CENTER
February 18, 1993

List of physicians who assist with medical needs:

WINFIELD
WNMH - 221-2300

DR. SAMUEL - 221-6100

DR. BHARGAVA - UROLOGIST - 221-3200

DR. BIRD - O.D. -221-0110

DR. WHITE - OPTOMETRIST - 221-0740

DR. JAMES - PODIATRIST - 221-3200

DR. BOXBERGER - CARDIOLOGIST - Sees at Medical Arts - 684-3838

ARKANSAS CITY

ARK CITY HOSPITAL - 442-2500

DR. AUCAR - ENT - 442-1710

DR. SINGH - OPTOMETRIST/CATARACT - 442-4300

WICHITA

ST. FRANCIS - DR. BARTAL - 268-5000

WESLEY MEDICAL CENTER -
OB-GYN - 688-3120
SURGERY - 688-3210
ORTHO - 688-3200
VIDEOSALLOW - 688-7900

WICHITA CLINIC - DAY SURGERY - 686-9349

HENTHORN -OCULAR PROTHESIS - 688-5235

DR. COHEN - OPTOMETRIST - 684-5158

DR. REYNOLDS - RHEUMATOLOGY, INTERNAL MEDICINE - 689-9400

DR. BARTAL - ORTHOPEDIC - 268-5040

DR. LUCAS -ORTHOPEDIC - 268-5000

DR. PENCE -ORTHOPEDIC - 689-9468

DR. KNEIDEL -ORTHOPEDIC - 2677-1924

10-18
3 (cont'd)

DR. MENKING MANDFORD -ENDERINOLOGIST - 689-9336

DR. R. LUTZ - ENDOCRINOLOGIST - 688-2362

DR. GUTHERIE - DIABETES - 687-3100

DR. OLGA TATPATTI - DIABETES - 687-3100

DR. CHO - CHROMOSOMAL - 688-2362

DR. LEITNER -ENT - 689-9227

DR. CUMMINGS - ENT - 686-6608

DR. SCHLIECHER -DERMATOLOGIST - 689-9344

DR. PASSMAN - DERMATOLOGIST - 685-4395

DR. SANFORD - UROLOGIST - 689-9185

DRS. SUERO,JONE - PULMONARY - 681-3371

DRS. BLOXHAM,THOMAS -PULMONARY - 689-9215
PRE-REGISTER- 689-9207

DR. KNIGHT - GASTROENTEROLOGIST - 263-0296

DR. SHARPIRO - NEUROLOGICAL - 263-0348

DR. JM ALLEY -DENTIST - 265-0856

SURGICARE - 685-2207

DR. KAHN - OPHTHALMOLOGIST - 689-9316

DR. ABAY - SURGERY, NEUROLOGICAL - 267-2622

DONNA SWEET - INTERNAL MEDICINE - 261-2622

DR. WINN - OPHTHALMOLOGIST - 265-7241

DR. ALMONTE/RADALFO - OB-GYN - 686-3791

DR. MORGAN - OB-GYN - 722-5141

DR. GILMARTIN - NEUROLOGIST - 686-6866

DR. LEVINE - PSYCHIATRIST

10-19

3 (cont'd)

ST. FRANCIS REGIONAL MEDICAL CENTER

Sister M. Sylvia Egan, SSM
President and Chief Executive Officer

Dick
2-18
Mike

February 18, 1992

Senator Dick Rock
Kansas State Senate
Topeka, Kansas

Dear Mr. Rock:

During the past three years, we have developed a strong working relationship with William Newton Memorial Hospital and the Snyder Clinic in Winfield. By working together, the availability of specialty medical services in Winfield has improved and additional full-time physicians have been recruited to practice and live in the community.

Because of our close working relationship, we are concerned about the analysis and recommendations of the Department of Social and Rehabilitation Services regarding the possible closure of Winfield State Hospital. While we are not opposed to the concept of deinstitutionalization, we question some of the statements and conclusions in the SRS report and believe that a comprehensive and detailed plan for deinstitutionalization should be articulated prior to any closure decision.

We are particularly puzzled by a statement in the report that cites "a lack of comprehensive and specialized medical services within the Winfield community" as one of several reasons for selecting Winfield State Hospital for possible closure. We believe there is a well established and growing Winfield medical community that is generally broader and more specialized than most Kansas communities of similar size.

Please be assured that St. Francis Regional Medical Center will continue to work with William Newton Memorial Hospital, the Snyder Clinic and other physicians in Winfield to improve the availability of primary and specialty care medical services in a manner that best meets the needs of the community.

We hope and pray that the current hearings and committee discussions regarding State hospital closure will lead to a more rational plan for providing care and support to clients in the future.

Sincerely,

Sister M. Sylvia Egan

M. Sylvia Egan, SSM
President and Chief Executive Officer
St. Francis Regional Medical Center

10-20
3 (cont'd)

929 N. St. Francis, Wichita, Kansas 67214-3882 / 316-268-5102 / Toll Free 1-800-362-0070 / FAX 1-316-291-7999

Osteopathic Clinic

1700 EAST NINTH AVENUE
WINFIELD, KANSAS 67156

DON PHILLIP GIBSON, D.O.
ALVIN D. BIRD, D.O.

February 18, 1993

The physicians of this clinic are willing to evaluate and treat the residents of the Winfield State Hospital & Training Center as necessary.

Sincerely,

Alvin D. Bird, D.O.

Don Phillip Gibson, D.O.

10-21

3 (cont'd)

Winfield Medical Arts, P.A.

1211 East 5th Street
WINFIELD, KANSAS 67156

FAX: 316-221-7680
316-221-6100

SURGERY

JAMES M. WINBLAD, M.D.
Fellow American College of Surgeons
Fellow International College of Surgeons
Diplomate American Board of Surgery

CHANDY C. SAMUEL, M.D.
Fellow American College of Surgeons
Diplomate American Board of Surgery

OBSTETRICS-GYNECOLOGY

J. KENT WINBLAD, M.D.
Fellow American College of Obstetricians & Gynecology
Diplomate American Board of Obstetrics & Gynecology

FAMILY PRACTICE

JOHN M. WINBLAD, M.D.
Fellow American College of Family Physicians
Diplomate American Board of Family Practice

JORGE M. STURICH, M.D.
Fellow American College of Family Physicians
Diplomate American Board of Family Practice

CARDIOLOGY CONSULTANTS

JOSEPH P. GALICHIA, M.D.
Fellow American College of Cardiologists
Diplomate American Board of Cardiology

GREGORY R. BOXBERGER, M.D.
Fellow American College of Cardiologists
Diplomate American Board of Cardiology

ADMINISTRATOR
KRISTIN FRAHM, B.S.N.

OFFICE MANAGER
GLORIA FINUF

February 18, 1993

To Whom It May Concern:

This is to state that we have taken care of the residents of Winfield State Hospital and Training Center for their medical and surgical needs in the past and would be willing to continue the care as needed in the future.

Sincerely,

Samuel C.C.

C.C. Samuel, M.D.

CCS:kkk

10-22

3 (cont'd)

WELLS-KAUFMAN CLINIC
221 WEST 8TH STREET
P. O. BOX 643
WINFIELD, KANSAS 67156

Bruce W. Wells, M.D.
(316) 221-3350

L. R. Kaufman, M.D.
(316) 221-3350

February 18, 1993

To Whom It May Concern:

This is to affirm that I am willing to evaluate and treat Winfield State Hospital and Training Center residents as necessary for acute medical problems.

Sincerely,

Bruce W. Wells, M.D.

BWW/cs

10-23
3 (cont'd)

1/13/93

Requested by Sen. Kerr

JOAN FINNEY, GOVERNOR OF THE STATE OF KANSAS

KANSAS DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

DONNA WHITEMAN, SECRETARY

Mental Health & Retardation Services
Fifth Floor North
(913) 296-3561
TDD #: (913) 296-3471
FAX #: (913) 296-6142

M E M O R A N D U M

TO: Gary Daniels, PSH/TC
Bob Day, KNI
Tony Lybarger, WSH/TC

FROM: Russ Pittsley

DATE: January 8, 1993

RE: Report to the Legislative Research

On Monday, Legislative Research requested a report on placements. Enclosed, for your information, is a copy of what was completed and forwarded to Legislative Research on Wednesday. If you have questions about any of the information, do not hesitate to give me a call.

RP:eb

Enclosure

Attachment 4

10-24

HALFWAY REPORT

Introduction

On February 21, 1991, leaders from four community mental retardation centers (CMRCs), superintendents from the three state operated institutions (ICFs/MR),and staff from State MR/DD Services met to explore and discuss whether a partnership could be developed to redefine and improve the process for moving residents from the state operated ICFs/MR into community programs. The goal for this group was to develop a transition model through a four-way partnership consisting of families, community providers, state operated ICFs/MR, and State MR/DD Services. The purpose was to integrate individuals residing in state operated ICFs/MR into the community of choice supported by the appropriate resources and services.

Eventually placement goals were developed and the project planned to net a total of 79 persons from July 1, 1991, through June 30, 1992. The plan indicated that 35 placements would be made from Winfield State Hospital, 34 from KNI, and 10 from Parsons State Hospital. The closing campus populations compared to population goals for this period were as follows:

Hospital	Population 7-1-92	Population Goal	Balance Carried
KNI	314	310	4
Winfield	336	332	4
Parsons	276	270	6

The balance figures from the 91-92 placement year were carried over to the 92-93 year and added to the population goals to be accomplished during the 92-93 placement period.

Six months of the time frame allowed to accomplish the 92-93 population goals has passed. The purpose of this report is to review those goals and look at the number of persons in the placement process.

1992/93 PLACEMENT GOALS

Placement goals were established based upon total campus population and the ending campus population goal included the unplaced numbers from 91-92. Thus, subtracting the current campus population from the initial population does <u>not</u> indicate the number of placements that have been made. If admissions have been made to any of the hospitals they are counted as "campus population" and erase actual out-placements. A quick review of the data indicates four persons have been admitted since July of 1991 at the request of the central office. Two of these placements were at KNI and two at Parsons. In addition Winfield admitted five persons in July of 1992 from mental health hospitals.

10-25
4 (cont'd)

Campus population goals were established as follows:

HOSPITAL	CAMPUS POPULATION JULY 1, 1992	CAMPUS POPULATION GOAL JUNE 30, 1993
KNI	314	282
WINFIELD	336	304
PARSONS	276	242

The total campus population for the three hospitals on July 1, 1992, was 926 persons and the campus population goal for June 30, 1993, is 828 persons. This indicates that the placement process needed to net a total of 98 placements to meet June 30, 1993, campus population goals. The total of 98 placements is 84 placements for 92-93 plus the 14 placements needed to meet the June 30, 1992, campus population goals.

On July 1, 1992, the campus population at KNI was 314 persons. The campus population goal was established at 282 persons by June 30, 1993.

On July 1, 1992, the campus population at Winfield was 336 persons. The campus population goal was established at 304 persons by June 30, 1993.

On July 1, 1992, the campus population at Parsons was 276 persons. The campus population goal was established at 242 persons by June 30, 1993.

Placement Process Reporting Methodology

For the purpose of this report the placement process has been divided into four steps. Each step will indicate where a specific referral is in the placement process at this time.

STEP I
All efforts in this step are dependent upon action taken at the state hospital. This step involves the actual referral of a person for placement, the development of a lifestyle plan, and forwarding that lifestyle plan to a community provider. Hospitals are responsible for maintaining a referral list with at least 1.5 persons for each placement needed to meet the campus population goal. This ratio is considered conservative and was selected on placement experience. Problems can and do develop with the best planned placements and having extra persons on the placement list is prudent planning.

STEP II
All efforts in this step are dependent upon the community provider. This step includes the development of a support plan and a cost proposal.

10-26
attachment

STEP III
This step is dependent upon approval of the community support plan and cost proposal by the central office.

STEP IV
Persons counted in this step have had all plans approved and move dates have been set. Generally the provider is seeking a roommate, hiring staff, or making living arrangements. These persons will move in the immediate future.

K N I

The campus population at KNI on January 1, 1993 was 311 persons which is 29 short of the June 30, 1993, goal. The placement list should contain the names of 44 persons to maintain the 1.5:1 referral to placements needed ratio. The placement list for KNI contains the names of 42 persons. Step I will contain 2 persons for whom referral has not been made. In addition to these 2 persons the list contains the names of 17 persons for whom lifestyle plans have not been developed or the plans have not been sent to community providers.

Twenty (20) persons on the KNI placement list have had plans developed and sent to community providers. Providers are developing support plans or cost proposals.

Two (2) persons on the KNI placement list have had cost proposals developed and sent to the central office. Central office is negotiating or working on approval of these plans.

Three (3) persons on the KNI placement list have had all plans approved and await final arrangements for placement.

KNI SUMMARY DATA

Campus population

JUL	AUG	SEP	OCT	NOV	DEC	JAN	GOAL	BALANCE
314	314	313	313	313	312	311	282	29

Placement List

	Step I	Step II	Step III	Step IV
Number	17+2	20	2	3
Percentage	43%	45%	5%	7%

10-27

4 (month)

W I N F I E L D

The campus population at Winfield on January 1, 1993 was 330 persons which is 26 short of the June 30, 1993, goal. The placement list should contain the names of 39 persons to maintain the 1.5:1 referral to placements needed ratio. The placement list for Winfield contains 36 names. Step I will contain 3 persons for whom referral has not been made. In addition to these 3 persons, the list contains the names of 4 persons for whom lifestyle plans have not been developed or the plans have not been sent to community providers.

Twenty-five (25) persons on the Winfield placement list have had plans developed and sent to community providers. Providers are developing support plans or cost proposals.

Two (2) persons on the Winfield placement list have had cost proposals developed and sent to the central office. Central office is negotiating or working on approval of these plans.

Five (5) persons on the Winfield placement list have had all plans approved and await final arrangements for placement.

WINFIELD SUMMARY DATA

Campus population

JUL	AUG	SEP	OCT	NOV	DEC	JAN	GOAL	BALANCE
336	341	340	335	334	333	330	304	26

Placement List

	Step I	Step II	Step III	Step IV
Number	4+3	25	2	5
Percentage	18%	64%	5%	13%

P A R S O N S

The campus population at Parsons on January 1, 1993 was 266 persons which is 24 short of the campus June 30, 1993 goal. The placement list should contain the names of 36 persons to maintain the 1.5:1 referral to placements needed ratio. The placement list for Parsons contains 27 names. Step I will contain 9 persons for whom referral has not been made. In addition to these 9 persons the list contains the names of 7 persons for whom lifestyle plans have not been developed or the plans have not been sent to community providers.

Twenty-five (25) persons on the Parsons placement list have had plans developed and sent to community providers. Providers are developing support plans or cost proposals.

10-28

Two (2) persons on the Parsons placement list have had cost proposals developed and sent to the central office. Central office is negotiating or working on approval of these plans.

Five (5) persons on the Parsons placement list have had all plans approved and await final arrangements for placement.

PARSONS SUMMARY DATA

Campus Population

JUL	AUG	SEP	OCT	NOV	DEC	JAN	GOAL	BALANCE
276	273	271	269	269	268	266	242	24

Placement List

	Step I	Step II	Step III	Step IV
Number	7+9	13	3	4
Percentage	44%	36%	8%	11%

S U M M A R Y

The campus population at KNI, Winfield, and Parsons on January 1, 1993 was 907 which is 79 short of the statewide campus population goal for June 30, 1993. This includes the nine admissions which occurred in this placement period.

The current placement lists should contain the names of 119 persons to maintain the 1.5:1 referral to placements needed ratio. The placement lists for all three hospitals contain 105 names. Step I accounting will contain 14 persons for whom referral has not been made. In addition to these 14 persons the list contains the names of 28 persons for whom lifestyle plans have not been developed or the plans have not been sent to community providers.

Fifty-eight (58) persons on the KNI, Winfield, and Parsons placement lists have had plans developed and sent to community providers. Providers are developing support plans or cost proposals.

Seven (7) persons on the KNI, Winfield, and Parsons placement lists have had cost proposals developed and sent to the central office. Central office is negotiating or working on approval of these plans.

Twelve (12) persons on the KNI, Winfield, and Parsons placement lists have had all plans approved and await final arrangements for placement.

10-29

4 (month)

SUMMARY DATA

1992-93
Campus Population

	JUL	AUG	SEP	OCT	NOV	DEC	JAN	GOAL	BALANCE
KNI	314	314	313	313	313	312	311	282	29
Winfield	336	341	340	335	334	333	330	304	26
Parsons	276	273	271	269	269	268	266	242	24

Placement List

	Step I	Step II	Step III	Step IV
KNI	17+2	20	2	3
Winfield	4+3	25	2	5
Parsons	7+9	13	3	4
TOTALS	42	58	7	12
Percentage	35%	49%	6%	10%

Fifty percent of the time frame for reducing the campus population at our state operated ICF/MR facilities from 926 persons to 828 persons has passed. The campus population on January 1, 1993, was 907 persons. Approximately 19% of the campus population goal has been accomplished.

Thirty-five percent of the referrals on the list are in need of action by staff at the state operated ICFs/MR and forty-nine percent of the referrals in the process await action by the community providers. Ten percent of the referrals are in the final stages of placement and six percent of the referrals await approval from the central office.

January 7, 1993

10-30

CAPACITY OF SERVICES PROVIDED
45–Mile Radius
Report Dated: 2/9/93

SERVICE	WSH	KNI	PSH
Adult Life Skills		32	
Adult Residential	37	86	
Adult Training/Adjustment	77	441	70
Early Childhood Development		60	55
Early Intervention & Child Development		30	
Group Home		6	
Group Living	99	127	45
Independent Living		42	
Infant Stimulation		8	
ICF/MR			
Respite Care		12	
Preschool Training		95	54
Semi–Independent Living		24	36
Semi–Supervised Living	12		
Sheltered Employment		15	
Supervised Living	20	11	
Unsupervised Apartment Living	24		
Vocational Services			145
Work Activity	127	263	
Youth & Adult Training	170		
TOTAL	566	1252	405

10-31

Attachment 5

CAPACITY OF SERVICES PROVIDED
60–Mile Radius, Inclusive
Report Dated: 2/9/93

SERVICE	WSH	KNI	PSH
Adult Life Skills	60	32	
Adult Residential	37	112	
Adult Training/Adjustment	77	476	70
Early Childhood Development	34	60	55
Early Intervention & Child Development		30	
Group Home		6	
Group Living	135	127	45
Independent Living	8	66	
Infant Stimulation		8	
ICF/MR	15		
Respite Care		12	
Preschool Training		111	54
Semi–Independent Living	22	24	36
Semi–Supervised Living	12		
Sheltered Employment		15	
Supervised Living	20	11	
Unsupervised Apartment Living	24		
Vocational Services			145
Work Activity	127	296	
Youth & Adult Training	170		
TOTAL	741	1386	405

10-32

Attachment 6

THE TOPEKA CAP' JOURNAL

February 27, 1993 Page 7-A

Prospects good for workers

Anyone laid off at KNI likely to find another job with state

By ROGER MYERS
The Capital-Journal

The state has no policy guaranteeing other state jobs to workers at the Kansas Neurological Institute in Topeka, or that the facility would be used for other purposes.

However, state officials said Friday they are confident any employees who are laid off at KNI can find other positions with the state and follow-on tenants can be found for the KNI buildings.

A House appropriations subcommittee created the possibility of mass layoffs at KNI by voting 3-1 Friday to recommend its closing. Shutting down one of the state's three mental retardation facilities is part of the plan for moving disabled people out of institutions and into community-based programs.

The closing of a hospital for the mentally retarded will begin when the population in the three hospitals drops to about 500.

Officials in the state Department of Social and Rehabilitation Services estimate that will occur in about five years.

There were 817 people working at KNI as of Tuesday.

While the state doesn't have a policy that guarantees laid-off KNI workers other state jobs, it does have layoff rules and regulations that should make it possible for most or all to find new state employment.

Nancy Echols, state director of personnel, said any classified state employee who is laid off gets a layoff score and is placed on a reemployment list.

Topeka State Hospital, the state Department of Corrections and other state agencies headquartered in Topeka have many of the same job descriptions as KNI, she said. Laid off KNI workers will have first claim to vacancies in other agencies that match their job descriptions and are of the same or lower level.

Echols said the prospects for displaced KNI workers to land new state jobs are good because closure won't happen for another four or five years.

She pointed out there is a concentration of state jobs in Topeka. She also said private sector agencies offering community-based services for the mentally retarded will need additional employees as they expand.

"SRS has been really good about finding new state jobs for its people," she said. "When Norton State Hospital closed several years ago they found people jobs in other institutions, and that's what we expect will happen this time."

ATTACHMENT 11

DOWNSIZING 3 MR HOSPITALS/END COMMUNITY WAITING LIST

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
COMMUNITY FUNDING	$71,960,000	$86,220,000	$102,760,000	$118,540,000	$130,460,000	$142,958,400	$156,247,936	$170,358,853
COMMUNITY PERSONS SERVED	5,143	6,058	6,861	7,645	8,385	8,585	8,785	8,985
COMMUNITY WAITING LIST	656	321	214	126	0	0	0	0
MR INSTITUTION	$72,730,000	$71,280,000	$69,850,000	$68,450,000	$71,190,000	$74,037,600	$76,999,104	$80,079,068
INST. ADC	828	744	660	576	576	576	576	576

CONSOLIDATE TO 2 MR HOSPITALS/END COMMUNITY WAITING LIST

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
COMMUNITY FUNDING	71,960,000	86,220,000	102,760,000	118,540,000	130,460,000	142,958,400	156,247,936	170,358,853
COMMUNITY PERSONS SERVED	5,143	6,058	6,861	7,645	8,385	8,585	8,785	8,985
COMMUNITY WAITING LIST	656	321	214	126	0	0	0	0
MR INSTITUTION	70,640,000	68,760,000	65,710,000	59,990,000	56,050,000	58,292,000	60,623,680	63,048,627
INST. ADC	828	744	660	576	576	576	576	576

MR HOSPITAL STATUS QUO / END COMMUNITY WAITING LIST

	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
COMMUNITY FUNDING	71,960,000	86,220,000	102,760,000	118,540,000	130,460,000	142,958,400	156,247,936	170,358,853
COMMUNITY PERSONS SERVED	5,143	6,058	6,861	7,645	8,385	8,585	8,785	8,985
COMMUNITY WAITING LIST	656	321	214	126	0	0	0	0
MR INSTITUTION	72,730,000	75,639,200	78,664,768	81,811,359	85,083,813	88,487,166	92,026,652	95,707,718
INST. ADC	828	828	828	828	828	828	828	828

ATTACHMENT 17

MEMORANDUM

24 February 1993

To: Representative Gary Blumenthal

Re: Client Demographics and Budgetary Comparisons for Kansas MR/DD Institutions

This is in response to your request for comparative data about Winfield State Hospital and Kansas Neurological Institute. Much of what is in this memorandum was presented earlier to the House Appropriations Subcommittee. I added to that answers to your enquiries about administrative costs, and the comparative use of overtime at the institutions. The administrative information was supplied by the hospitals. The overtime information was supplied by the Department of Social and Rehabilitation Services.

ATTACHMENT 13

The following table shows some basic client demographics for Kansas mental retardation institutions. Most of the figures are from a data run of 16 October 1992. Some of the figures are from a telephone survey that was conducted on 22 October 1992. In spite of the fact that the run was conducted in October, the figures will still provide a fairly reliable picture of the institutions' respective client populations. The figures come from the Developmental Disability Profile and were supplied by the institutions. The Department of Social and Rehabilitation Services compiled the total number of client disabilities at the institutions. From that number, it is relatively easy to extrapolate an average number of disabilities per client.

Basic Client Demographics

	KNI	Parsons	Winfield
Population (16 October 1992)	330	265	359
Clients with Psychiatric Label	145	244	29
(Percentage)	43.9%	92.1%	8.1%
Clients on Psychoactive Medications	38	79	63
(Percentage)	10.86%	29.2%	18.6%
Clients Requiring Daily Nursing Procedures (e.g., Feeding Tube)	27	–	73
(Percentage)	8.6%	0.0%	21.6%
Non-Ambulatory Clients	127	2	194
(Percentage)	38%	.01%	54%
Clients with Seizures in Past Year	150	51	164
(Percentage)	45.5%	19.2%	45.7%
Total Population Disabilities	975	456	750
Disabilities per Client (Ave.)	2.95	1.72	2.09

Staff-to-Client Ratios and Cost per Client-Day

	KNI	Parsons	Winfield
Population (24 February 1993)	310	265	331
Number of Employees (23 February 1993)	817[a]	544[b]	904[c]
Staff-to-Client Ratio	2.64	2.05	2.73
Gov. Rec. FY 1993 Budget	$24,686,186	$17,984,079	$28,950,649
Cost per Client-Day	$217.47[d]	$185.23	$239.63[e]

a) Assumes 815.5 funded FTE positions, 13.8 FTE positions vacant, 6.5 FTE trainees and 9 FTE temporary positions.

b) Assumes 537 funded FTE positions, 12 FTE positions vacant, 5.5 FTE trainees and 13.5 FTE temporary positions.

c) Assumes 862.5 funded FTE positions, 38.5 positions vacant, 8.5 FTE temporaries and 71 FTE trainees.

d) Keep in mind that KNI provides food to Topeka State Hospital (ADC of 273), the Topeka Correctional Facility (115) and the SRS Comprehensive Screening Unit (24).

e) Keep in mind that Winfield State Hospital provides utilities to Winfield Correctional Facility.

Adjusted Budget Figures

Using data provided by the hospitals, the budget figures for KNI and Winfield State Hospital have been adjusted to reflect the services that they provide to other state institutions, and which they receive from other institutions. KNI provides food services to Topeka State Hospital, the Topeka Correctional Facility, and the SRS Comprehensive Screening Unit. Topeka State Hospital does laundry for KNI. Winfield State Hospital provides utilities to the Winfield Correctional Facility.

	KNI	Parsons	Winfield
Population (24 February 1993)	310	265	331
Number of Employees (22 February 1993)	817.2	544.0	903.5
Adjust for KNI's Food Service to TSH	(33)	–	–
Adjust for TSH's laundry services to KNI	10	–	–
Adjust for WSH's utilities to WCF	–	–	–
ADJUSTED FTE POSITIONS	794.2	544	903.5
Staff-to-Client Ratio	2.63	2.05	2.73
ADJUSTED STAFF TO CLIENT RATIO	2.55	2.05	2.73
Gov. Rec. FY 1993 Budget	$24,686,186	$17,984,079	$28,950,649
Adjust for KNI's Food Service to TSH	(1,547,903)	–	–
Adjust for TSH's laundry services to KNI	354,812	–	–
Adjust for WSH's utilities to WCF	–	–	(127,266)
ADJUSTED FY 93 GOV. REC.	$23,493,095	$17,984,079	$28,823,383
Cost per Client-Day	$217.47	$185.23	$239.63
ADJUSTED COST PER CLIENT-DAY	$206.96	$185.23	$238.57

Winfield's FY 1993 recommended budget (adjusted), is $5,330,288 higher than KNI's, which equates to a difference of 22.7 percent.

Adjusted per-diem costs per day are approximately 15.3 percent higher at Winfield than at KNI.

Winfield has 6.4 percent (20) more clients than KNI.

Winfield's staff-to-client ratio (adjusted) is 7.1 percent higher than KNI's.

Approximately 90 percent of clients at KNI are severely and profoundly retarded. Approximately 97

percent of clients at Winfield have severe and profound retardation.

Other Budgetary Figures

Administrative Costs

	KNI	Parsons	Winfield
Adjusted Administrative Costs as Percent of Total Budget	3.3%	3.5%	3.4%
Annual Administrative Costs per Client	$2,663	$2,307	$3,087

Administrative costs, as a percentage of the agency budget, are about three percent higher at Winfield than at KNI. On a per annum per client basis, they are about 15.9 percent higher at Winfield than at KNI.

Use of Overtime Funding

	FY 1991	FY 1992	FY 1993 GOV. REC.	FY 1994 GOV. REC.
KNI	$10,751	$2,137	–	–
Parsons	$1,389	$1,481	–	–
Winfield	$367,078	$325,649	$127,138	–

I hope that this information is helpful to you. If you have other questions, please let me know.

Timothy Colton
Fiscal Analyst

CREATING CHOICES,

PROVIDING OPTIONS:

ONE PERSON AT A TIME

Social and Rehabilitation Services
Mental Health & Retardation Services

ATTACHMENT 14

CREATING CHOICES, PROVIDING OPTIONS: ONE PERSON AT A TIME

I. Executive Summary 1

II. The Evolution of Services 4

A. Preface 4

B. Introduction 5

C. Underlying Premises 8

III. Important Considerations 11

A. Addressing the Residents' Needs 11

B. Minimizing the Impact on Families 13

C. Fiscal Issues 15

D. Easing the Impact on Employees 16

IV. Principles of Placing Individuals 22

V. Procedures for Placing Individuals 26

VI. Action Plan 30

VII. Background Leading to Consolidation Announcement 36

VIII. House of Representatives Appropriations Subcommittee Factors 38

IX. SRS Analysis of Institutional Closure Factors 39
Decision Chart 1 42
Decision Chart 2 47

X. Client Characteristics Graphs 48

XI. Appendix 49

Executive Summary

A revolution is occurring for individuals with mental retardation or other developmental disabilities (MR/DD). Service models have improved, philosophies have shifted and the community at large has much greater acceptance for individuals who are MR/DD. These critical changes are allowing individuals who are MR/DD to live, work and recreate in integrated community settings no matter how severe their disability. Individuals who are severely mentally retarded and multiply physically disabled are securing homes and jobs of their own in typical communities. They are supported in these settings by friends and service providers who go to their home and jobs and wrap the necessary supports around them in order that they might succeed. We have created choices for community integrated living for individuals who are MR/DD by providing options one person at a time.

The success of these opportunities means that there is continually less need for large segregated institutional settings to serve these individuals. Like many other states, Kansas has come to the realization that it no longer needs and cannot afford, both full institutional and community services for individuals who are MR/DD. It is clear that reliance on large institutions must be reduced in Kansas, ultimately resulting in the closure of at least one state mental retardation hospital. This document explains why this must occur and how it should be done.

Sections two and three were written by Robert Day, Ph.D., Superintendent of Kansas Neurological Institute, with the advice of an ad hoc committee made up of parents and key professionals. The introduction explains the historic reliance on institutions and how this reliance has been greatly reduced in recent years. It further describes the challenges faced in moving individuals currently living in state hospitals into community settings. All placements into community integrated settings must be predicated on improving the quality of life of the individual.

The underlying premises in section two state the values used in developing the final recommendations. These premises include the need to utilize a value based approach to the development of community services. These values should be based on a people first philosophy. This people first philosophy must result in the development of individualized services and supports and not on funding programs. These individualized supports and services must be developed around an evaluation of a persons' desired quality of life and lifestyle. Since all of these plans are built individually and do not fund programs, this approach does not require massive readiness activities on the part of the community service providers. They will get ready to serve individuals living in state hospitals one person at a time.

The third section describes important considerations which must be addressed in moving individuals to community settings and closing a state hospital. These considerations are divided into four areas and contain specific recommendations that are summarized as follows. Services for residents leaving state hospitals should be closely monitored and held to high standards. Technical assistance should be provided to assist community agencies in meeting these high standards and providing quality services. Individuals placed in community services should be

provided with one time start-up funds to cover the cost of relocating in a new home. Individuals who are medically challenging not initially placed in community services should be consolidated into one state hospital. The state hospital staff should remain involved with the individual placed as long as is desired.

In addition, it is recommended that families should be contacted to determine who would initially volunteer to seek community placement. Individuals and their families should have an active role in the development of community services to meet their needs. The individuals and their families should be empowered to direct the services they receive.

It is further recommended that the Home and Community Based Services waiver must continue to be expanded to address the needs of individuals seeking placement out of state hospitals as well as those in the community waiting for services. A workable and manageable plan should be designed and implemented which allows funds to follow individuals into community services while not crippling the operation of the state hospitals.

Finally, it is recommended that state employees' needs should be addressed through such efforts as providing them opportunities for early retirement, giving them priority hiring consideration by other state agencies, providing them job counseling and training, and automatic early vestiture in KPERS. There should be a detailed plan which describes staff reduction goals each year. Staff training in state hospitals should be changed to address new community value-based training. As many individuals as is reasonable should be placed in the geographic region near the closed hospital to minimize the economic impact to the area.

The fourth and fifth sections detail the principles and procedures currently used in placing individuals out of state hospitals into community services. These principles include: 1) Giving individuals and their families a choice whether they participate in community placement, 2) Designing person centered plans for serving individuals in community services, 3) Monitoring community services to make certain services meet minimum quality standards and, 4) Developing and maintaining necessary services in state hospitals for those individuals who do not initially take part in community placement. The fifth section contains a summary of the actual placement planning process currently used in placing individuals out of state hospitals.

Section VI is a detailed action plan which consolidates all of the recommendations contained in the previous sections and describes the necessary action steps which must be taken to achieve them. The action plan describes the steps in measurable detail and indicates who would be primarily responsible for each step. It is critical that these steps all be implemented if there is to be the successful development of sufficient, quality community integrated services which will allow the closure of a state hospital for persons with mental retardation.

Information comparing the hospitals on the various dimensions outlined in the House Appropriations Subcommittee report is also provided in addition to background information relating to institutional closure across the country.

Providing support and services to everyone who is MR/DD so they may live and work in the community is now possible no matter how severely disabled the person may be. There is no one who "needs" segregated institutional services. Providing this opportunity and choice is the right

thing to do. It is not practical to provide the choice of full community inclusion to these individuals and to maintain three state mental retardation hospitals. The sensible and practical approach is to close at least one state hospital in favor of providing community inclusionary services. This paper describes how this can be done. With the help and cooperation of the individuals to be served, their families, advocates, providers, the administration and the legislature we can indeed create choices and provide options which dramatically improve the quality of life for individuals with mental retardation or other developmental disabilities in Kansas one person at a time.

THE EVOLUTION OF SERVICES

A. PREFACE

This section of this report was prepared at the request of the Commissioner of Mental Health and Retardation Services, George Vega. The section itself, however, represents the views of a number of persons who served on an ad hoc advisory committee. These members represented a broad spectrum of persons involved in the area of developmental disabilities. It is a given that not all of the desires of every member of the committee are represented in this document. I hope that as much as was possible, some consensus was achieved. It is important to note that while the committee met, MH&RS, at the request of the interim committee, developed a comprehensive service plan. The ad hoc advisory committee wishes to go on record as supporting this plan, a critical feature of which is the acceptance on the part of SRS of some form of program and service oversight.

It must be said that the consolidation of the state hospital system into two rather than three institutions creates great anxiety among many family members whose loved ones currently reside in these three facilities. The parents who served on the ad hoc committee expressed deep reservation about the reasons for consolidation and the community's ability to absorb and serve current residents at the hospitals.

While this section supports the concept of consolidation it does so with two important caveats. First, the movement of persons with severe disabilities into the community should be done in a gradual manner over four to five years. The entire success of the consolidation requires that there be an appropriate amount of time allowed for the community to expand its capacity and for family members of current residents to gain faith in the concept of community inclusion. Second, the state must assure that adequate protections are in place to monitor the care provided for persons with severe disabilities. In consolidating and expanding community placements we are going to place a far more vulnerable population into the community system than has heretofore been served.

I want to thank the members of the ad hoc committee for their time, effort, and patience. Clearly the issues surrounding consolidation produced strong feelings which were at times difficult to work through. The patience and perseverance of all members was greatly appreciated. I only hope that we all walked a way with a better understanding of the issues involved in developing services for persons with disabilities. Finally, let me say that while it is hoped that the recommendations put forth reflect the consensus of the group, I must accept the ultimate responsibility for what is written. I only hope that I have adequately captured the ideas of the committee members.

AD HOC ADVISORY COMMITTEE

Renee Gardner
Governor's Office

Charles Dodson
KAPE, Inc. (Kansas Association of Public Employees, Inc.)

R. A. Caraway
AFSCME Council 64 (American Federation of State, County & Municipal Employees)

Karen Testa
GAP, Inc. (Group Homes, Alternative & Programming)

Susan Williamson
State Department of Education

Lila Paslay
TARC (Topeka Association for Retarded Citizens, Inc.)

Rud Turnbull
University of Kansas, Bureau of Child Research

Dawn Merriman
Parent of child with severe disabilities residing at home

Mrs. Lillian Razak
Parent of Winfield Client

George Vega, Acting Commissioner
Mental Health & Retardation Services

Rick Shults, Director, Community MR Programs, MH&RS

Darvin Hirsch, Director, MR/DD Services, MH&RS

Robert Day, Superintendent
Kansas Neurological Institute

Rosie Marstall
Parent of KNI Client

Mrs. Alice Hixson
Parent of Parsons Client

Mrs. Virginia Zimmerman
Parent of Parsons Client

Yo Bestgen
Kansas Assoc. of Rehabilitation Facilities

B. INTRODUCTION

"Say, representatives of Kansas, will you today, when asked to vote upon this measure, when there rises clearly before you a glimpse on the one hand of the sleepless horror which broods over the poor abodes of your fellow citizens, your constituents, which crushes their hearts and lives and hopes, and on the other of those noble shrines of Christ's sweet charity, where these children of sorrow are gathered and cared for, vote a contemptuous "no", and pass out to meet the fathers and mothers, and excuse yourselves as best you may--pass out to meet that

Judge who will sentence you with that tremendous work, 'Inasmuch as you did it not to one of the least of these, you did it not to me'?"

In 1881 these words spoken by James Legate convinced his fellow house members to establish the Kansas State Asylum for Idiotic and Imbecile Youth. Originally founded in Lawrence, the institution was moved to Winfield, Kansas in 1885. With the establishment of an institution for persons with mental retardation Kansas joined the rest of the nation in the development of an institutional service model. Although created for the purpose of training and education, it was not long before the function changed to one of long term care. In 1911 of the hundred employees at Winfield only two had any background in education. In 1917 the name was changed from the Home for the Feeble Minded to the State Training School, a change which reflected the development of the institution along industrial lines. While it was established with the intent of being a training school, resembling a boarding school for persons with disabilities, Winfield quickly became inundated with persons with severe disabilities. This increase in persons with severe disabilities led to the pessimistic view that the training school's function was primarily one of custodial care. This perspective combined with intense overcrowding lead to a dark period for Kansas' treatment of persons with disabilities. These "children of sorrow" became the recipients of a moralistic attitude that was reflected in the use of castration as a method of behavior management, a practice founded on the erroneous belief that persons with mental retardation were a sexual threat to the population.

By the late 1940s it had become apparent that there was a need for a change in attitude and practices. In 1953 the Legislature established a dual purpose for the State Hospital for Epileptics at Parsons. The hospital was designated a training school and was given the mission of providing care and training to children between 6 and 14 years of age who experienced mild retardation. Patients at Winfield State Training School who met the admissions criteria were transferred to Parsons. Again in 1959 in an effort to address issues of overcrowding and of long waiting lists the Legislature authorized the State Board of Social Welfare to apply for the vacated grounds and buildings of the old Winter Veterans Hospital in Topeka. In January 1960 Kansas Neurological Institute began receiving patients from Parsons and Winfield. Finally in 1963 Norton State Hospital was transformed from a treatment center for tubercular patients to a training school for persons with mental retardation.

While all four institutions accepted as their charge the three fold mission of treatment, research and professional training, it was not until the ability to access Title XIX Medicaid funds in the mid 70's that the state hospitals were subject to regular review of the care and treatment they provided. This reliance on Federal support and acceptance of the accompanying regulations set in motion events that in the mid 80's were to have a significant impact on all four of the institutions in the state.

Although the state had expanded services through the opening of new institutions, many persons with disabilities remained unserved either because their parents did not wish to place them in an institution or because they did not meet the admissions requirements established by each hospital. In the 50's and 60's local associations for retarded citizens were formed to advocate for, and in many cases actually develop, community services

for citizens with retardation who required supports and services. In 1970 the legislature amended legislation authorizing the use of local property tax money for community mental health centers to include community facilities for the mentally retarded. Beginning in 1973 the Legislature enacted a series of grant programs designed to assist the development of community mental retardation programs. This included in 1974-75 a project designed to reduce the census at the state hospitals, known as Project Reintegration; patients were moved from state institutions to community facilities, including the large bed private ICFs/MR. By 1980 Kansas, as had other states, had established a two track program for persons with mental retardation. Persons with mild retardation received both residential and vocational services in the community while those persons with more severe disabilities were relegated to institutional care.

At the beginning of 1986, first Winfield State Hospital and Training Center and subsequently Kansas Neurological Institute, Parsons State Hospital and Training Center and finally, in 1987, Norton State Hospital and Training Center were found out of compliance with active treatment standards of the Medicaid regulations. Threatened sanctions by the Health Care Financing Administration lead to dramatic increases in the number of staff and subsequent costs of care at all four hospitals. The results of these actions assured the continued matching of Title XIX funds to each of the facilities. Again in 1988, Winfield and then KNI were found out of compliance with active treatment standards and, as a consequence, additional staff were added to both facilities. In 1988 a decision was made to close Norton State Hospital and Training Center. The reasons for the closure were the difficulties in operating both an institution for persons with mental retardation and a correctional facility in the same buildings and the belief that many of the persons residing at the State Hospital could be served in the community.

The closure of Norton State Hospital and subsequent successful movement of many former residents with severe retardation and behavior problems into the community provided the first visible proof that existing community programs had the capacity to serve persons with severe disabilities. Despite the successes of the Norton closure some important lessons were learned. First, the reliance upon Title XIX dollars to fund the high cost of community placement carried the same liabilities that the state institutions had, being forced to comply with unnecessary and costly regulations. Second, because the state was obligated to reimburse providers for fair and reasonable costs there was no method for the state to contain costs, a problem similar to the issues encountered in the state institutions. Third, reliance on Title XIX funds meant that community agencies would continue to be in the position of seeking funding for a program rather than a person, since ICF/MR regulations are heavily oriented towards not only program but facility. Finally, the rapid closure of Norton State Hospital was an unnecessarily disruptive process that hurt both staff and clients.

With these issues in mind the 1990 legislature established a moratorium on further development of small bed ICF/MR homes while Mental Health and Retardation Services submitted an application for a Home and Community Based Waiver, which would allow for a more flexible funding mechanism and maximize federal participation at the same time. This waiver was finally approved in 1991 and funded to commence in FY 92.

All of these recent events have occurred behind a national backdrop of profound change in how persons with disabilities are perceived. The eighties and nineties have witnessed a virtual revolution in the conceptualization of services for persons with disabilities. All of the old myths and stereotypes about persons with disabilities have been swept aside. Today across the nation persons with severe and profound mental retardation are being provided individualized supports designed to make community inclusion a reality rather than a dream.

Within this context of rising institutional costs, increased belief that persons with disabilities should be served in their home communities, and the realization that the only real cost savings which can occur from reduced institutional census is through closure, the Governor and Legislature have turned to the issue of consolidating institutional services into two rather than three facilities.

C. THE PREMISES UNDERLYING THIS REPORT

Consolidation of the state hospital system and the subsequent movement of persons with disabilities into the community should be based on a value that affirms persons with disabilities. As a consequence, this document is premised on the following statement.

"Most adults with developmental disabilities eat the bread of others and know only the way that goes up and down stairs that are never their own." (John O'Brien, 1991)

> All Kansans, including those with mental retardation and other developmental disabilities, have the right and should have the opportunity to participate and be integrated into the life of their community: to exercise options to choose where and with whom they live and work, to participate in preferred leisure activities, to be educated in schools of their choice in their neighborhoods, and to maintain relationships with family and friends.

Any change in the current services, even those resulting in closure of a state hospital, must be premised on a people first philosophy.

> History tells us that how we perceive certain groups of people often affects how we behave toward them. These perceptions lead to stereotyping which ignores individuality and assumes a false homogeneity. In the field of developmental disabilities social policies and accompanying services have been premised on a stereotypical view of persons with disabilities. The development of institutional services, for example, were based on the view that people with disabilities needed protection from the demands of society. This plan is based on the view that persons with disabilities are not fundamentally different from other typical

people, and that we must not provide supports to address their disability at the expense of their "person" needs. Thus, services must be for persons with disabilities and not for the *disabled*.

In keeping with the values espoused and the people first perspective, individualized services and supports should be funded rather than programs.

The traditional service model for persons with disabilities has focused on maintenance of existing buildings and a group program. This funding of a "program" or "system" of service has at its core a conflict of interest between the agencies, both community and institution which are committed to employees and property, and the needs of the person with a disability. Any alteration in the current practices must be premised on the belief that the needs of the person with a disability are always the primary consideration. In sum, it is the obligation of the agencies providing supports and services to fit these to the individual rather than to attempt to fit the individual into the service.

Development of supports and services for a person with disabilities should be developed around an individualized evaluation of a persons quality of life needs.

Too often programs and services for persons with developmental disabilities have been built around the perceived needs, often based on an evaluation of the individuals deficits, of professionals and others, including parents and guardians. Supports and services must be based not on the perceived deficits but the expressed wants and needs of the individual person. These needs are not programmatic but rather are basic to very individualized nature and personality of the person being supported.

Consolidation of the state hospital system does not require a restructuring of community system.

"We must reformulate community services one person at a time." (Quote from advocate for community programs.)

The closing of a state hospital should not be based on the belief that the community needs time to prepare. The preparation of communities will occur one person at a time. Each successful placement based on the development of individualized supports will enhance the placements to follow. The argument that the community is "not ready" for persons who are currently served in institutional

settings is not born out in fact. The last several years has seen the successful support of formerly institutionalized persons with severe and multiple disabilities in a variety of community settings.

IMPORTANT CONSIDERATIONS

A. ADDRESSING THE RESIDENTS' NEEDS

Presently 960 Kansans with disabilities reside in the three state hospitals. This may be contrasted with the fact that slightly more than 3,000 persons are receiving residential services in community settings. Fully 85% of those persons residing in the state hospitals have severe to profound disabilities. Only 12% of those persons in community mental retardation programs have similar disabilities. Currently over 200 of the residents in the institutions are of school age (under 21 years of age) while mental retardation centers have traditionally served few persons with disabilities who remain eligible for special education services. In short, the state hospitals currently serve the most vulnerable persons with disabilities; persons who are generally unable to make their wants and needs known in a traditional manner, who have historically been subject to abuse and neglect, and who have extreme needs in terms of systematic habilitation.

"Today, many adults around the country who previously were thought to require care in institutions or congregate group homes now live in typical housing and need less than full-time supervision." (Task Force on Developmental Disabilities of the National Conference of State Legislatures, 1991)

The current community system serves individuals who do not provide the same level of challenge or need as those in institutional settings. Over 120 persons in the three state hospitals routinely require medical procedures which must under current state statute be conducted by licensed medical personnel. While 90% of the persons served at CMRCs can walk without any assistance only about half that number are able to do so in state hospitals.

Data indicate that approximately half of the state hospital residents engage in some form of serious aberrant behavior, such as aggression or self injury. Data from the community facilities indicate that less than 20% of the persons served engage in similar behavior. While some of these behavioral challenges may be ameliorated by providing individual life style choices, it is likely that there will remain serious challenges to the community agencies. These challenges will require an increased degree of technical support than has been required by community agencies.

RECOMMENDATIONS

1. Mental Health and Retardation Services must assure that Community Mental Retardation Centers meet a basic standard of service, including the right of institutionalized persons to an established quality of service in their home communities.

MH&RS should establish performance contracts with each of the 27 designated Community Mental Retardation Centers. These contracts should guarantee at a minimum that they will develop an acceptable range of services for all eligible persons with a disability provided adequate resources to do so are available. Discrimination against persons with disabilities who present challenging needs should be not considered an acceptable practice.

In addition to the establishment of a right to service provision, MH&RS should require that each CMRC have a plan of quality assurance approved by MH&RS. This plan should provide for monitoring on a regular basis, not only the quality of service the agency provides but also the degree to which the service provided meets current professional values held regarding services for persons with disabilities. Included in this plan should be a clear determination of how the service provider will assess the degree of satisfaction the individual being served has with their personal support staff. Finally the plan should include a pivotal role for customers of the agency, parents, local citizens, and advocates.

Quality Assurance

"Quality assurance enables human services agencies to pursue five fundamental goals:

(1) to assure that service providers have the capability to provide an acceptable level of service;

(2) to assure that client services are provided consistent with accepted beliefs about what constitutes good practice;

(3) to assure that a given commitment of resources produces a reasonable level of service;

(4) to assure that the services that are provided have the intended effect; and

(5) to assure that the limited supply of services is provided to the clients most in need." (Evaluation of Arizona's Developmental Disabilities Quality Assurance System: Final Report, Human Services Research Institute, 1991)

2. MH&RS should establish with the Kansas University Affiliated Program at the University of Kansas a grant to hire persons to serve as technical consultants on quality enhancement to assist CMRCs meet the challenges presented by persons with severe disabilities.

Placement of institutionalized persons in community settings requires that the community agencies be prepared to provide new technologies in habilitation, innovative service supports and more advanced staff training. As in other states, these needs are ideally met by university affiliated programs. The KUAP should serve as an excellent link between the technical expertise of the various programs at KU and applied application of this expertise.

3. Medically challenging persons should be consolidated in one of the two remaining hospitals.

Those individuals currently requiring license nursing care would, at present, be more practically served in a system which can maintain a high concentration of medical personnel. The movement of the medically fragile should be carefully coordinated across the hospital systems to reduce disruptions to lives of all persons and families.

"The present evaluation of the short-term transfer effects found no significant increases in mortality, medication usage, or maladaptive behaviors (abnormal, antisocial, negative affect). Hence the present results support the research literature (reviewed in Heller, 1984) which has indicated that "transfer trauma" is not an inevitable outcome of residential relocation of developmentally disabled people." (Tamar Heller & David Braddock, 1985)

4. State hospital placement staff should remain actively involved with persons leaving the state hospital as long as the parents/guardians desire.

"....I'm glad to leave this place but I'll miss my friends. Am I ever going to see them again?" (comments of a person leaving a state institution)

The transition from institution to community living can be an unpredictable and disconcerting experience for the person being transitioned as well as their family. The involvement of state hospital staff as support persons who know and care about the individual can help smooth this transition. This support role should have no "case management" function or authority over the program services, rather this person would serve as a personal bridge between the past and the future for the individual. It must be remembered that persons with disabilities need to establish a continuity in their lives just as people without disabilities. Such a position can assist in maintaining valued relationships formed at the institution.

In addition, the hospital staff can serve as a valuable resource for the CMRCs if they encounter unexpected problems in serving the individual. It is the experience of staff involved in the Community Reintegration Demonstration Project, a project designed to establish a working partnership between state hospitals and CMRCs in placing persons from institutions into individualized community settings, that even the best of plans can fail to account for unexpected events.

5. Persons leaving state hospitals should be provided a one-time state aid grant which may be utilized as start up support.

Most of the persons who will return to their home communities have resided for many years in the institutional setting. The majority do not have sufficient personal possessions to begin a meaningful life. Currently MH&RS has established a two thousand dollar one-time grant for those persons leaving state hospitals. The provisions of this grant are that the person owns all items purchased with the monies. It is recommended that this practice be continued in all future hospital placements.

B. MINIMIZING THE IMPACT ON FAMILIES

For many parents of children with developmental disabilities one of the greatest concerns they confront centers on issues surrounding a place for their sons or daughters to live away from

home. Concerns for the safety and stability of out-of-home placements are, with justification, uppermost in their minds. Because of such concerns it is not surprising that closure of an institution is viewed by many parents with great fear, suspicion, and, in some cases, active resistance.

"....studies in which parental attitudes were sampled both before and after deinstitutionalization mirrored other studies showing high levels of general satisfaction with institutional placements before deinstitutionalization and high levels with community placements after deinstitutionalization." (Larson and Larkin, 1991)

While many parents endorse institutional placement, others are resigned to institutional placement as the only out-of-home placement option currently provided for persons with severe disabilities. For these parents real choice is an illusion not a reality, because it is based on alternatives that do not address the individuality of the person with a disability. Maintenance of three state hospitals and the accompanying costs has reduced their choice of service because of inadequate supports for community alternatives.

"What choice did we have? We didn't want our son to go to the institution, and we couldn't care for him at home. We had no other alternatives." (Parent of a child institutionalized at KNI)

Closure must address the very real, competing concerns of parents who desire the current stability of institutional placement and those persons who accepted the institutional option because there was no real alternative.

RECOMMENDATIONS

1. Determine which individuals currently residing in each of the three state hospitals would voluntarily seek community placement.

   Parents and guardians of current residents at the three state hospitals should be surveyed by MH&RS as to their desire for appropriate community placement or for continued care at one of the state hospitals. These data should be used to coordinate with each of the three hospitals, plans for movement and consolidation as well as for determining community placement time frames. These data should be updated annually to address changes in parental and guardian desires.

"The process of supporting people in life styles of their own choosing requires that we shift our "investments" in service development. We typically spend relatively little time in individual planning and more time in locating or developing a program. This approach requires that we spend more time in planning." (Smull & Harrison, 1991)

2. Parents, guardians and friends must be assured of an active role in the development of individual community alternatives.

   All placements from the state hospitals to community living should utilize person centered planning. This involves the development of individualized service plans which take into account the critical quality of life issues identified for each individual. This person centered planning should be led by

"Essential lifestyle planning helps people to discover their choices and then helps them to have those choices honored. There is no bias for or against a type of service or a predetermination of the number of people who should live together. It is focused on the individuals and what they value.

"specifically designated staff at each of the three state hospitals. The community agency should determine the actual service combination which would meet the needs identified in the person centered plan.

"Empowering individuals and their families to require a review of their plans clearly gives individuals an opportunity to seek redress where choice is not honored, the individual is at risk, or where families and individuals have divergent opinions about the services; the individual has the final say." (Smull, 1991)

3. Mental Health and Retardation Services must assure the empowerment of persons and their families by stating, either by policy or through contract, that they may request at anytime a review of the plan by the service provider or MH&RS as represented by the state hospital staff.

Placement in the community must be seen as a right, not a privilege to be earned. Individual problems encountered by persons leaving the state hospitals should be addressed within the community context and not be the reason given for returning the individual to the institution. All parties involved in the placement of the individual must be afforded the right to reexamine the client centered plan if it fails to meet critical needs of the individual. This basic right to revise the plan accepts the dynamic nature of human existence and acknowledges the fact that human needs are subject to change. Although there is some risk that this right to revise the plan at will may seem disruptive and inefficient to the service providers, the risk seems minimal when contrasted with the problems encountered by failing to meet a person's individual needs.

C. FISCAL ISSUES

During Fiscal Year 1992 more than 150 millon dollars, not including education funds, was spent on services for persons with developmental disabilities. These monies are made up of a combination of federal, state, local and private funds. Almost half of these expenditures went to the support of the three state hospitals. State general fund dollars comprise 49% of these funds as contrasted to ten years ago when state general fund dollars comprised 54% of all funds expended on programs for persons with disabilities. In addition, to an increased reliance on federal dollars on the part of the state, the community agencies have become increasingly dependent on the state for their revenues. In 1988, 37% of the funding for community programs came from the state. By 1991 the percentage of state contribution had risen to 52%.

The increasing dependence of the community agencies on state funds and the increasing dependence of the state on federal assistance make the issue of local programs more a myth than a reality. Community agencies are more likely to reflect the needs of the entire state while the state accepts the financial incentives put forth by the federal government. Key to these incentives is the new HCBS/MR waiver begun in July of 1991. The new waiver provides the vehicle for letting the "money follow the person".

This leveraging of state dollars and the state's ability to create individualized services provides the vehicle for funding the consolidation of the state hospitals and the expansion of the community system.

RECOMMENDATIONS

1. In order to assure that persons on the community waiting list are not adversely affected by consolidation, the HCBS/MR waiver program should be expanded beyond its current limit, and tiered rates must be established and properly funded.

   While the consolidation of the state hospital system would clearly be a major undertaking for the state, it should not occur at the expense of those families who have kept their relative at home and who will need HCBS funded community care. It is further recommended that MH&RS should not link placement of persons from the state hospitals with HCBS/MR placements from the community waiting list. Historically, such linkage has created a great deal of suspicion and animosity between community agencies and the state. It must be remembered that the premise behind consolidation is to develop a full array of services with each component, community agencies and state hospitals, playing a key role in the overall service system. It also must be remembered that not everyone who is severely MR/DD is living in state hospitals. These individuals should have equal access to these more intensive services.

2. State hospitals should be fully funded for each succeeding fiscal year at the previous years ending census.

   The present practice of estimating placements and then appropriating monies to reflect the placements presents serious management problems to each of the facilities. The disruption to staff and residents' lives can be severe when the reality does not match the estimated timelines. During this process of consolidation clients must move within and across institutions as well as into community placements. It is the obligation of all parties to assure that this process be as orderly and smooth as possible. Continuous budgetary problems which must be managed can only exacerbate this problem.

   An alternative to the current practice would be for MH&RS to seek statutory authority to adjust the budget of the targeted facility on a quarterly basis. This would allow the Commissioner and hospital director to transfer funds from the hospital budget to the general SRS budget. The transferred funds could then be used to fund additional resident moves to community agencies.

D. EASING THE IMPACT ON EMPLOYEES

"In the public sector, over 46 state mental health and retardation institutions closed between 1970-1983." (Braddock & Heller, 1984)

The Governor's recommendation for FY 1993 establishes a combined employment at all three mental retardation facilities of 2,228 FTEs. Based on SRS' work force analysis these positions can be sorted into eight basic categories. Eighty-six percent of the

employees at all three hospitals are at range 18 or below. The total combined payroll of all employees at the state hospitals comes to over sixty-five millon dollars. Based on current data 73 percent of the employees at all three facilities have less than ten years employment with the state. Fifty-one percent have less than five years of employment.

With the implementation of the Phase III in 1989 direct care workers have realized a significant increase in their salaries averaging a seven percent increase overall. Turnover rate across all three facilities was significantly reduced from an annual rate of over 30 percent to just under 15 percent. Current data suggest that the average pay for persons in similar jobs in community programs is approximately three dollars per hour less than the direct care staff at state hospitals. While there are no data available on turnover rates in community facilities there is general agreement that turnover is a problem for many agencies.

On the average, direct care wages in community programs are about 40% less than the wage paid by State Hospitals ($5.06 compared to $8.45.)

Current practice established by the Department of Administration regarding reductions in force specify that each agency must have a reduction in force plan. This plan must outline the specific procedures for selecting positions to be eliminated. This plan may also protect the rights of affected employees. In general these plans are based on the principle of seniority. When entire classes of jobs are to be eliminated, persons may bump others less senior in other job classes provided they meet the minimum qualifications of that job. At present, agencies and departments of state government are not required to hire state employees who are displaced. Following the closure of Norton State Hospital SRS made a concerted effort to see that staff who wished to work at other SRS agencies were provided jobs. Twenty-three percent of those persons who were displaced were employed by other agencies in SRS.

SRS was able to assist two thirds of the Norton State Hospital employees in finding work as state employees. Of the 225 staff identified only 75 were actually laid off. More recently, out of 120 positions eliminated at WSH only 20 employees were actually laid off.

Finally, the targeting of a facility for closure as the process unfolds can present less tangible but no less serious morale problems within the facility itself. As closure becomes a reality, employees feeling abandoned by the state begin to seek employment elsewhere. Norton State Hospital, for example, faced serious problems once the plan to close was announced. Staff losses to Corrections placed client care in jeopardy, creating a crisis atmosphere within the facility. In addition to the high turnover experienced is a general lack of motivation by those staff who remain. The result of all these factors can place client care in jeopardy. The uncertainty of the situation leaves employees with an inability to plan their lives and to anticipate the future. This can create a problematic work environment.

"Several studies have found that job loss ranks between seventh and ninth in the degree of stress it creates relative to as many as 61 other life events." (Holmes & Rahe, 1967; Paykel, 1971)

RECOMMENDATIONS

1. SRS and the Department of Administration should establish an early retirement program for employees who will lose their jobs through closure. This program should be based on any combination of age plus years of service which equals 70.

   Kansas Public Employees Retirement System currently recognizes one variation of this early retirement formula allowing for early retirement with an age of 55 and 15 years of service. Other states have used the "70 years" formula as a standard for early retirement when faced with a possible lay off policy. The advantage of such a plan is that it allows the displaced worker to remain in their community with some financial support. Employees should remain eligible for this program for up to one year after they have left state employment. Finally, such a plan should allow the affected employee to choose early retirement at any time during the process of closure.

2. The administration of the selected hospital, MH&RS staff, and personnel from the Division of the Budget should develop a detailed closure plan which sets budget and census targets for each fiscal year. This should be used to project staff reductions.

   Nothing can be more disconcerting to employees than a sense of not being able to predict the future of their employment. Advanced and coordinated planning would provide sufficient lead time to find alternative employment or to begin training in order to acquire new skills. In addition advanced planning should prevent much of the disinformation and rumor spreading which can be so destructive to a process of closure.

   "When individuals are faced with uncertain situations, such as potential job loss or transfer, they are likely to appraise the extent to which the new situation poses a threat to their old valued outcomes." (Brett, 1980; Folkman & Lazarus, 1980) "Plant facility closures disrupt career plans, job security, social relationships, and patterns of daily life."

3. The Governor should direct all state agencies to give priority to hiring employees displaced by the closure process.

   Current practice establishes that an employee subject to lay off has the opportunity to "bump" employees in the same job class with less seniority. This applies, however, only

to the agency involved in the lay off. Preferential re-employment only applies to the agency from which the former employee was laid off. Unless so directed, other agencies and departments in state government are not subject to a preferential rehire policy.

Currently SRS has a Job Search Program which assists employees in transferring and finding promotions within SRS. A part of the Job Search Program is to match the employees' skills with job categories within SRS. In addition, the interest survey allows employees to assess what additional training they might require to qualify for advancement into job categories of specific interest. The expansion of this program to address all agencies of state government would be an asset to the future employment of displaced workers.

"In the closure reported here employees noted that the most important function served by the organization were providing information about closure procedures, employee rights, and potential job transfer sites; on-site outplacement services; job assistance training; and counseling." (Heller, Harris & Braddock)

4. The facility to be closed should be budgeted to hire job counselors to assist displaced employees in the transition.

The targeted facility should be budgeted to hire at least two full-time job counselors at range 23 to assist employees in Job Search and to help in the development of new work skills. In addition, these positions could serve the role of advocate and liaison to community programs to promote the hiring of state hospital staff. While the disparity between the wages paid in the community and at state hospitals is great, proposed rates for direct care workers in the HCBS guidelines are close to those currently paid direct care staff at the state hospitals. Finally, it should be noted that in its comprehensive plan MH&RS has proposed that monies be appropriated to close the gap between state and community staff.

5. The institution to be closed should budget monies which maybe used to retrain staff who are likely to lose their jobs.

While each of the three institutions currently provide college credit for the training they provide direct care staff, this training is narrowly focused on the immediate needs of the facility. As such, the skills trained are not necessarily transferable to other job duties. It would seem reasonable that the institution to be closed ought to assist employees in gaining new skills by providing some release time and tuition assistance. Precedent for this has already been established. Kansas Neurological Institute has for a

number of years provided as a job benefit, tuition assistance to employees taking work related courses.

6. Employees who lose their job as a result of the closure should be allowed to have automatic vestiture in KPERS after five years of service.

73% of the employees at the three state hospitals have less than 10 years tenure. 51% have less than five years of service.

State employees who lose their jobs after less than ten years of employment lose eligibility to receive retirement income from KPERS. They also lose the employer matching share of their mandatory retirement investment. In order to protect their well being in the future, employees who have worked five years or more should be vested in KPERS.

7. Modify the staff training program of the institution so that it has a community focus and is value-based.

"The management and staff of Laconia are perhaps the unsung heroes of New Hampshire's decade-long struggle. The staff members had to understand and be dedicated to the process of moving individuals into community services and to supporting the parents who remained in the final placement process." (TASH Newsletter, 1991

Current training for direct care staff at each of the state institutions has focused on a traditional curriculum of behavior modification, general information on mental retardation and health care issues. This training reflects a "disability first" focus rather than a people first view. In order to enlist the support of staff at the institution it is necessary for them to share the expanded vision being set for persons with disabilities. By sharing this vision and recognizing their role in this process they are more likely to support the movement from institutional life to community settings. This will improve the moral of staff as the process of closure proceeds.

8. MH&RS should commit itself to placing as many persons as possible with disabilities within the economic region to be affected by state hospital closure.

At present there are approximately 100 residents in the state hospitals for whom there is no identifiable home community. In addition, each hospital has a large number of residents from their immediate surrounding counties. MH&RS should, over the period of closure, work with the CMRC's surrounding the targeted facility to increase their capacity to absorb former residents of the three hospitals.

Current estimates suggest that two direct care jobs are created in the community for every one resident placed. New HCBS/MR rate guidelines, in their preliminary stages of preparation, would set reimbursement for direct care

staff at close to the average wage earned by state hospital staff. This could mean that local area would need to be able to absorb up to a third of the total placements. The impact of this practice would be to minimize the potential economic impact on both the local community and on many of the direct care staff employed by the hospital.

PRINCIPLES OF PLACING INDIVIDUALS

In 1990 MH&RS presented the possibility of closing one unit of Winfield State Hospital and Training Center. The legislature, in reaction to this proposal approved a provision in the state hospital appropriations bill which specified certain issues SRS should address prior to such action being taken. In recent months the discussion has broadened, under the leadership of the MH&RS legislative subcommittee, to include the possibility of completely closing one state mental retardation hospital. Since the end of the 1990 legislative session, Mental Health and Retardation Services (MH&RS), state mental retardation hospitals, interested parents, and community mental retardation centers (CMRCs) have held many in-depth discussions about how to proceed in placing individuals out of state mental retardation hospitals. These discussions have resulted in the development of certain principles and procedures which are being used in the Community Integration Demonstration (CID) project. These principles and procedures address the concerns regarding placement of individuals out of state mental retardation hospitals contained in the 1990 legislative proviso. The consistent application of these principles can easily result in the closure of a state mental retardation hospital unit or an entire state mental retardation hospital.

The principles which are being used in the CID project include: 1) Giving individuals living in state mental retardation hospitals and their families a choice whether they participate in community placement, 2) Designing individual person center plans for serving individuals who do choose to be placed from state mental retardation hospitals to community services, 3) Monitoring CMRCs to be certain that quality services are provided and 4) Developing and maintaining necessary services in state mental retardation hospitals to meet the needs of individuals who may have special severe needs who are not initially placed in the community.

Due to the large number of state mental retardation hospital beds, the individuals living in state mental retardation hospitals and their families can be given a choice whether to participate in community placement even with the closure of one of the hospitals. Over 125 individuals from state mental retardation hospitals have applied for and been accepted on community mental retardation center waiting lists. These people have applied for community services despite being discouraged from doing so by the large community waiting list. Based on this and our recent experience in the CID project, it is generally agreed that there would be no problem finding sufficient numbers of individuals who would prefer community services to allow the closure of one state mental retardation hospital. Therefore, MH&RS sees no reason why the individuals living in state mental retardation hospitals and their families should not be given a complete choice at this time whether or not to participate in community placement.

However, when individuals are given a choice whether or not to participate in community placement two other issues are created. First, in order to meet the necessary placement goals needed to close a hospital, placements must occur from all the state mental retardation hospitals. This will necessitate the movement of individuals within the hospitals in order to most efficiently provide services. This will mean there will be more individuals moved than if individuals were given no choice at all to participate in community placement. However, the movement of individuals within a hospital is a relatively common occurrence and, while this process will

increase the number of such moves, the state mental retardation hospitals and the individuals they serve can learn to deal with them.

Second, individuals living in the hospital which is closed who choose not to participate in community placement will have to move to another state mental retardation hospital. This may create some physical and emotional hardship for the families and individuals served. However, it must be realized that the state mental retardation hospitals do not serve specific geographic regions of the state. The individuals they serve are from all over the state. Some individuals may be moved farther away from their families in this process; others may move closer. The net effect is impossible to predict until all community placements are made. Even though parents from all three hospitals would state otherwise, there is no significant difference in the quality of services individuals receive in any of the hospitals. Individuals who have to move to another hospital will still have their needs met by dedicated and caring staff.

In order to accept these individuals from state mental retardation hospitals, the CMRCs must develop the necessary services to meet their needs. It has been suggested, during these deliberations, that a complete array of community services should be fully developed to meet the needs of the general state mental retardation hospital population before the decision to close a hospital is made. Clearly, given the experiences in Kansas as well as other states, this is not at all necessary or appropriate. The needs of each individual who is mentally retarded are unique. The only way services can be designed and implemented to meet those needs is to create choices and provide community service options one person at a time. The CID project embraces this principle through person centered planning. This is the approach which should be used in reducing state mental retardation hospital census sufficiently to close one hospital.

The next section describes in detail the procedures used in developing these person centered plans. In summary, based on the general principles developed by Michael Smull, Beth Mount and others, a person centered plan is developed for an individual by people who know and care about him. Once the plan is completed it is presented to a community mental retardation center which determines how the plan can be implemented. In the absence of standard tiered rates for HCBS/MR funded services, the community mental retardation center estimates the cost of implementing the plan. The CMRC submits the implementation plan and associated costs to the state mental retardation hospital for review and approval. The plan is then submitted to MH&RS for review and approval of the reimbursement request and the HCBS/MR plan of care. Once the plan is approved, the community mental retardation center then develops the services knowing the individual will be placed with their agency and that the cost for the services will be funded.

Using this person centered planning approach the individual placed and his family will know and have agreed to what services will be provided. This approach will meet the needs of individuals placed in CMRCs while eliminating the need for a massive development and funding of specialized services across the state in all CMRCs without regard to the needs of the individuals placed.

Third, MH&RS must have at least 12 Area Office staff solely dedicated to the implementation of person centered consumer driven quality assurance in CMRCs. These staff would license and review all services provided by community mental retardation agencies. These staff would also

be responsible to organize local monitoring efforts with the involvement of interested families and individuals served. These monitoring efforts would go beyond existing licensing standards by evaluating the quality of life of the individuals served in the CMRC and the responsiveness of the agency in providing requested and necessary services. MH&RS is opposed to the closure of a state mental retardation hospital unless this critical monitoring of services is provided.

Finally, at least initially, there will be individuals some CMRCs will be unable to serve. Recent experience indicates that there are very few of these individuals. However, these individuals tend to fall into two distinct categories. Some of these individuals have very severe medical needs. CMRCs can meet the needs of these individuals in time but they need statutory support and adequate professional resources to do so. In the recent past it was very rare to find any CMRC which employed or consulted with a Registered Nurse. The practice is now fairly common. CMRCs now have statutory support to allow them to more fully use the expertise of these medical professionals.

Some individuals in state mental retardation hospitals present serious behavioral challenges. CMRCs are learning how to serve individuals who present these challenges. The key to successfully serving these individuals is adequate training and support of the direct service staff in the CMRCs. Progress is being made in this area through cooperative efforts between the CMRCs, MH&RS, the University Affiliated Programs and the state mental retardation hospitals. More and more individuals with challenging behaviors are being accepted into community services and are being successfully served. Many, however, remain in state mental retardation hospitals awaiting placement.

Individuals with the most challenging behaviors and medical needs may, in the short term, remain in state mental retardation hospitals. This means the remaining two hospitals must be given sufficient resources to develop and maintain specialized services to meet the needs of these individuals. This will result in increased per diem costs in the remaining institutions. However, it is unreasonable to expect the average cost of serving individuals in state mental retardation hospitals to remain level while the average relative level of need of the individuals remaining in these facilities greatly increases. It is critical that these increased costs are provided for adequately and that services in state mental retardation hospitals not be allowed to deteriorate.

In summary, the plan to close a state mental retardation hospital involves four primary principles. First, the individuals living in state mental retardation hospitals and their families will have a choice whether or not they will be placed in the community. Second, those who choose to participate will have their services individually planned and implemented to meet their needs. Third, MH&RS will monitor services very closely to be certain quality services are provided to everyone in CMRCs, especially those placed out of state mental retardation hospitals. Fourth, the two remaining state mental retardation hospitals will be supported in the development and maintenance of the specialized services to meet the needs of those individuals remaining in these facilities.

Clearly, Kansas has fallen dramatically from its former preeminence in the provision of services for individuals who are mentally retarded. The application of these principles and procedures in the placement of individuals out of state mental retardation hospitals and the closure of one

hospital will greatly help in moving Kansas back into a leadership role in this service area once again.

PROCEDURES FOR PLACING INDIVIDUALS

I. GENERAL PURPOSE

The following guidelines and procedures are designed to be used when placing people from the state institutions into community settings. It is the responsibility of each institution to follow these procedures in a manner which captures the spirit of the person centered planning approach. The underlying value to this approach is that people with disabilities are first and foremost people, who require and deserve a personalized lifestyle which addresses their human needs. The person centered planning approach subscribes to the philosophy that all people with disabilities have a right to live a normalized lifestyle outside of the institution. To be successful in this approach it is important that participants of the process recognize the need to wrap services around people rather than identifying slots and programs which people may fit into.

The person centered planning process focuses heavily on the individual, and the type of lifestyle which each person values. The placement process relies heavily on collaboration and a good working relationship between the people working in institutions, community agencies, the person moving, and his or her friends and family. This cooperative effort, along with the person centered focus, should help us to insure good lives in the future for those people we serve now.

To successfully accomplish the goals of the person centered placement approach, events should proceed in the following sequence:

A. People should be selected to move from the institution prior to contact with the Community Mental Retardation Center or the designated affiliate about specific people.

B. A Lifestyle Plan should be developed for selected people.

C. The Lifestyle Plan is presented to the community agency.

D. Community agency staff are invited to visit the selected person.

E. Community agency develops a proposed Support Plan for the person.

F. Community agency develops an HCBS/MR Plan of Care based on the Support Plan.

G. Institution staff review plans and negotiate with community agency.

H. Institution and community agency staff plan for the move from the institution.

I. The person moves to new home.

J. Follow-up visits by those who know and care.

K. Periodic review meetings with institution and community agency staff.

The progress of each person throughout this process should be followed.

II. SELECTING PEOPLE TO MOVE

Selection of people to move should be done by those in the institution who know the person along with family and friends, and should take the following into account:

A. Parents or guardians should have the opportunity to make an informed decision. For the parents or guardians to make an informed decision, however, it is important to help them to understand that, because of the HCBS/MR Waiver, the options for people moving from institutions are not necessarily limited to the types of programs and services currently available.

B. Successes are important. We are more likely to be successful with agencies who understand the person centered approach and who are interested in being part of the change. Community agencies should be informed of the Lifestyle Planning approach in a manner which encourages their interest.

C. Help people to move back home. It is generally desirable to help people move back to or near their home towns or relatives. It is important, however, that the location is one which is important to the lifestyle of each person moving - which the Lifestyle Planning process will help to determine.

III. DEVELOPING THE LIFESTYLE PLAN

Each institution should designate a facilitator for each person involved in the Personal Lifestyle Planning process. Only people who have been formally trained in the Lifestyle Planning Process should function in this role. The facilitator for each person should not change and should be involved with that person from start to finish - from the development of the plan until after the move.

The facilitator's job is more than just to run meetings and iron out practical details. The facilitator's role is to get to know as much about the person as possible - and then to act on the behalf of the person during the planning meeting and throughout the process. The facilitator should help everyone to get to know the person and not just the person's reputation.

Prior to the meeting, the facilitator should summarize the information gathered during the interviews into preliminary lists using the categories above, and display the lists on large sheets of paper at the meeting. Having gathered information from the interviews, the next step is to conduct a Personal Lifestyle Planning meeting.

The information contained in the completed Lifestyle Plan should be related to lifestyle choices of the person - i.e. those things which should lead to a reasonable quality of life. The Lifestyle Plan should not contain information about what kind of training programs a person should have or how programming should be implemented (e.g. staffing rations, etc.).

IV. PRESENTING THE PLAN TO THE COMMUNITY AGENCY

The Lifestyle Plan should be presented to the community agency along with an invitation to come meet this person. It then becomes the community agency's responsibility to:

A. Determine whether they can serve this person, and

B. Propose how they would provide services to them

Remember that the Lifestyle Plan is not an all encompassing document and that its primary purpose is to let the new providers see the person first. Below are some guidelines to help evaluate whether or not the Support Plan proposed by the community agency meets the spirit of the Lifestyle Plan.

V. REVIEWING THE PLAN OF CARE AND NEGOTIATING THE RATE

At this point in the transition process, the facilitator takes on additional responsibilities. Now the facilitator must begin to insure that all necessary supports are included in the plan of care submitted by the community agency.

The community agency submits the Plan of Care, a proposed Support Plan and any supporting materials that will provide information the facilitator will need to evaluate the plan of care. The proposed Support Plan must include specific information on how the community agency plans to provide the necessary supports for the person moving.

Those who know and care about this person will carefully review the materials and decide if the plan of care provides all the necessary support for the person to live in his or her new home. The first question the reviewers should ask about the proposed Support Plan is "DID THEY GET IT?" Do they seem to understand the person first, and not just the person's disabilities? Do you think the community agency has an idea about what supports will be needed to support this individual in the new location? For example, the proposed Support Plan submitted by the community agency states only that a job will be found for this person in the community. This is not enough information for the team to evaluate the effectiveness of the proposed Support Plan. In order for the team to determine if the community agency "GETS IT", the proposed Support Plan should include specific details such as: how the job will be located, the type of job, does the job match the individual's interests and skills, and what support will be given to the individual on the job.

VI. PLANNING THE MOVE

The primary goal of this process is to help the person moving to feel as comfortable as possible with all the changes which they will experience. Those who know and care about the individual, the person moving, and a representative from the community agency, must be involved in planning for the move. To be successful, it is important to address both practical concerns, and information sharing.

Conduct a meeting to plan the activities that must take place before the move in order to make the transition as smooth as possible. Some tasks that usually must be accomplished before the move are listed below. This is by no means an all inclusive list. The tasks to be accomplished will vary with each individual. Be sure to assign a target date and a person responsible for completing each task. If the person who is moving is interested in any of these steps, they should be included in the process.

-Setting a move date
-Locating a place to live
-Identifying and selecting furnishings for the home (The first step should be to check with the person's family and friends to see what they would be willing to donate. Then the community agency can apply for a startup grant from MH&RS.)
-Designating SSI payee
-Developing a budget
-If there are roommates, setting up times for the individuals to get to know each other
-Person moving should visit their new home
-Opening a bank account
-Locating a place of employment if applicable
-Community agency staff visiting institution
-Institution staff helping person on move day

The sharing of important information with the new support staff at the community agency is a critical component to a successful move and should be included in the move plan.

VII. FOLLOW-UP AFTER THE MOVE

Contact from the people who know and care about the individual after the move has occurred is crucial to a successful placement. Those who know and care about this person must stay involved. The follow-up is based on a concern and caring attitude by the person's friends. The length of follow-up is based on the individual's needs. Some contacts may be maintained a long time as with any friendship.

ACTION PLAN

What follows is a list of action steps which must be completed in order to implement the recommendations previously outlined. While these steps are assigned to persons or agencies, they will be accomplished through a cooperative and collaborative effort on the part of families, providers, government agencies, state hospital staff, and the legislature. Working together, these entities will be able to close a state hospital and ensure that institutionalized individuals have the opportunity for full inclusion into their home communities.

Recommendation: A.1. MH&RS must assure that Community Mental Retardation Centers (CMRCs) meet a basic standard of service, including the right of institutionalized persons to an established quality of service in their home communities.

Action Step(s):

a. Approve 12 FTEs for one MR/DD specialist in each SRS Area Office to perform on-going quality enhancement monitoring and to provide technical assistance to CMRCs.

Responsible: Legislature

b. Establish legislative intent that CMRCs must have "zero reject" policies and provide a prespecified minimal array of services.

Responsible: Legislature

c. Establish content requirements for a quality assurance plan to be prepared by each CMRC.

Responsible: MH&RS, in cooperation with the MR/DD Advisory Committee and Family Services Council

d. Prepare a quality assurance plan conforming to the requirements outlined.

Responsible: Each CMRC

e. Develop quality assurance review procedures

Responsible: MH&RS, in cooperation with the MR/DD Advisory Committee, Family Services Council, and Area Office staff

Recommendation:	A.2.	MH&RS should establish a grant to hire persons to serve as technical consultants on quality enhancement to assist CMRCs meet the challenges presented by persons with severe disabilities.
Action Step(s):	a.	Appropriate $700,000 to establish a complete interdisciplinary team of professionals. Responsible: Legislature
	b.	Prepare technical assistance grant Responsible: MH&RS, in cooperation with KUAP, CMRCs, individuals served and families
Recommendation:	A.3.	Medically challenging persons should be consolidated in one of the two remaining hospitals.
Action Step(s):	a.	Assign a Special Project person to oversee the person-centered planning process for all clients prior to their transfer or placement in communities. Responsible: MH&RS
Recommendation:	A.4.	State hospital placement staff should remain actively involved with persons leaving the state hospital as long as the parents/guardians desire.
Action Step(s):	a.	Designate two staff persons at each hospital to oversee the person-centered planning process. Responsible: State Hospitals
Recommendation:	A.5.	Persons leaving state hospitals should be provided a one-time grant which may be utilized as start-up support.
Action Step(s):	a.	Appropriate $200,000 per year for each of five years for start-up grants. Responsible: Legislature
	b.	Prepare request for proposals for start-up grants.

Responsible: MH&RS

Recommendation: B.1. Determine which individuals currently residing in each of the three state hospitals would voluntarily seek community placement.

Action Step(s): a. It will be determined which families are currently in favor of community placement through the person-centered planning process,

Responsible: State Hospitals

Recommendation: B.2. Parents, guardians and friends must be assured of an active role in the development of individual community alternatives.

Action Step(s): b. See A.4. a.

Recommendation: B.3. Mental Health and Retardation Services must assure the empowerment of persons and their families by stating, either by policy or through contract, that they may request at anytime a review of the plan by the service provider or MH&RS as represented by the state hospital staff.

Action Step(s): a. See A.1. c.

Recommendation: C.1. In order to assure that persons on the community waiting list are not adversely affected by closure, the HCBS/MR waiver program should be expanded beyond its current limit, and tiered rates must be established and properly funded.

Action Step(s): a. Request expansion of HCBS/MR waiver as needed to accommodate increased numbers of institutionalized clients.

Responsible: MH&RS

b. Implement tiered HCBS/MR rates

Responsible: Legislature, MH&RS, in cooperation with providers, families, and advocates and Legislature

Recommendation:	C.2.	State hospitals should be fully funded for each succeeding fiscal year at the previous year's ending census.
Action Step(s):	a.	Grant SRS/MH&RS authority to adjust state hospital budgets and transfer funds from hospitals to SRS budget to fund community services. Responsible: Legislature
Recommendation:	D.1.	SRS and the Department of Administration should establish an early retirement program for employees who will lose their jobs through closure. This program should be based on any combination of age plus years of service which equals 70.
Action Step(s):	a.	Grant SRS statutory authority to permit early retirement for eligible state mental retardation hospital employees. Responsible: Legislature, in cooperation with Department of Administration
Recommendation:	D.2.	The administration of the hospital, MH&RS staff, and personnel from the Division of the Budget should develop a detailed closure plan which sets budget and census targets for each fiscal year. This should be used to project staff reductions.
Action Step(s):	a.	Prepare a detailed staff utilization plan. Responsible: MH&RS, in cooperation with SRS Personnel and Department of Administration Personnel
Recommendation:	D.3.	The Governor should direct all state agencies to give priority to hiring employees displaced by the closure process.
Action Step(s):	a.	Issue an Executive Directive requiring all state agencies to give priority to hiring displaced hospital employees.

Responsible: Governor

Recommendation: D.4. The hospital should be budgeted to hire job counselors to assist displaced employees in the transition.

Action Step(s):

a. Re-allocate two hospital staff positions to serve as job counselors

Responsible: Hospital and MH&RS

b. Encourage increased CMRC staff wages via HCBS/MR tiered rates [see C.1.b.]

Responsible: MH&RS and Legislature

Recommendation: D.5. The hospital should budget monies which may be used to retrain staff who are likely to lose their jobs.

Action Step(s):

a. Re-allocate funds for staff training

Responsible: Hospital

b. Provide re-training for staff who will be displaced by closure.

Responsible: Hospital, SRS Personnel and Dept. of Administration Personnel

Recommendation: D.6. Employees who lose their job as a result of the closure should be allowed to have automatic vestiture in KPERS after five years of service.

Action Step(s):

a. Grant statutory authority to KPERS to allow displaced hospital employees the option to be vested in KPERS after five years of service.

Responsible: Legislature

Recommendation: D.7. Modify the staff training program of hospitals so that it has a community focus and is value-based.

Action Step(s):

a. Reconfigure staff training at the three mental retardation hospitals to emphasize community inclusion and person-centered planning.

Responsible: State Hospitals and MH&RS

Recommendation: D.8. MH&RS should commit itself to placing as many persons as possible with disabilities within the economic region to be affected by state hospital closure.

Action Step(s):

a. Within the parameters of the person-centered planning process, clients for whom there is no identifiable home county will be placed in the area of the hospital.

Responsible: State Hospital and MH&RS

b. See A.4.a.

BACKGROUND LEADING TO CONSOLIDATION ANNOUNCEMENT

1990 Legislature:	Directed MH&RS to transfer 50 individuals from state hospitals to community settings. In addition, the Task Force on Social and Rehabilitation Services was first established by the Legislative Coordinating Council and directed to prepare a report and recommendations to the Legislature based on the work of four (4) subcommittees.
1991 Legislature:	During the 1991 interim period, the Task Force on SRS was divided into four (4) subcommittees: mental health and retardation services; financing; prevention and medical services and long-term care. The subcommittees met each month to receive information and develop recommendations in their respective subject areas. In some cases, the subcommittees visited community facilities. An Ad Hoc Committee on Hospital Consolidation was established by SRS in 1991 to study the need to maintain three MR hospitals. The Committee was composed of family members, advocates, state agency employees, staff representatives from the three hospitals, union and provider representatives and a representative from the Governor's Office.
February, 1991:	Initial discussions began regarding the implementation of the Community Integration Demonstration (CID) project which was aimed at transitioning WSH and KNI residents to community settings.
July, 1991:	The staff of the State hospitals, in collaboration with CMRC personnel, began to develop the first personal transition plans for CID participants who would be moving from a State hospital to the community.
December, 1991:	The four subcommittees made reports to the full legislative Task Force on SRS. The Task Force consisted of 17 members of the Legislature and seven public members.
January, 1992:	The Task Force on SRS filed its final report with the Legislature. It included a recommendation that the number of state-operated MR hospitals be reduced from three to two over a five year period.
March, 1992:	The SRS Ad Hoc Committee on Hospital Consolidation filed its final report entitled, A Report on Consolidation of Institutional Services From Three to Two Facilities.

1992 Legislature:	The House of Representatives Appropriations Subcommittee established factors to be considered in analyzing closure of a state mental retardation hospital.
May, 1992:	A draft economic impact analysis on the proposed closure of Kansas Neurological Institute, Parsons, and Winfield State Hospitals was completed by Fayez Tayyem, Ph.D., an economist at Kansas State University.
June, 1992:	A draft economic impact analysis of relocating mentally handicapped patients to their home communities was completed by Dr. Tayyem.
	An expert team, consisting of Robert M. Gettings and Lyn Rucker, toured Parsons, Winfield and KNI, and submitted a report.

HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE FACTORS

The Subcommittee believes that SRS/MHRS is in the best position to ascertain which institution would be most appropriate to close. The process of determining which hospital to close should be driven by what is best for the system's clients and their families, keeping in mind that it has been the experience of both families and professional caregivers that community settings are generally more positive than institutional ones. The agency should also consider the following factors, among others:

* The impact that the hospital's closing would have on the hospital's clients and their families.

* The availability of appropriate community-care settings and supports in the service area of each institution.

* The effect of closing an institution on the institution's staff, their families, and the institution's host community.

* The efficiency of the institution's operation.

* Employee availability and labor costs.

* The ability of the institution's home community to deal with economic consequences of closure as determined by a financial-impact study; the community's general economic health, long-term labor trends in the community and employment alternatives for workers at the institution are among the factors that should be considered in this regard. In studying this factor, the finding of the Ad Hoc Committee that two jobs would be created for every client placed into the community should be kept in mind.

* The savings to the State of Kansas that would be generated by closing the institution. (It is the understanding of the Subcommittee that savings realized from the downsizing and closing of the institution would be used to augment community-care programs for people with mental retardation and developmental disabilities.)

* The state of the institution's physical plant, and future capital costs that would be incurred by the state if the institution were kept open.

In coming to the decision on which institution to close, SRS/MHRS should work in close consultation with a recognized outside expert.

The Subcommittee recommends that the pace of client movement from the institutions continue at the same pace as at present, i.e., approximately 84 clients a year. This should allow for the closing of the chosen hospital in approximately four years' time.

SRS ANALYSIS OF INSTITUTIONAL CLOSURE FACTORS

During the 1991 interim period, the Legislative Task Force on Social and Rehabilitation Services studied the system of services to persons with mental retardation/developmental disabilities. Consideration was given to the number of hospitals serving persons with mental retardation operated by the state. During this period, an Ad Hoc Committee on Hospital Consolidation was established by SRS in 1991 to study and recommend actions to be carried out in the closure of a mental retardation hospital. The Committee was composed of family members, advocates, state agency employees, staff representatives from the three hospitals, union and MR/DD provider representatives, and an observer from the Governor's Office.

In January, 1992, the Task Force on SRS filed its final report with the Legislature. It included a recommendation that the Legislature consider consolidating the number of state operated mental retardation hospitals from three to two over a five year period. In March, 1992, the Ad Hoc Committee on Hospital Consolidation filed its final report providing recommended actions if a hospital were to be closed. The 1992 Legislature established review criteria and instructed SRS to analyze which of the three mental retardation institutions it would be most appropriate to close. As a result,and in congruence with the plan for services for individuals with developmental disabilities (**Supporting Kansans with Developmental Disabilities**) prepared by Mental Health & Retardation Services (MH&RS), and approved by the Subcommittee on Mental Retardation Services of the Legislative Task Force, MH&RS has gathered the following information. This information is based on objective criteria outlined by the subcommittee and is condensed into three broad categories:

1. Personnel

2. Efficiency of operations and family considerations

3. Client characteristics

Personnel

This section examines turnover, absenteeism, and recruitment. The number of hours of sick leave used by WSH employees from January 1, 1992 to December 17, 1993 is 70,328, compared to the Parsons State Hospital (PSH) figure of 46,928 and the Kansas Neurological Institute (KNI) figure of 72,907. WSH has had considerable problems with turnover. For medical positions, turnover in FY 1990 was 43%; for the first six months of FY 1992 it was 10%. The turnover percentage for medical positions at each institution during the first six months of FY 1993 is 14% at KNI, 8% at PSH, and 37% at WSH.

Direct care staff turnover at each hospital for three and a half years is illustrated below.

	FY90	FY91	FY92	FY93*
KNI	23%	18%	9%	18%
PSH	17%	15%	6%	11%
WSH	36%	30%	14%	39%

*first six months

Professional staff turnover follows a similar pattern, with WSH having the highest percentage (27%), followed by PSH (19%), and KNI (18%).Although KNI can fill vacant professional positions in three weeks, it is reported to take eight weeks at PSH and four to six weeks at WSH. WSH contracts with Liberty Health Care to provide many of its professionals (i.e., physical therapists, occupational therapists, and medical director). The cost of this contract, for FY 1992, was $1,083,327 although the cost of this contract is expected to decrease. PSH and KNI recruit professionals without the use of a contracting agency which eliminates additional overhead costs as well as obtains the professional service within state-approved salary ranges. WSH also takes up to four weeks to fill direct care positions.

The decision to close a state mental retardation hospital must also take into consideration the staff working at the hospital. These staff need other employment opportunities or the option of early retirement. Clearly, staff at the institution selected to close must be given the same opportunities that Norton State Hospital staff were in terms of having priority for other state jobs. Currently, 116 staff at WSH are eligible for early retirement using the formula of years of service plus age equals seventy; at KNI and PSH such staff number 101 and 80, respectively. This retirement formula would require legislative action to be implemented.

Alternative employment opportunities in the private sector must also be examined. Approximately 65% of the clients at WSH have parents or guardians who live within a 45 mile radius of Winfield, or have families which live out of state. There are ten community mental retardation centers (CMRCs) within this area which will expand in order to provide services to these WSH clients. Conversely, 40% of KNI clients have guardians, or come from, within 45 miles of Topeka, and 6 CMRCs would be involved with these placements. Twenty-nine percent of PSH have guardians in, or come from, the Parsons area, served by only two CMRCs.

Analysis of Efficiency of Operations and Family Considerations

Costs related to client needs are legitimate. However, the data for FY 1993 show that WSH may be more inefficient in its operation compared to KNI and PSH. WSH has the highest per diem cost of the three hospitals - $253.09, compared to $228.65 at KNI and $191.60 at PSH. KNI and WSH are generally comparable in size and client characteristics. The administrative costs, as a percent of total cost, at WSH are also higher than at KNI - 5.58%, compared to 3.34%. PSH, however, because of its smaller size, has the highest administrative cost percentage - 7.68%. In addition, costs budgeted under staff training and education cost center are higher

at WSH - $427,607, compared to $297,189 at KNI and $264,136 at PSH. The number of staff positions dedicated to staff education and research at WSH is almost twice that of either KNI or PSH.

In the area of overtime expenditures, WSH has spent $329,524 from January through December, 1992. By contrast, KNI spent $1,210 in overtime for the same period; PSH has spent $0. These figures are consistent with the previous year's: WSH - $333,514, KNI - $10,021 ($7,850 of which was an audit requirement to pay employees with more than 60 hours of compensatory time), and PSH - $2,085.

The preliminary ten year capital improvement plan for the three hospitals indicates that WSH will require $34,718,500; 40% of this is requested for program requirements, including a new hospital building to serve medically fragile clients. KNI and PSH will need $21,485,400 and $32,545,400, respectively, in capital improvements. The bulk of these requests (73% and 83%) is for rehabilitation and repair of existing buildings.

Costs for professional staff are higher at WSH. A simple average (total gross wages divided by FTEs) indicates that WSH professionals are paid $37,831 annually. KNI and PSH professionals average $26,915 and $28,153 annually. Average medical professional cost for FY 1992, as indicated by average gross salary, is $28,317 at WSH, $26,915 at KNI, and $30,203 at PSH. WSH and KNI have roughly the same number of medical FTEs. Approximately 12% of the $1,083,327 Liberty contract is the salary for a medical director. The FY 1992 contract also included five occupational therapists and seven physical therapists. The cost to WSH for Liberty to provide these twelve professionals averages approximately $80,000 for each professional.

Another factor to consider when determining which mental retardation hospital should be closed is the distance which families must travel to visit their family members who reside in those hospitals. An analysis based on home counties indicates that, on average, families must travel farther to PSH (166.5 miles) than to KNI (74.5 miles) or WSH (102.3 miles).

Decision Chart 1, House of Representatives Appropriation Subcommittee Factors provides an aggregate view of efficiency factors and family considerations.

DECISION CHART 1

Corrected 1/27/93

HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE FACTORS

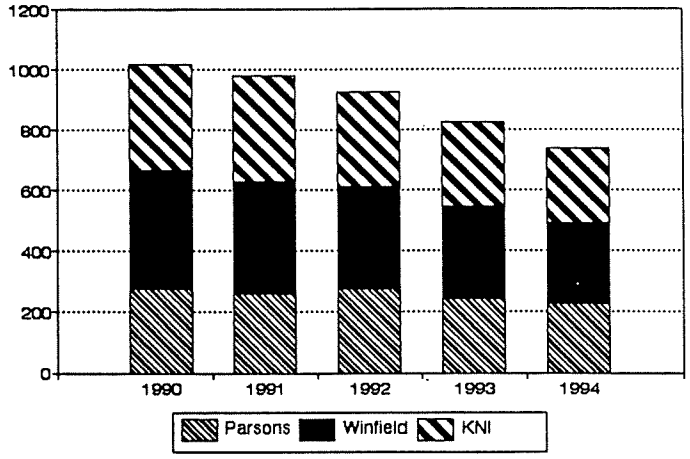
		RANK		
	FACTOR	KNI	PSH&TC	WSH&TC
*	Average distance of family travel	3	1	2
*	Availability of appropriate community settings & supports in service area (45 miles)	2	3	1
*	Positive impact economically (Tayyem)	2	3	1
*	Efficiency of operation			
	Highest cost per resident	2	3	1
	Highest use of overtime	2	3	1
	Cost of training staff	2	3	1
	Richest staff/resident ration	2	3	1
*	Employee availability/quality of care			
	Highest use of sick leave	2	3	1
	Average % turnover - medical	2	3	1
	Average % turnover - professional	3	2	1
	Average % turnover - direct care	2	3	1
	Longest time to fill professional	3	1	2
	Longest time to fill direct care	2	2	1
#	Economic consequences (Tayyem)			
	Share of county personal income	1	3	3
	Share of county employment base	1	2	3
	Least economic impact in dollars	3	1	2
*	Retention of most residents in area	2	3	1
*	Most savings generated by closing	2	3	1
*	Future capital costs	3	2	1
	TOTAL	41	47	26

The factors are scaled on a one, two, three ranking with a one indicating which institution should be the first to be consolidated and a three indicating which institution should be last to be considered based on that particular factor. The institution with the least total points would be most likely to be designated for closure based on all the factors identified by the legislature to be considered.

14-94

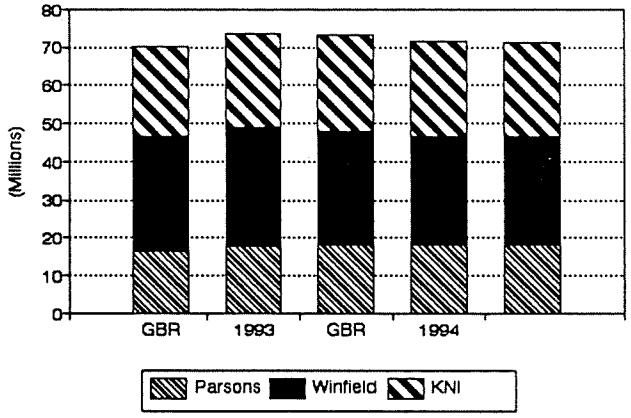
STATE MENTA. HEALTH HOSPITAL . OMPARISONS

Fiscal Year End Census-State Hospitals



	Actual 1990	Actual 1991	Actual 1992	GBR 1993	GBR 1994
Parsons	275	261	277	242	227
Winfield	390	369	336	304	269
KNI	352	352	314	282	247
Total	1017	982	927	828	743

Fiscal Year Budgets - State Hospitals
All Funds



	Actual 1990	Actual 1991	Actual 1992	GBR 1993	GBR 1994
Parsons	$16,492,181	$17,661,721	$18,167,917	$17,984,079	$18,068,524
Winfield	$30,508,147	$31,363,415	$30,179,334	$28,950,649	$28,794,913
KNI	$23,658,863	$24,726,369	$25,091,797	$24,686,186	$24,555,656
Total	$70,659,191	$73,751,505	$73,439,048	$71,620,914	$71,419,093

Date Issued: January 21, 1993

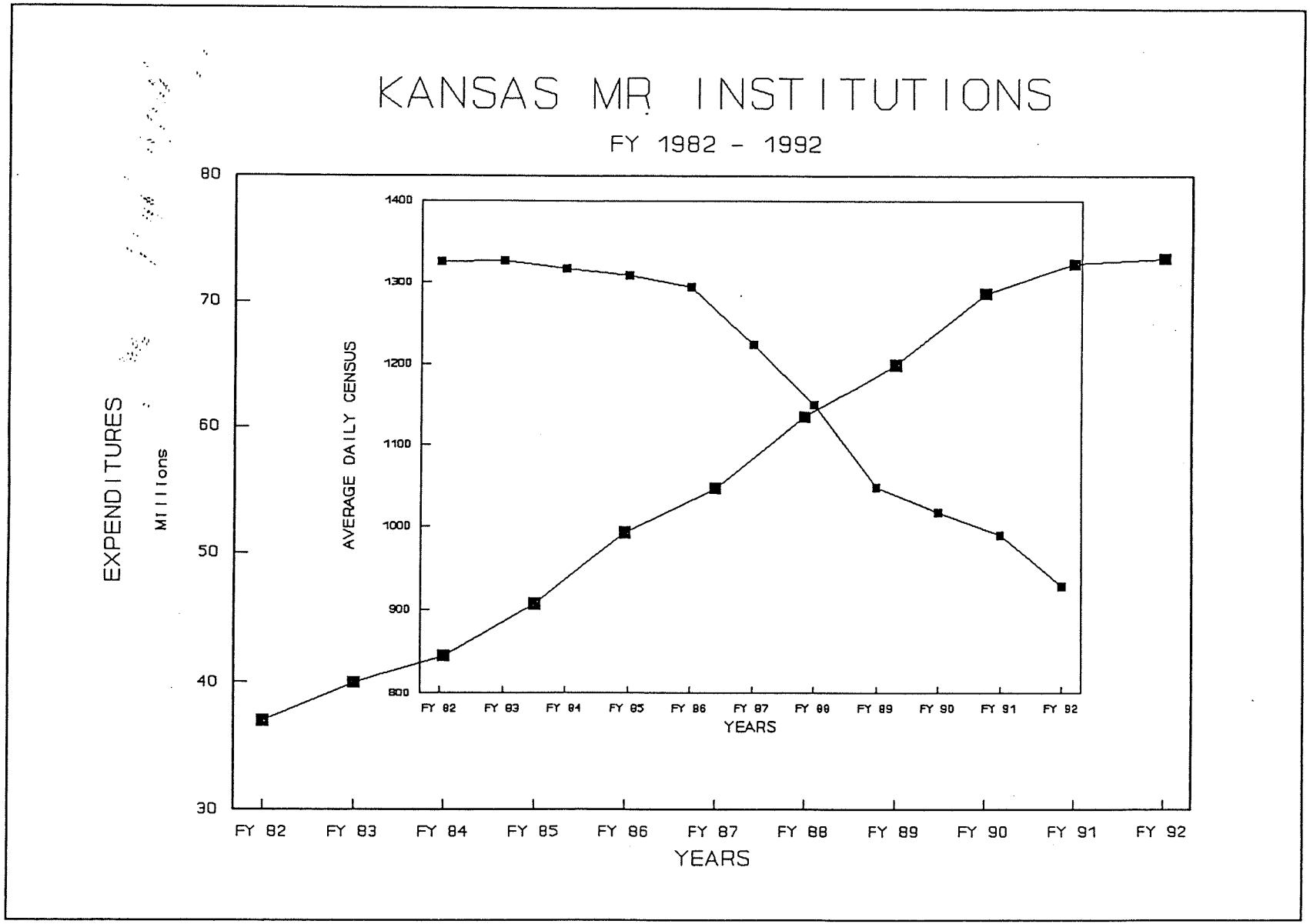
14-45

INSTITUTIONAL OVERVIEW

	FY 92	FY 93
Kansas Neurological Institute		
Average Daily Census	322.0	296.0
Number of Positions	862.5	852.5
Average Cost per Day	$213.27	$228.65
Parsons State Hospital		
Average Daily Census	270.0	256.0
Number of Positions	563.0	563.0
Average Cost per Day	$184.33	$191.60
Winfield State Hospital		
Average Daily Census	336.0	318.0
Number of Positions	992.5	872.5
Average Cost per Day	$246.37	$253.09

Source: MH&RS Fiscal Services
August 1992

14-46


KANSAS MR INSTITUTIONS
FY 1982 - 1992
EXPENDITURES
Millions
80
70
60
50
40
30
AVERAGE DAILY CENSUS
1400
1300
1200
1100
1000
900
800
FY 82
FY 83
FY 84
FY 85
FY 86
FY 87
FY 88
FY 89
FY 90
FY 91
FY 92
YEARS

Analysis of Client Characteristics

WSH clients, on average, have greater medical needs than either KNI or PSH clients, as evidenced by the Developmental Disabilities Profile (DDP) health index scores listed below. WSH also has a larger percentage of clients whose health index scores are higher than the average health score for the state (5.69).

	AVG HEALTH INDEX	% > STATE AVG
KNI	9.15	26.6%
PSH	5.86	15%
WSH	11.01	34.8%

In addition, more WSH residents were hospitalized due to a medical condition in the last year (32%), compared to 25% at KNI and 14% at PSH. More individuals at WSH missed more than two weeks of programming due to medical conditions, as well (25%). Eighteen percent of KNI residents and 9% of PSH clients missed substantial amounts of training because of their medical conditions.

The difficulty in recruiting and retaining medical staff, the substantially higher cost of medical staff, and the lack of comprehensive and specialized medical services within the Winfield community, all combine to make it extremely difficult to serve medically fragile clients at WSH.

Although WSH serves a higher percentage of clients with medical needs, PSH serves more individuals who display aberrant behaviors and have psychiatric diagnoses. Ninety percent of residents at PSH carry a psychiatric diagnosis, compared to 45% at KNI and 7% at WSH. Only 28% of PSH residents are not physically assaultive, whereas 56% of KNI clients and 66% of WSH clients are not. Over half (59%) the PSH clients run, or wander, away compared to 23% and 20% at KNI and WSH, respectively. In addition, 88% of all individuals living at PSH require a structured setting to avoid behavior problems. The majority of KNI and WSH residents do not require such a setting (70% and 66%). If what are generally regarded to be the three major aberrant behaviors (physically assaulting others, self-injury, and property damage) are examined, PSH clearly has more residents who display two or more of these behaviors - 69% - compared to KNI and WSH - 42% and 36%, respectively. In addition, 40% of PSH clients display all three of these behaviors with some frequency.

Looking at client characteristics in another way - which institution has the most clients who could most easily be served in the community -- one must analyze for single variables and frequency of occurrence. Using this method, one asks, "Of the characteristics measured, which did not occur in the past year?" Based on this process, clearly WSH and KNI, on the average, have more residents who could more easily be served in a community setting. The analysis indicates there is very little difference between WSH and KNI on client characteristics projecting ease of service. The clients at WSH indicate higher medical involvement on the average and the clients at KNI indicate higher behavioral involvements on the average.

This analysis is aggregated on Decision Chart 2, State Hospital Resident Characteristics.

14-48

DECISION CHART 2

STATE HOSPITAL RESIDENT CHARACTERISTICS

	FACTOR	RANK KNI	PSH&TC	WSH&TC
*	Behavioral Domain			
	Psychiatric Diagnosis	2	3	1
	Need structured setting	1	3	2
	Staff physical intervene	2	3	1
	Behavior prevents moving	1	3	2
	Feces smearing behavior	1	3	1
	Inappropriate sexual	1	3	1
	Stealing	2	3	1
	Elopement	2	3	1
	Resists supervision	1	3	1
	Self-injurious behavior	2	3	1
	Abusive-others	2	3	1
	Physically assaultive	2	3	1
	Damages property	2	3	1
	Displays tantrums	2	3	1
	Teasing/harassing	1	3	1
	Disrupts activities	2	3	1
	Specific behavior program	1	3	2
	Displays two of three major aberrant behaviors[1]	2	3	1
	Displays all three major aberrant behaviors	2	3	1
	Behavioral Subtotal	31	57	22
*	Medical Domain			
	Walks independently	2	1	3
	Normal vision	3	1	2
	Normal hearing	1	3	2
	Uses wheelchair	2	1	3
	Trained staff needed	2	1	3
	Seizures	1	3	2
	Receives anticonvulsant	3	1	2
	Receives maintenance meds	2	1	3
	Cardiovascular condition	2	1	3
	Neoplastic condition	1	1	2
	Neurological condition	3	2	1
	Genito-urinary condition	3	1	2
	Gastro-intestinal condition	1	2	3
	Respiratory condition	1	2	3
	Hepatitis B carrier	2	1	1
	Two/more medical conditions	2	1	3
	Three/more medical conditions	2	1	3
	Medical Subtotal	33	24	41
	TOTAL	64	81	63

The factors are scaled on a one, two, three ranking with a one indicating which institution has the most residents where that factor would not affect community placement and a three indicating which institution has the most residents where that factor must be considered in community placement. Based on the factors measuring resident characteristics, the institution with the least total points would be most likely to be designated for closure if the decision were made on those factors alone.

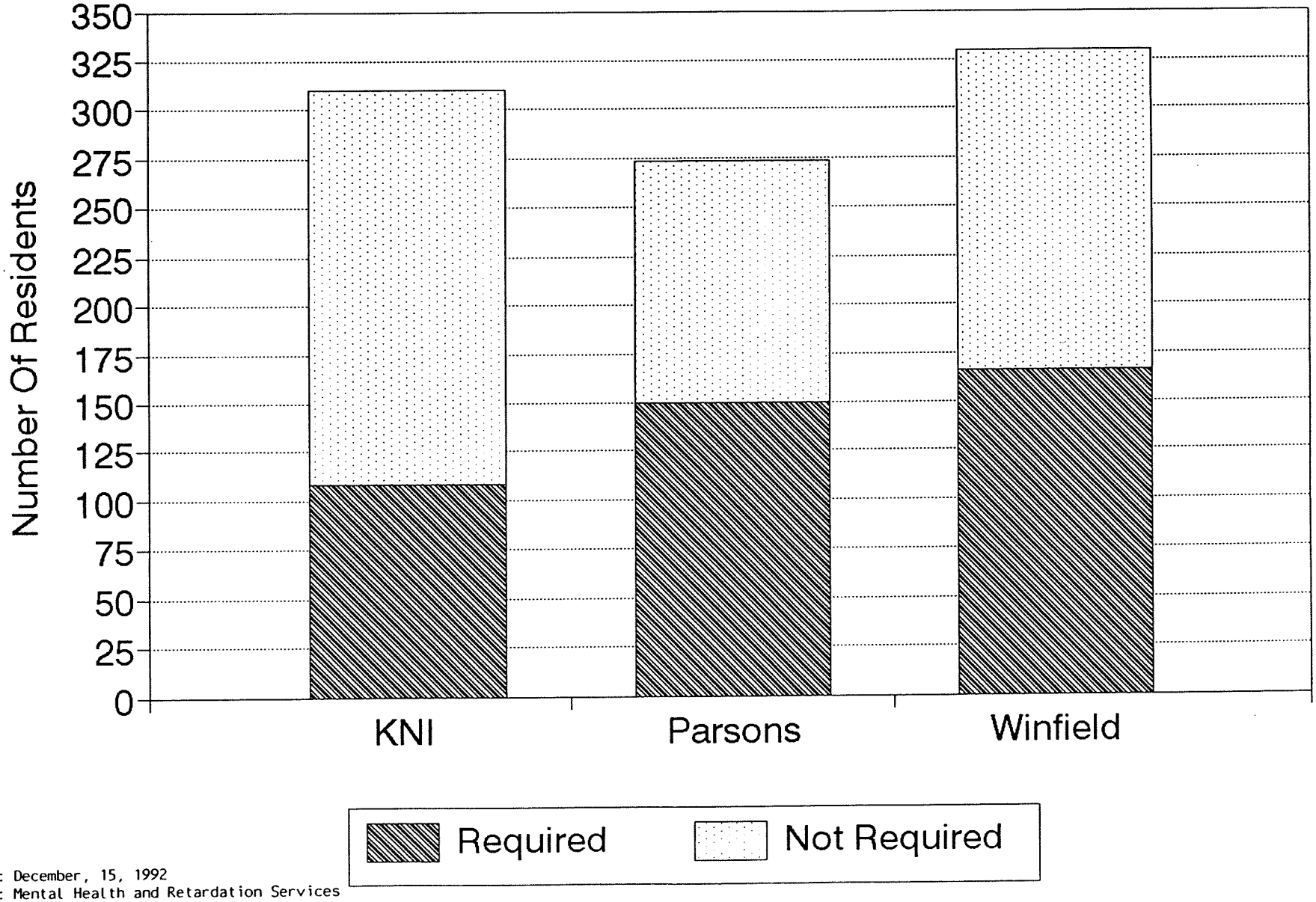
[1]Physical assault, self injurious behavior, and property damage

CLIENT CHARACTERISTIC GRAPHS

14-50

Kansas Mental Retardation Hospitals

Specific Behavioral Programming Or Procedures Required For Residents

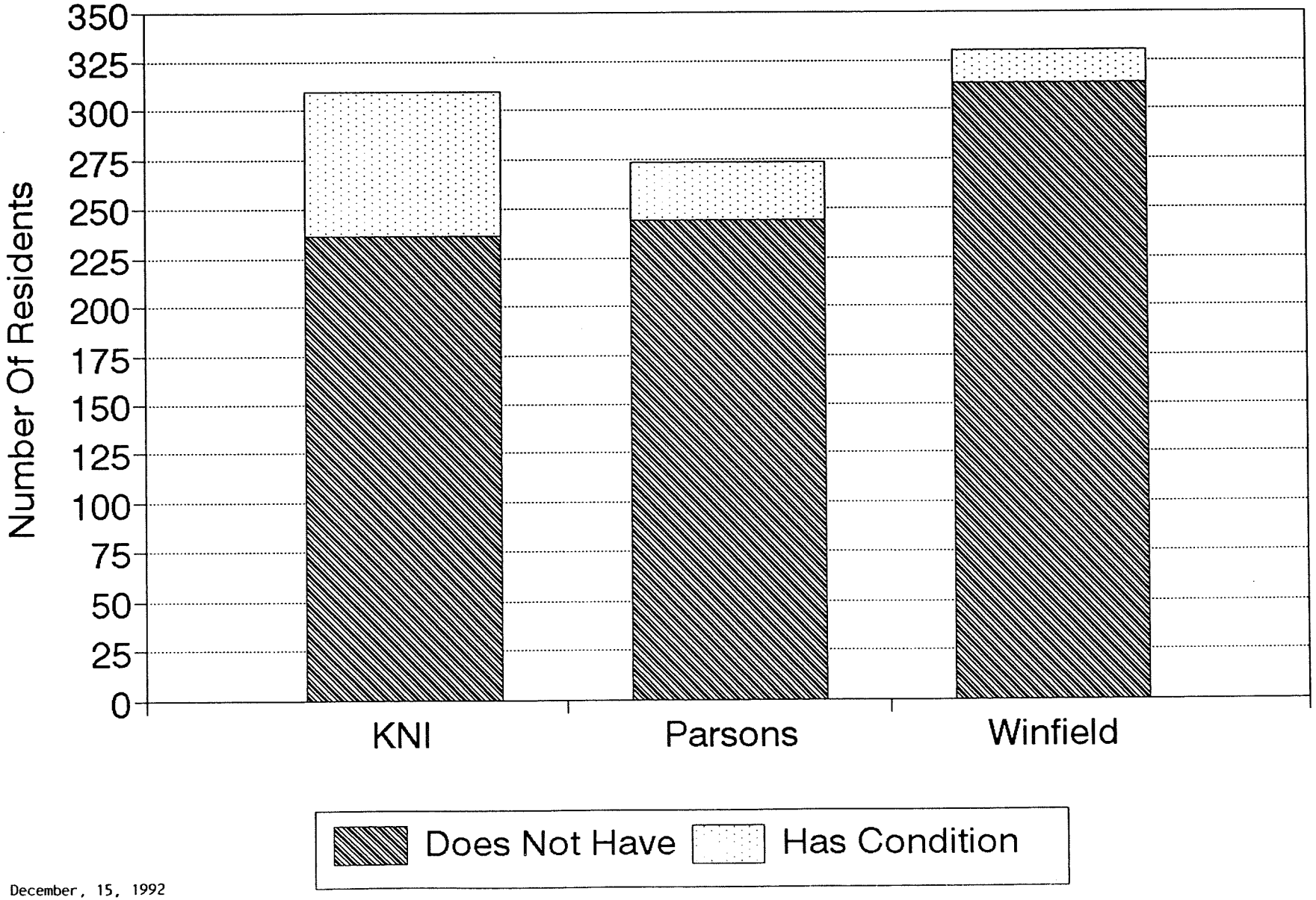


Date : December, 15, 1992
Source: Mental Health and Retardation Services

14-51

Kansas Mental Retardation Hospitals

Residents Who Do Not Have A Neurological Medical Condition

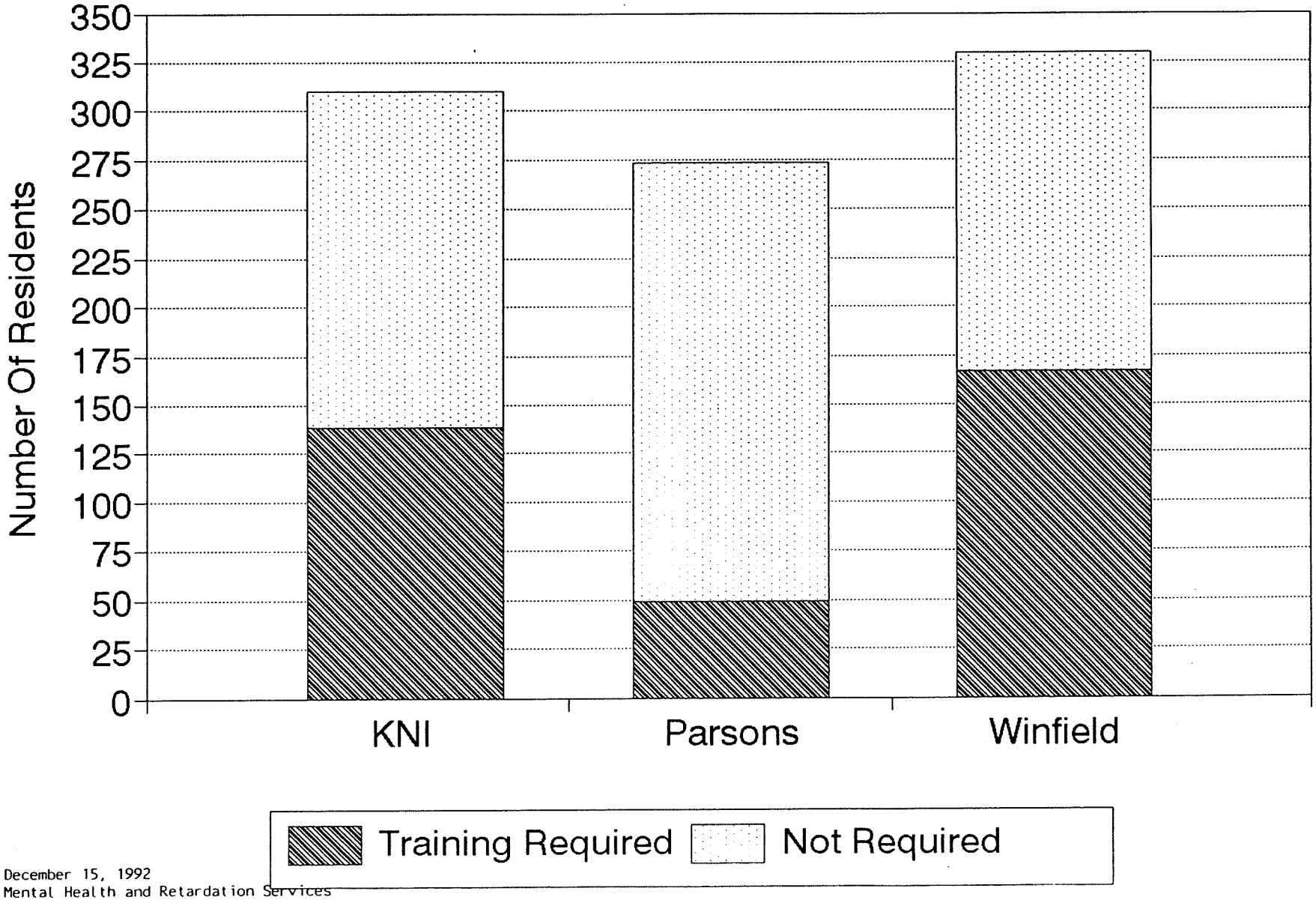


14-52

Date : December, 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Requiring Staff To Be Trained In Special Health Care Procedures

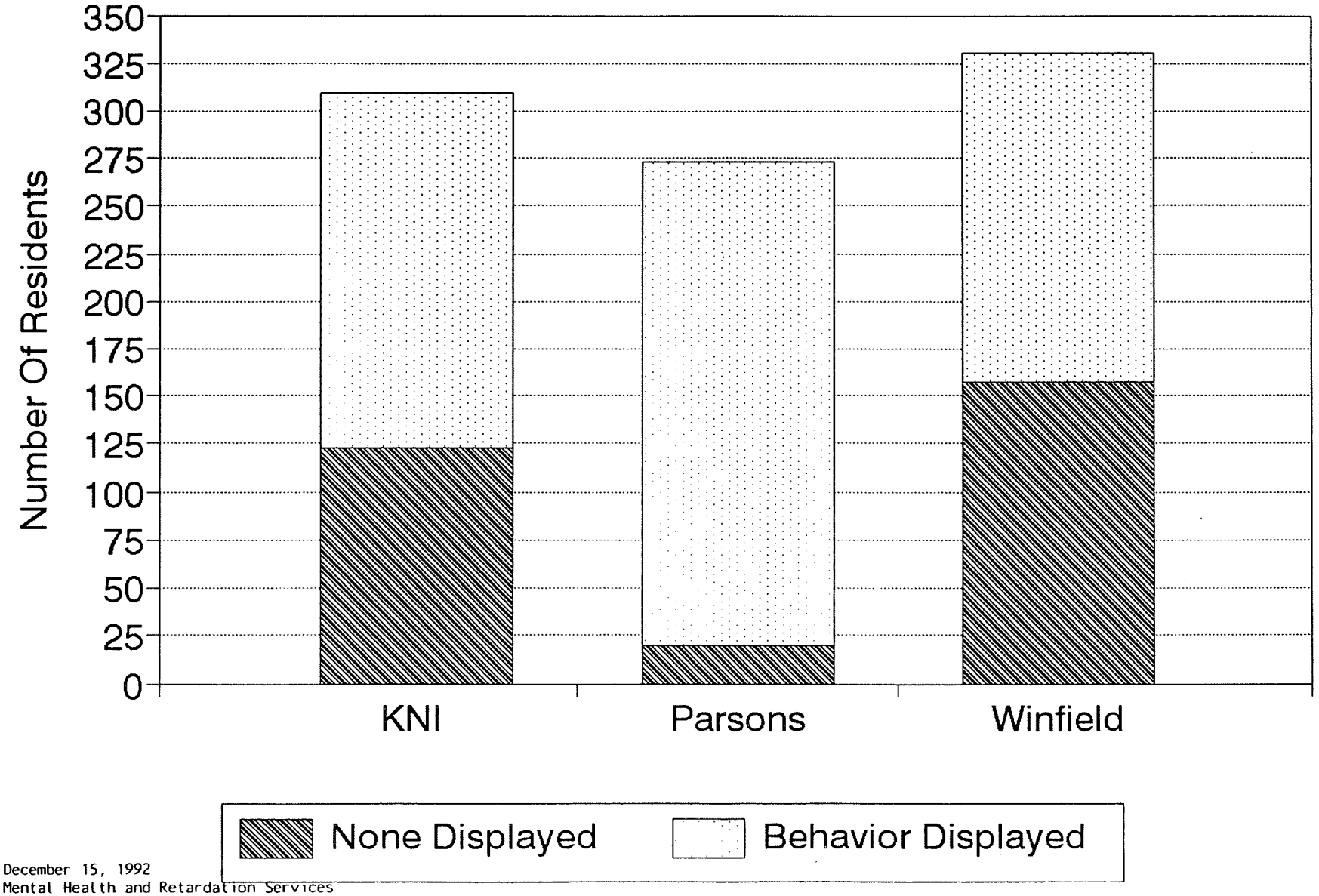


14-53

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Tantrum Or Emotional Outburst Behavior Displayed Within Last Year By Residents

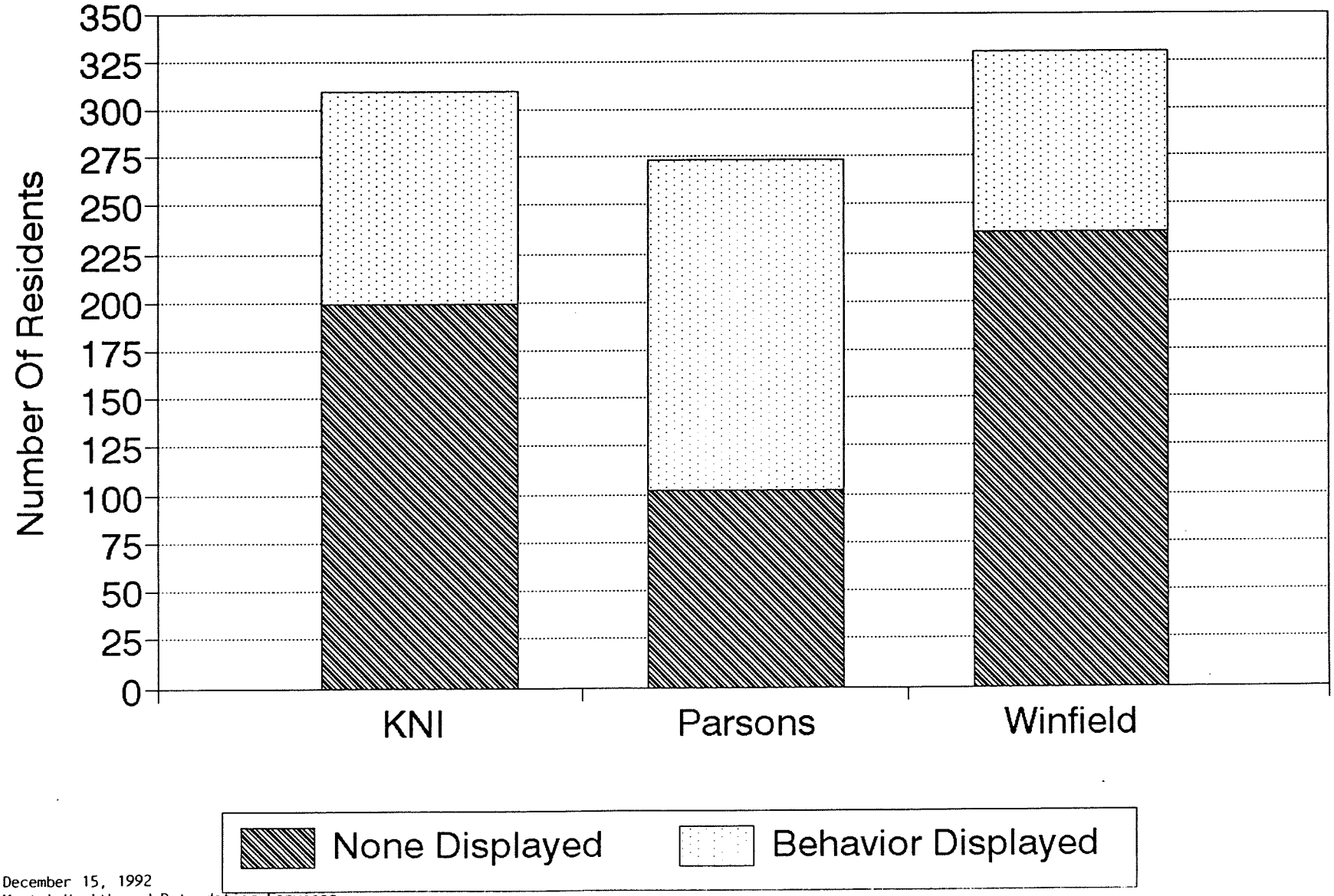


14-34

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Damaging Of Property Behavior Displayed Within Last Year By Residents

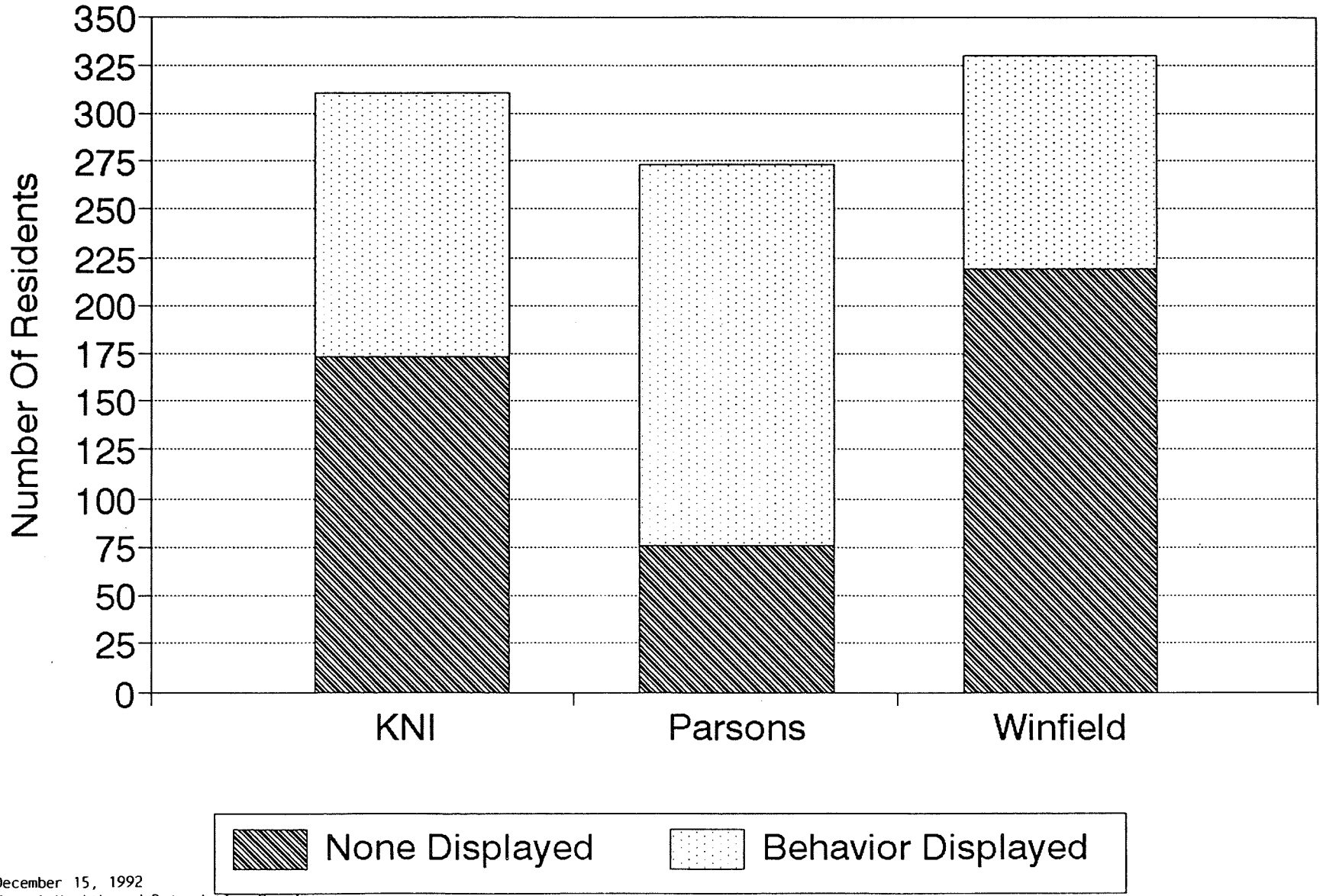


14-35

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Physical Assaulting Of Others Behavior Displayed Within Last Year By Residents

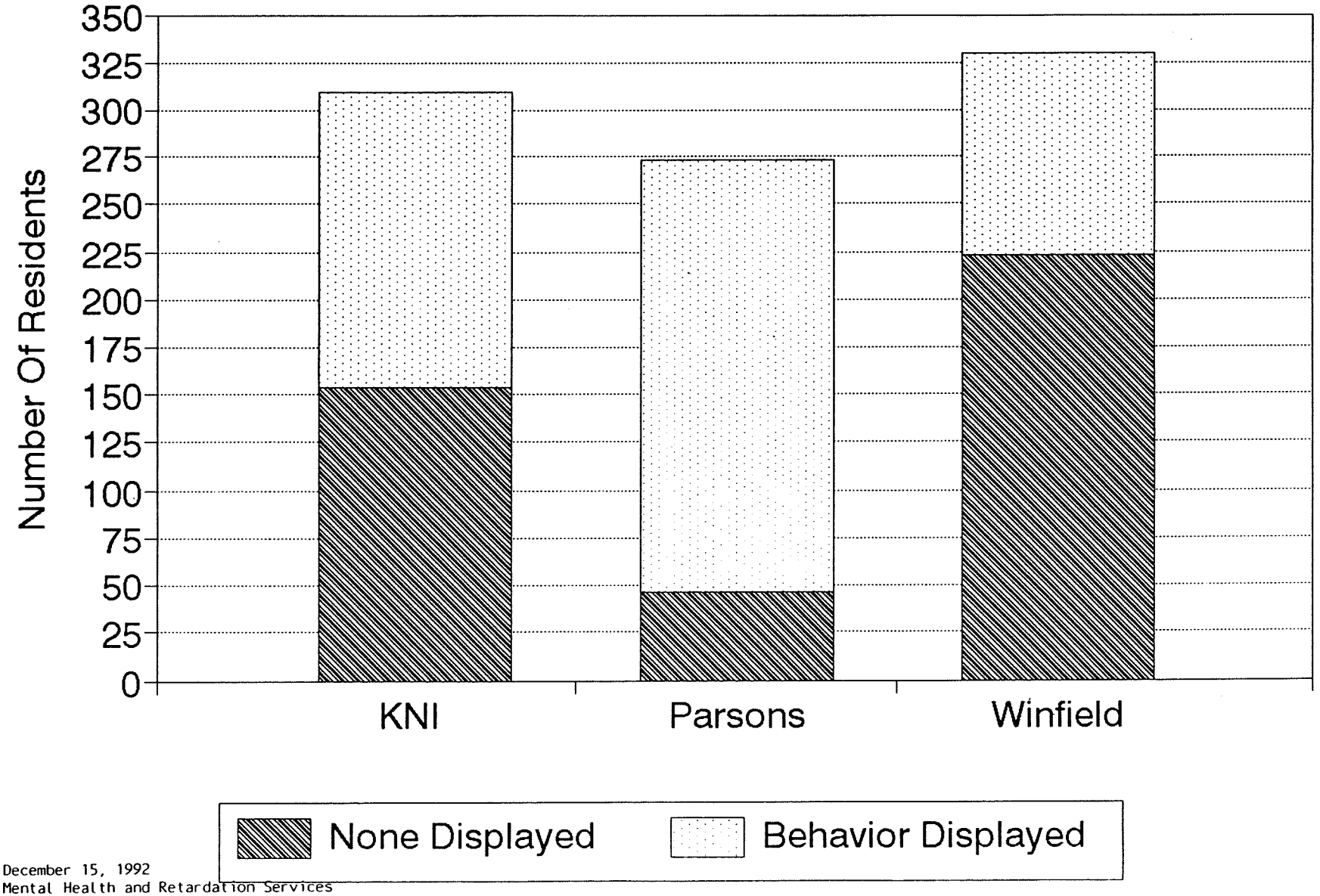


14-54

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

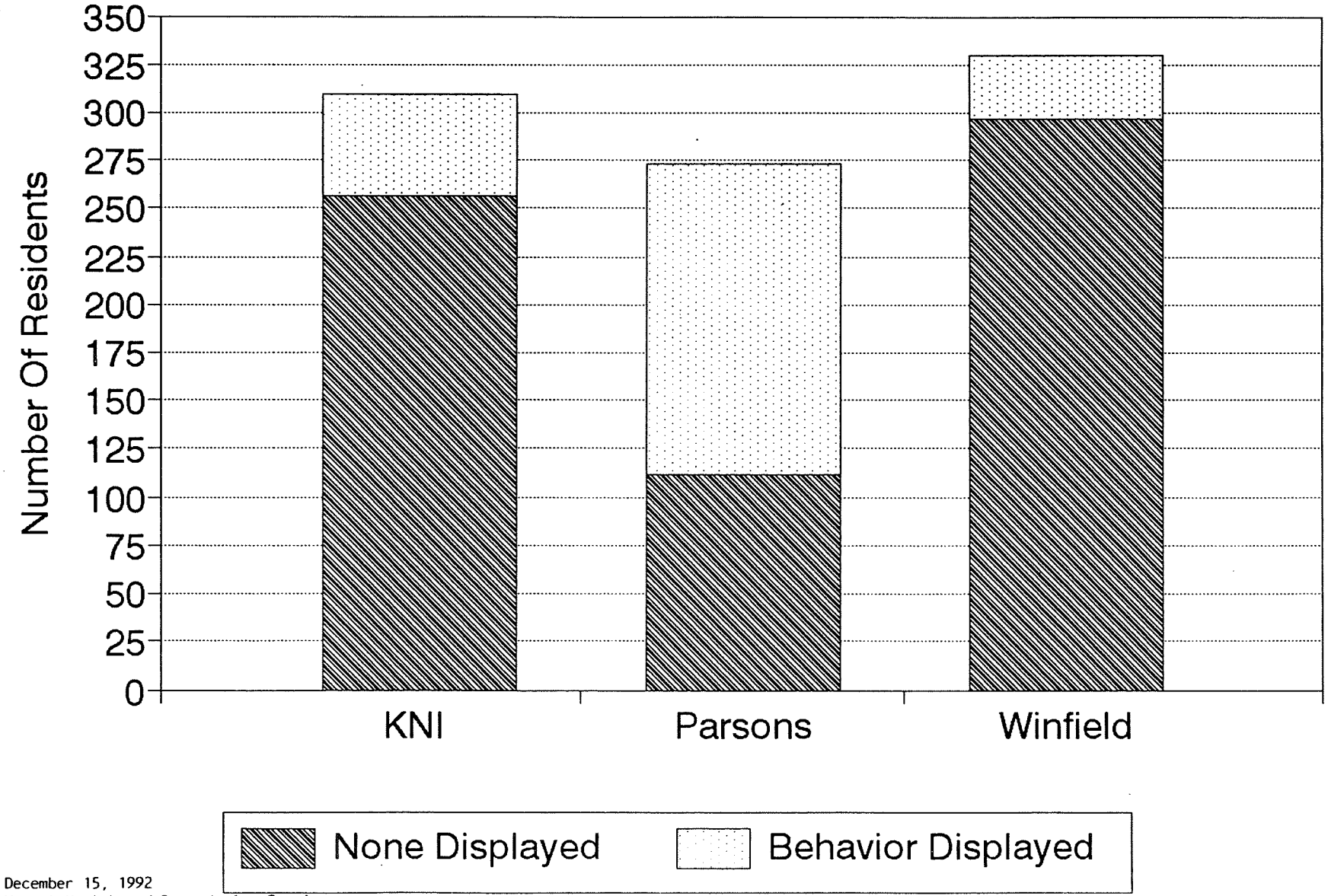
Disrupting Others Activities Behavior Displayed Within Last Year By Residents



Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Verbally Or Gesturally Abusive Behavior Displayed Within Last Year By Residents

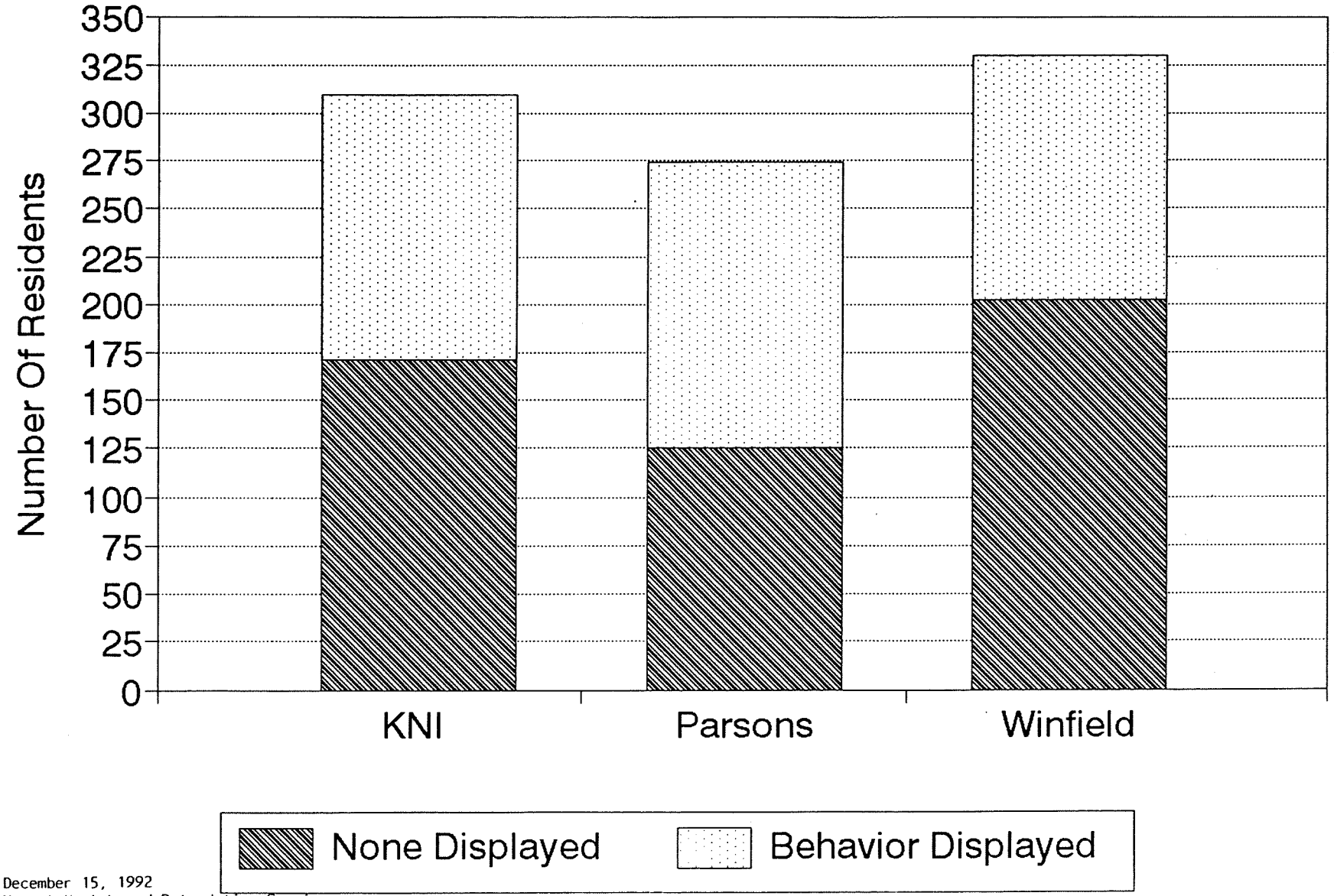


83-61

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Self-Injurious Behavior Displayed Within Last Year By Residents

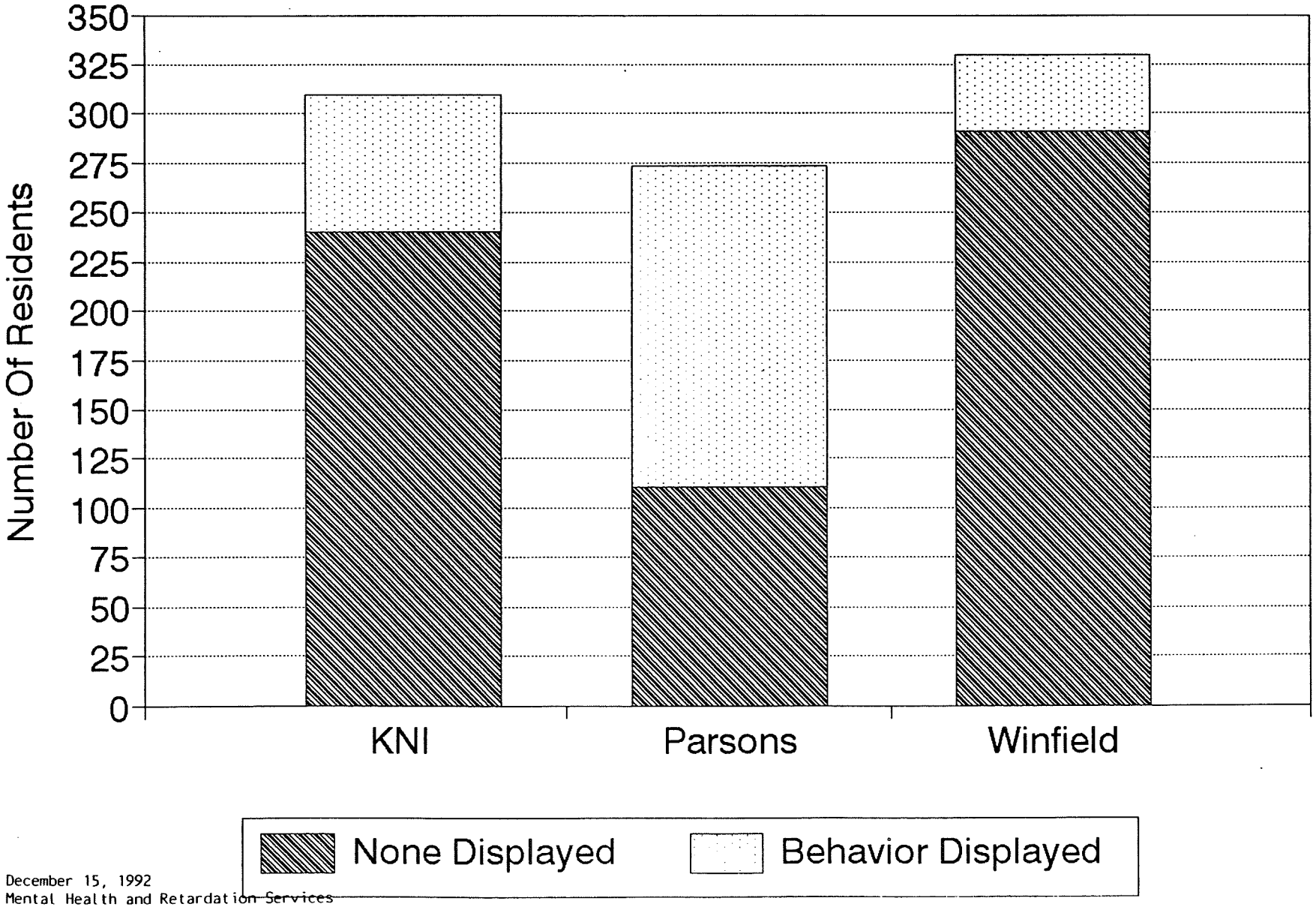


6-8-41

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

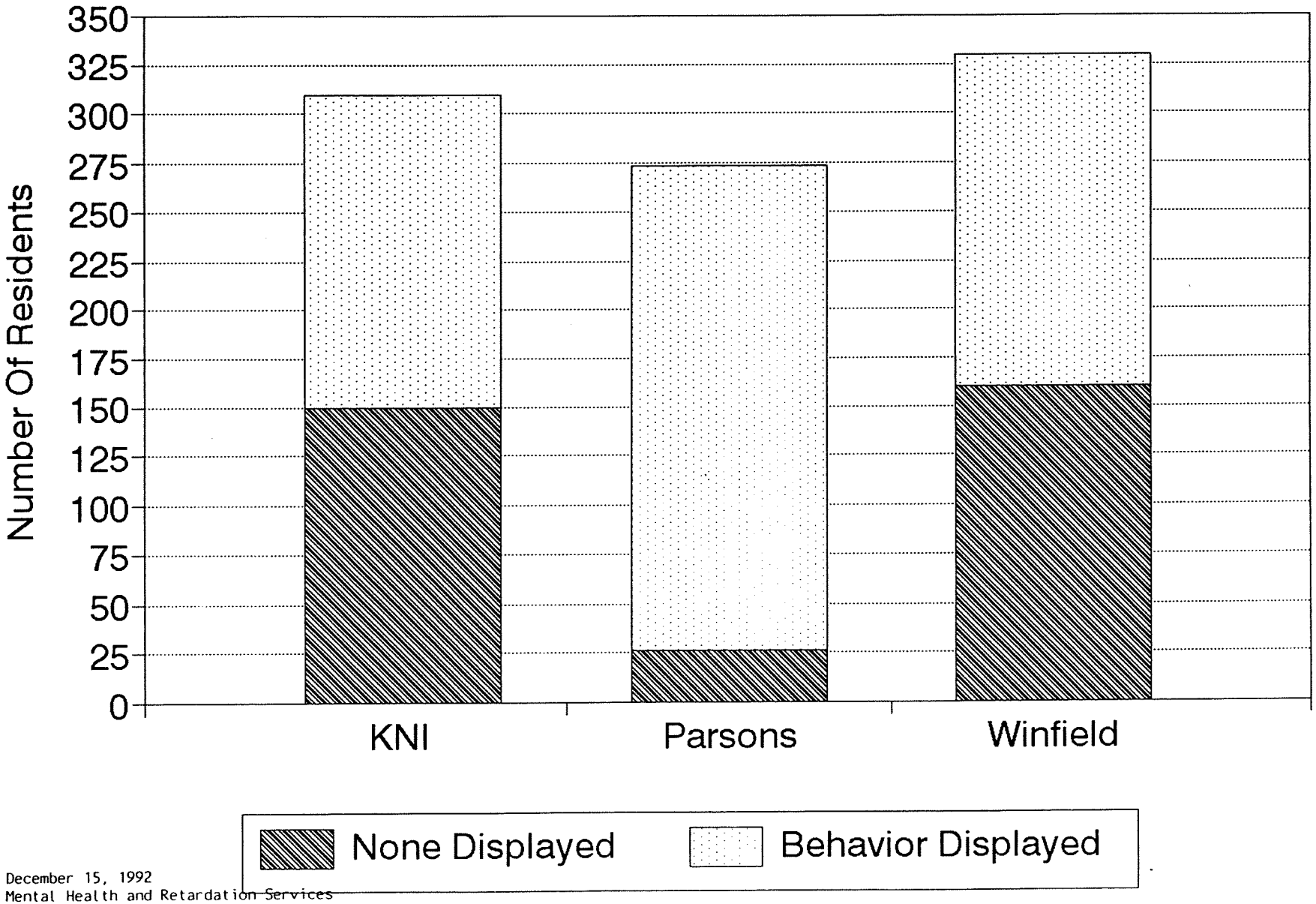
Teasing Or Harassing Of Peers Behavior Displayed Within Last Year By Residents



Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Resistive To Supervision Behavior Displayed Within Last Year By Residents

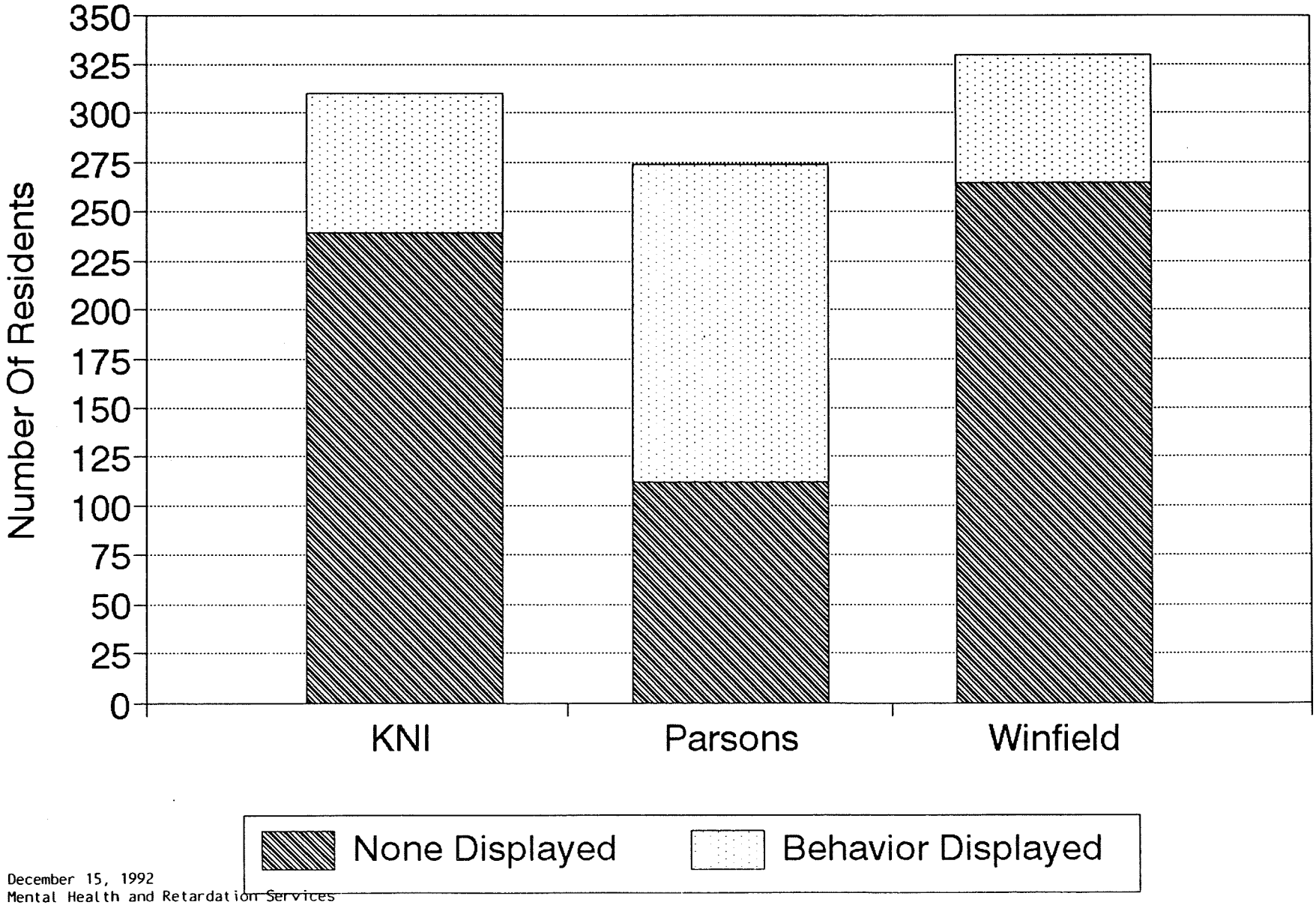


19-21

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Running Or Wandering Away Behavior Displayed Within Last Year By Residents

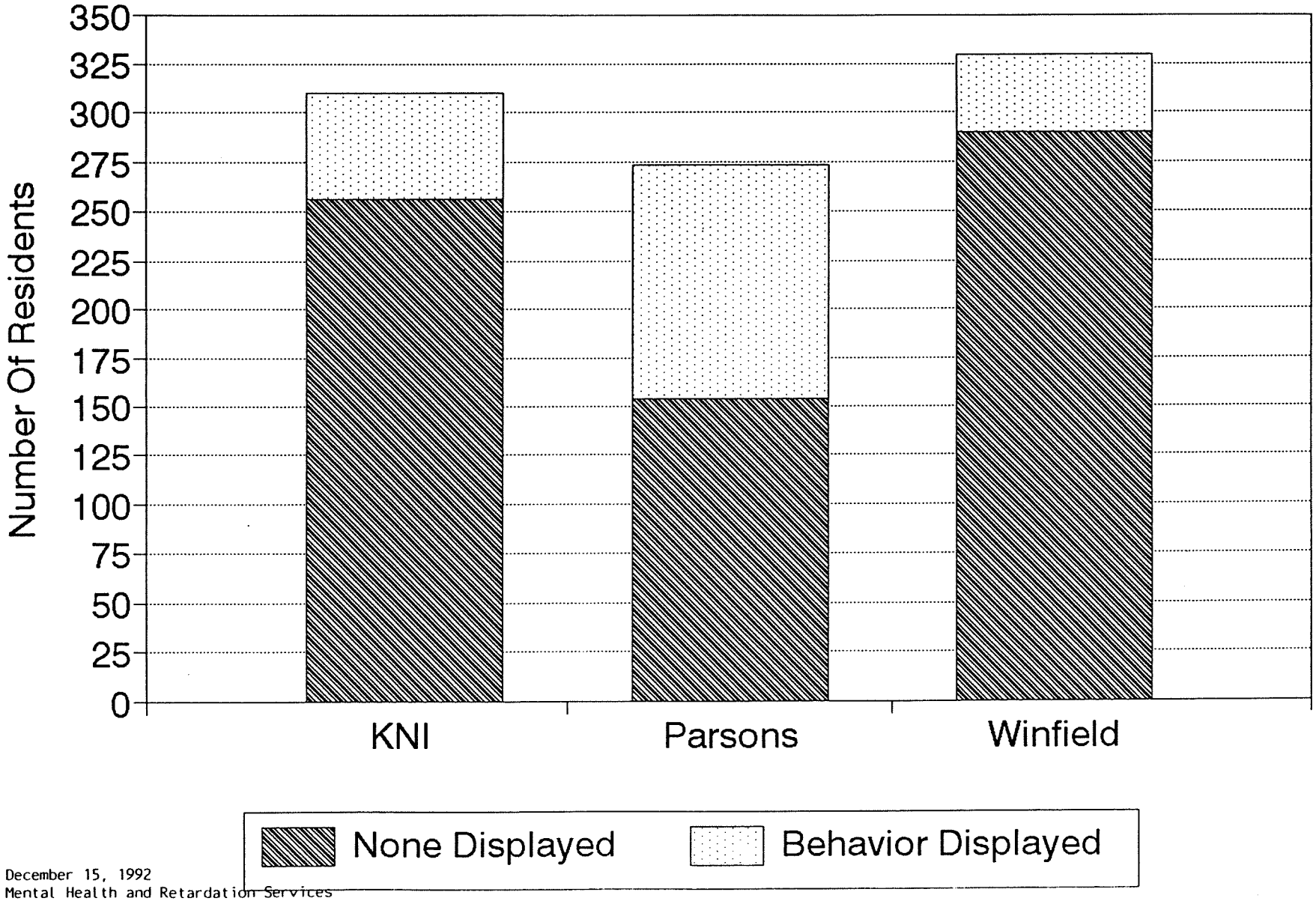


14-62

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Stealing Behavior Displayed Within Last Year By Residents

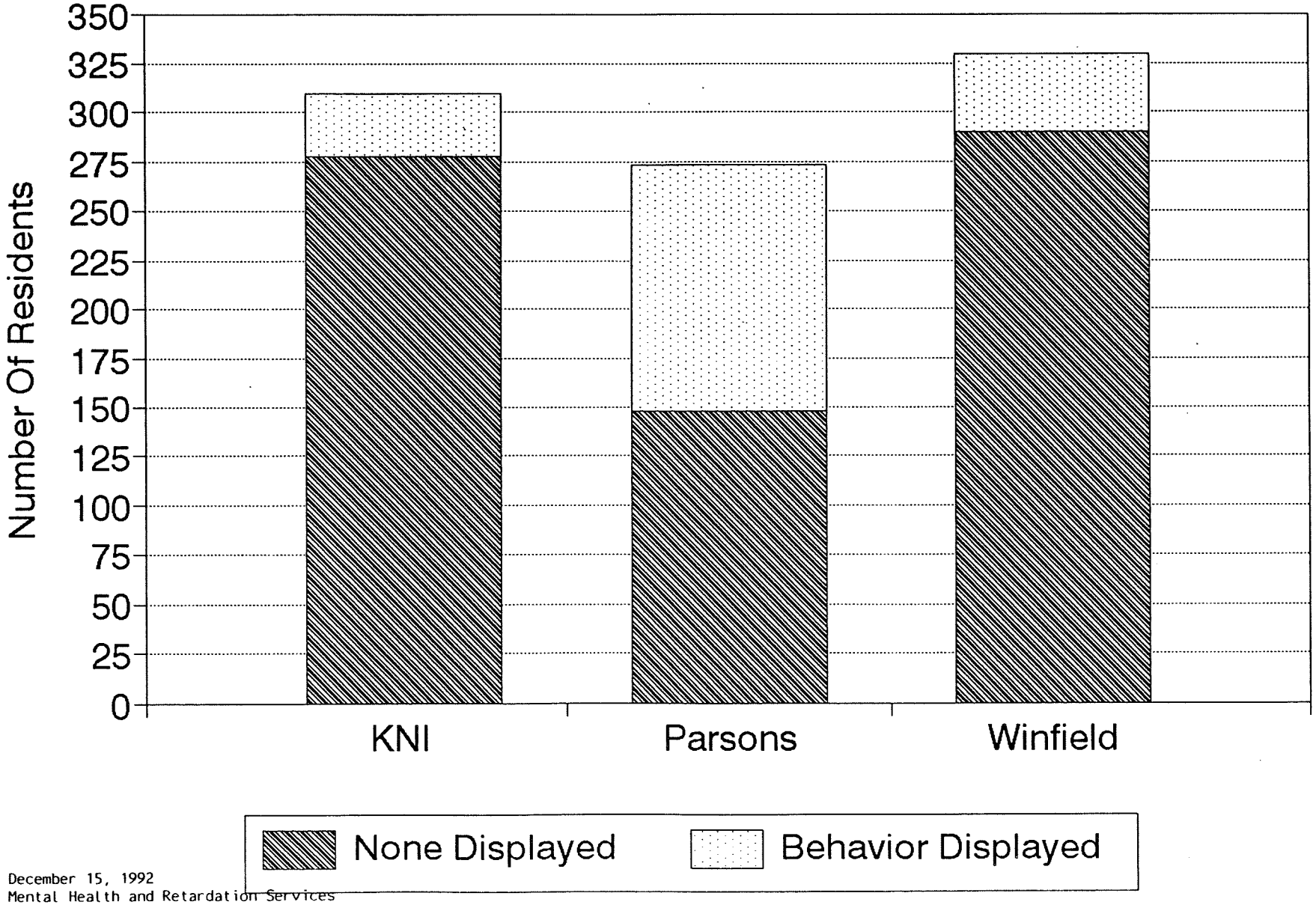


14-93

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Inappropriate Sexual Behavior Displayed Within Last Year By Residents

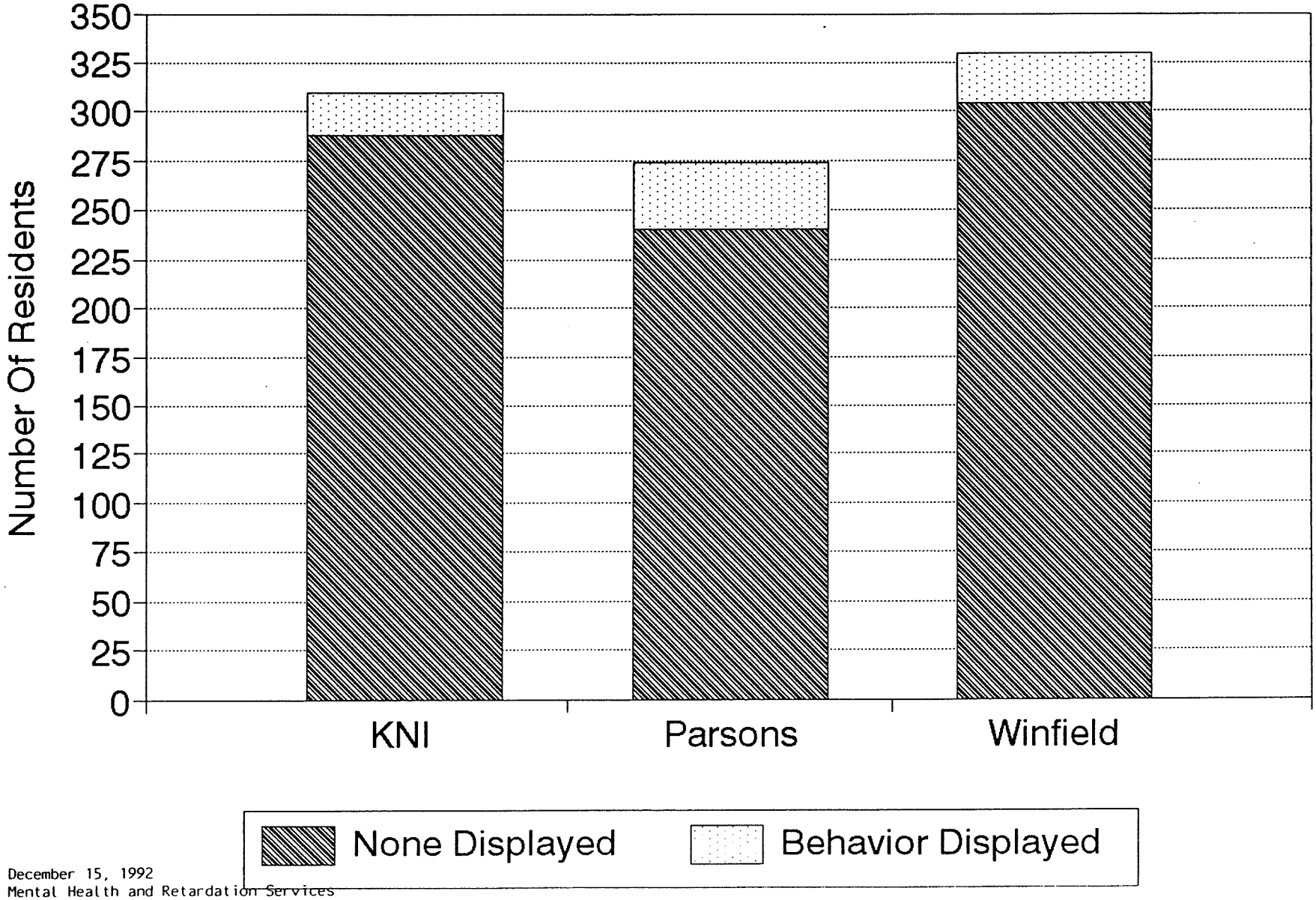


47-61

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

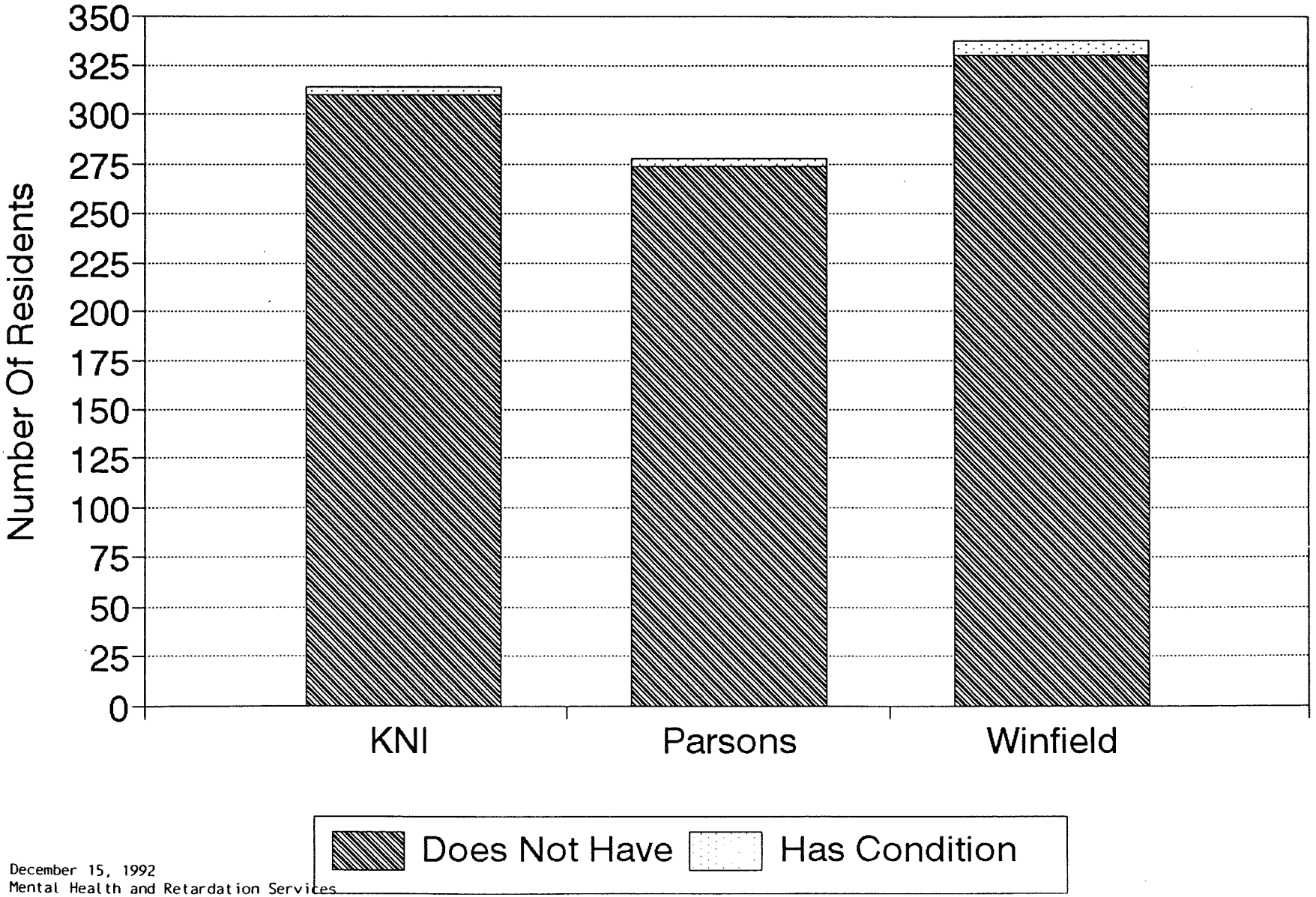
Smearing Feces Behavior
Displayed Within Last Year By Residents



Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Who Do Not Have A Neoplastic Medical Condition

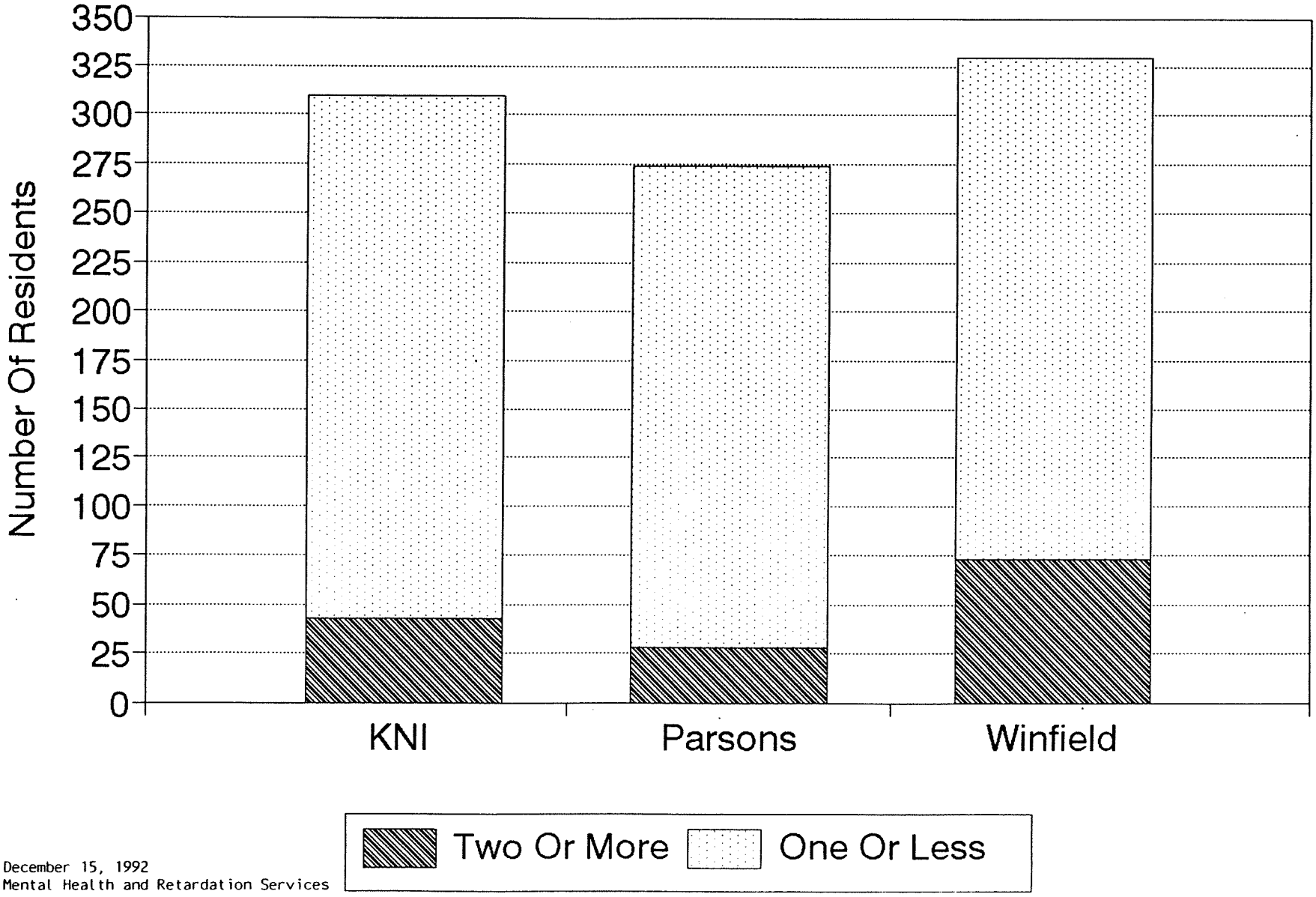


93-11

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

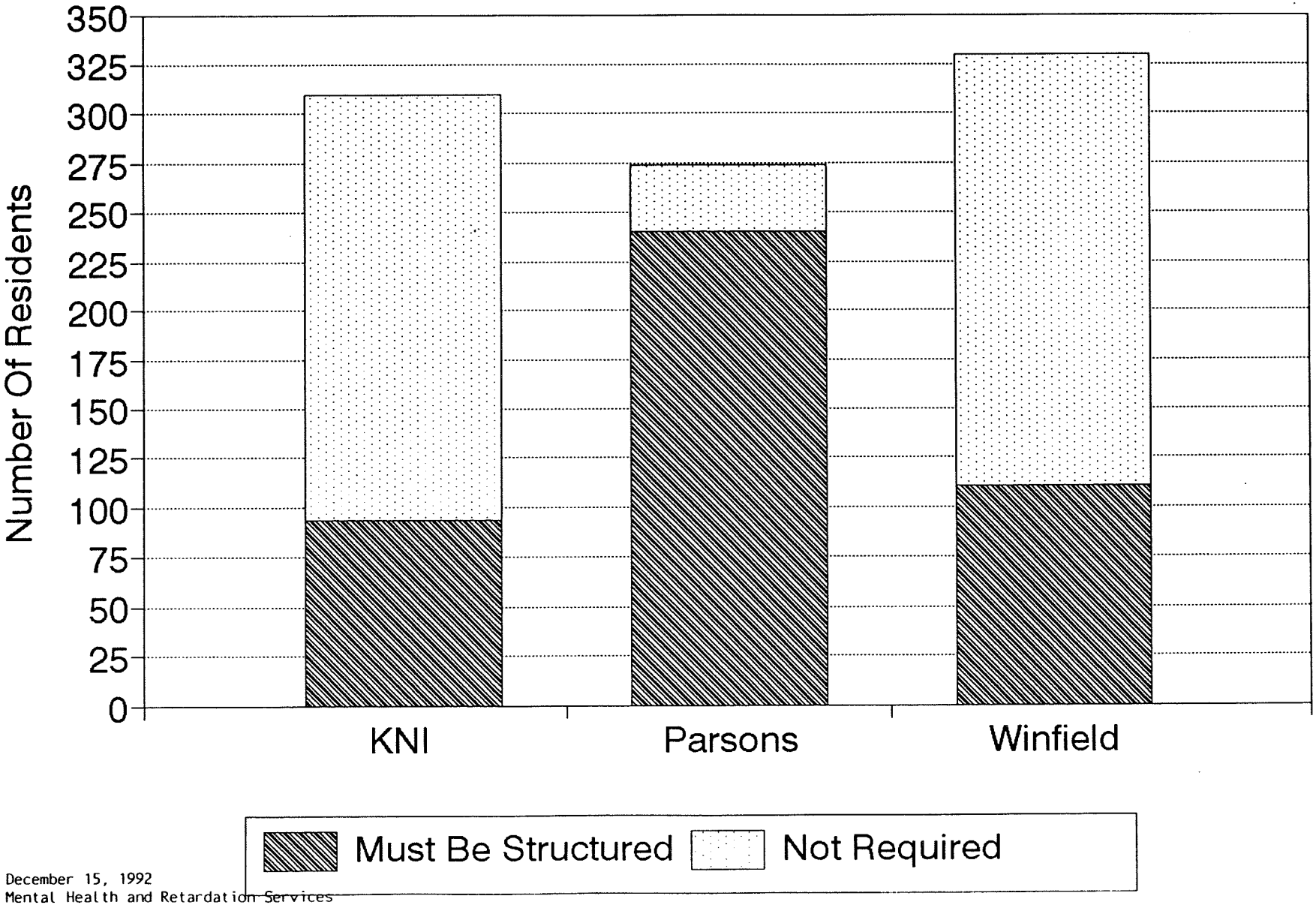
Hospitals Having Residents With Two Or More Medical Conditions



Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Environment Of Residents Must Be Structured To Avoid Behavior Problems

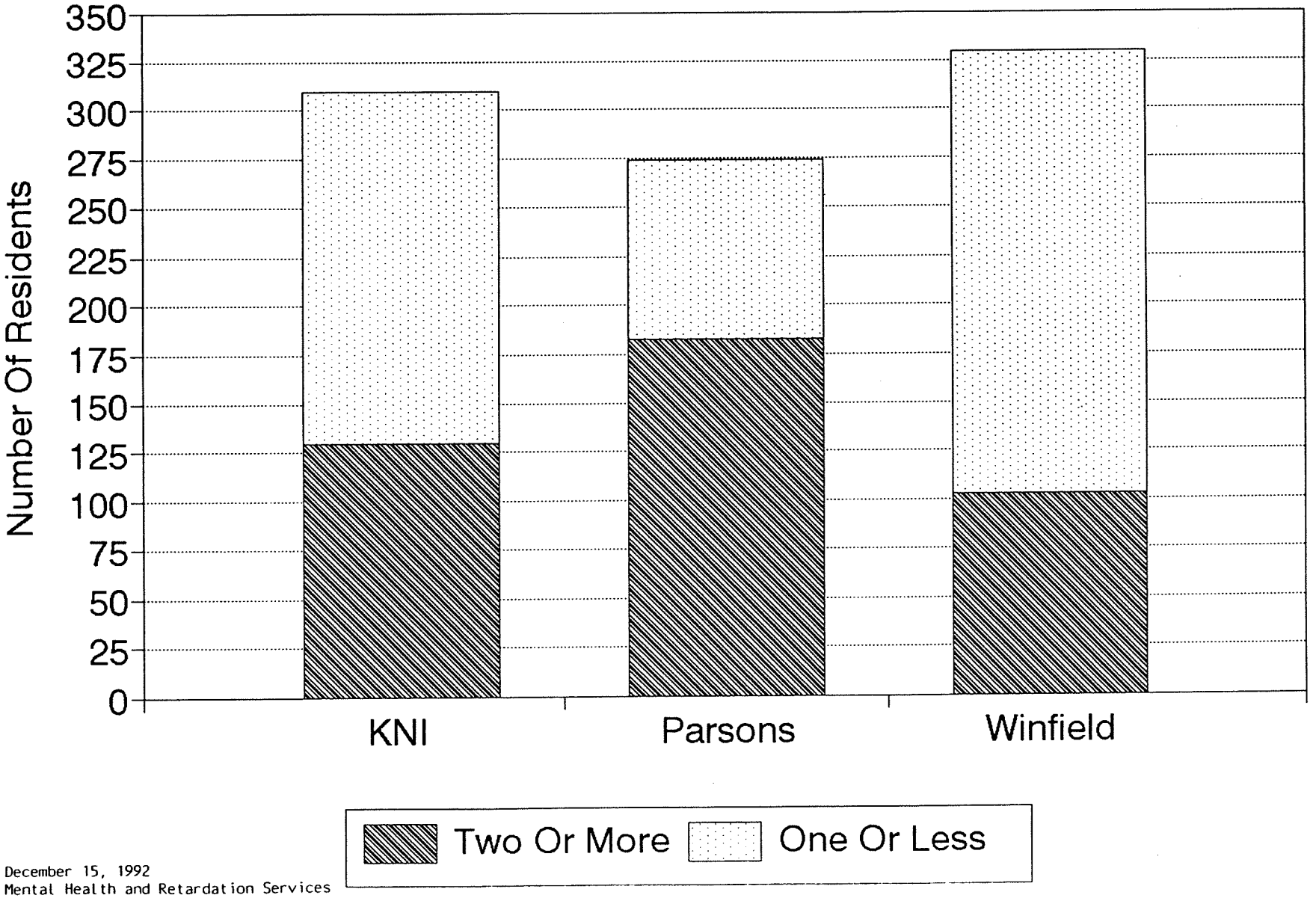


89-41

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

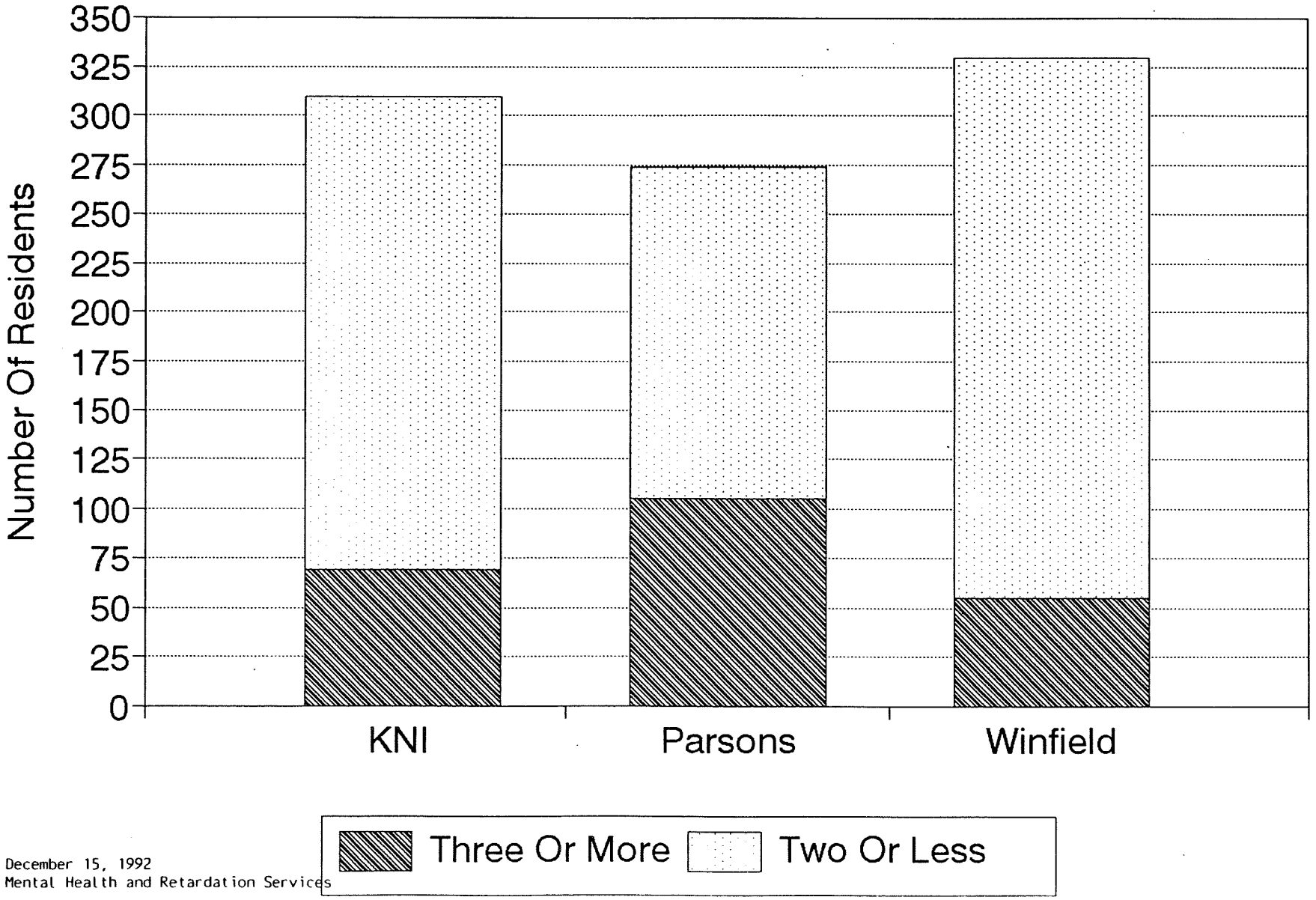
Hospitals Having Residents Displaying Two Or More Aberrant Conditions



Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Hospitals Having Residents Displaying Three Or More Aberrant Conditions

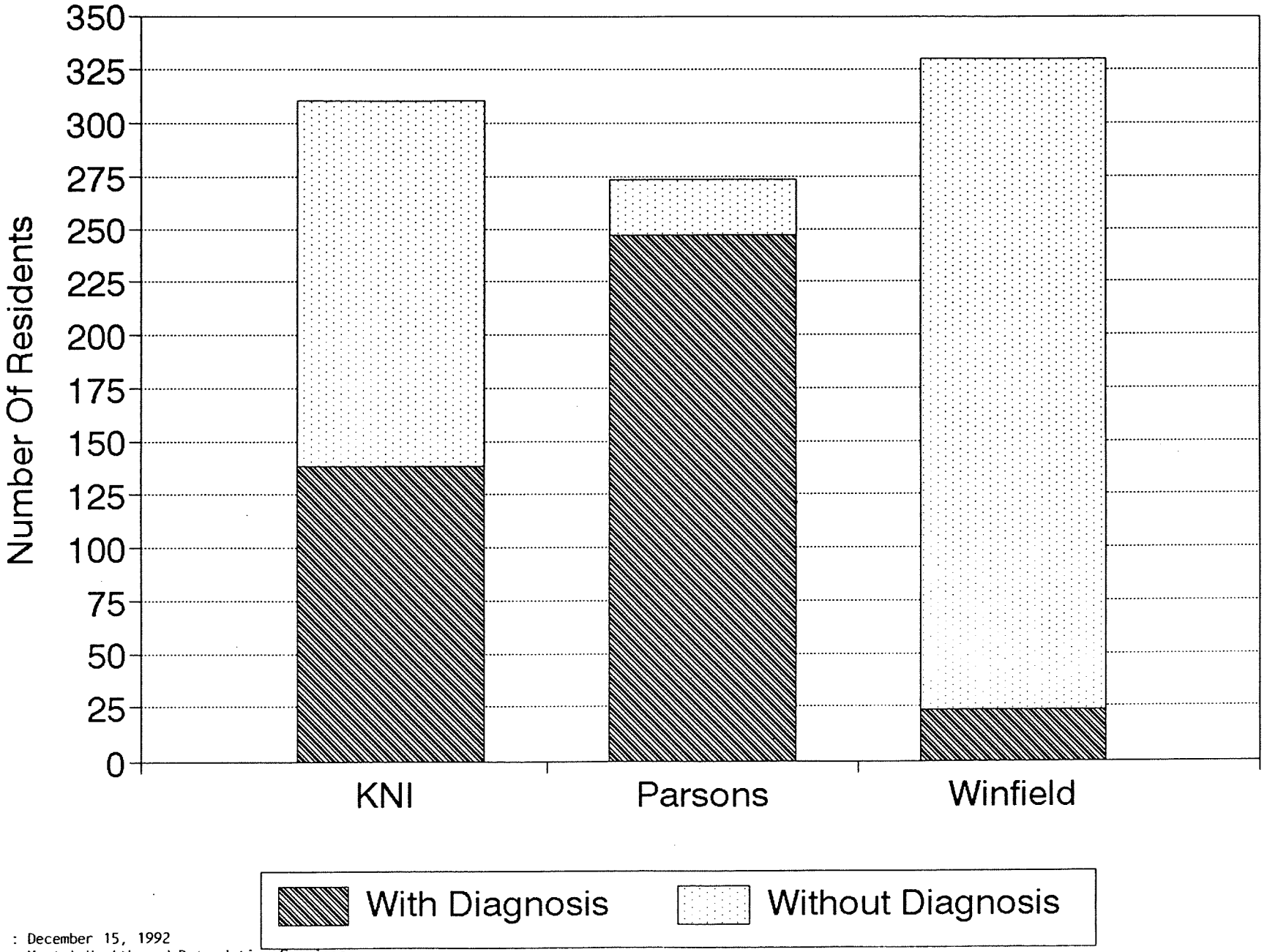


14-28

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents With A Psychiatric Diagnosis

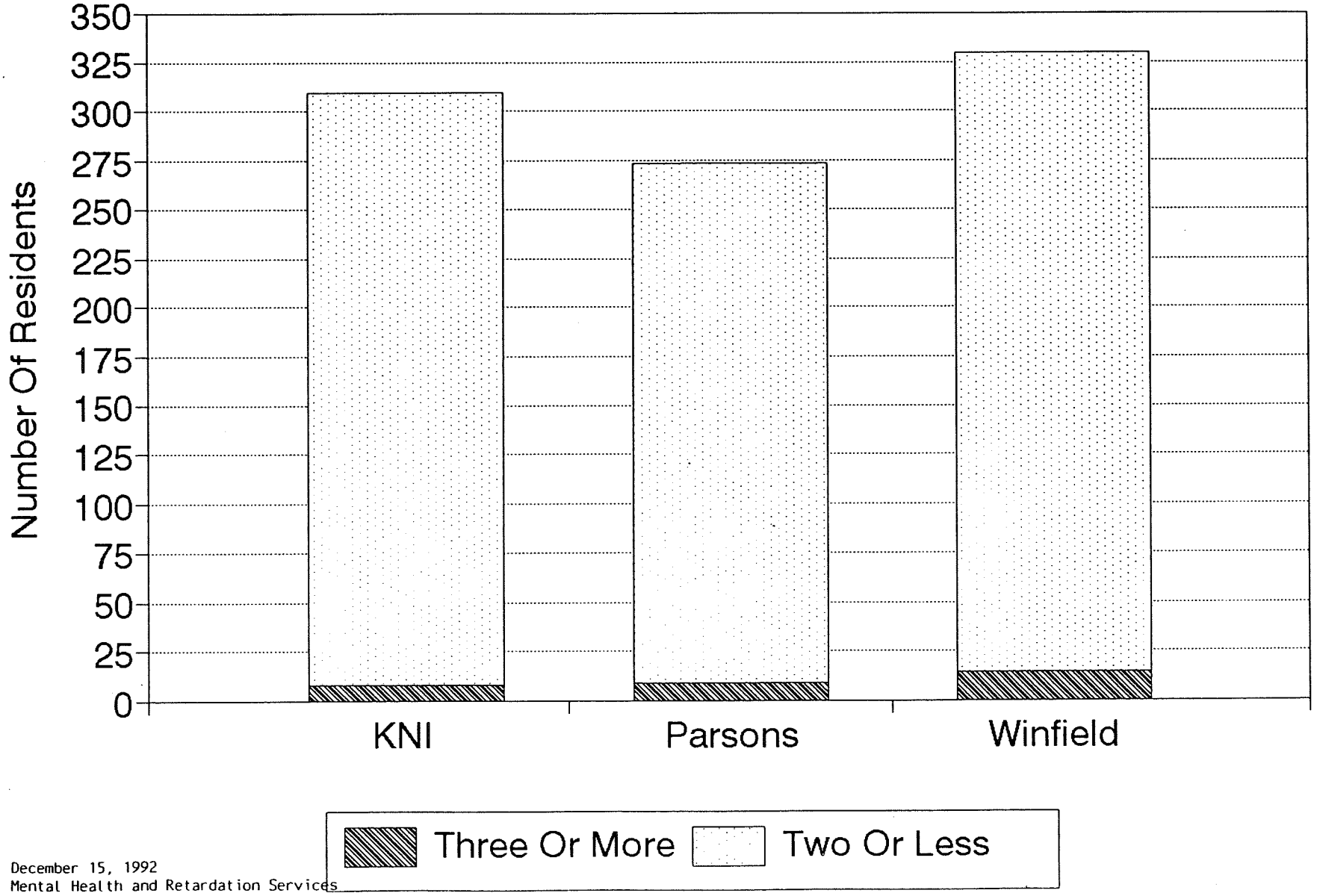


14-7

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Hospitals Having Residents With Three Or More Medical Conditions

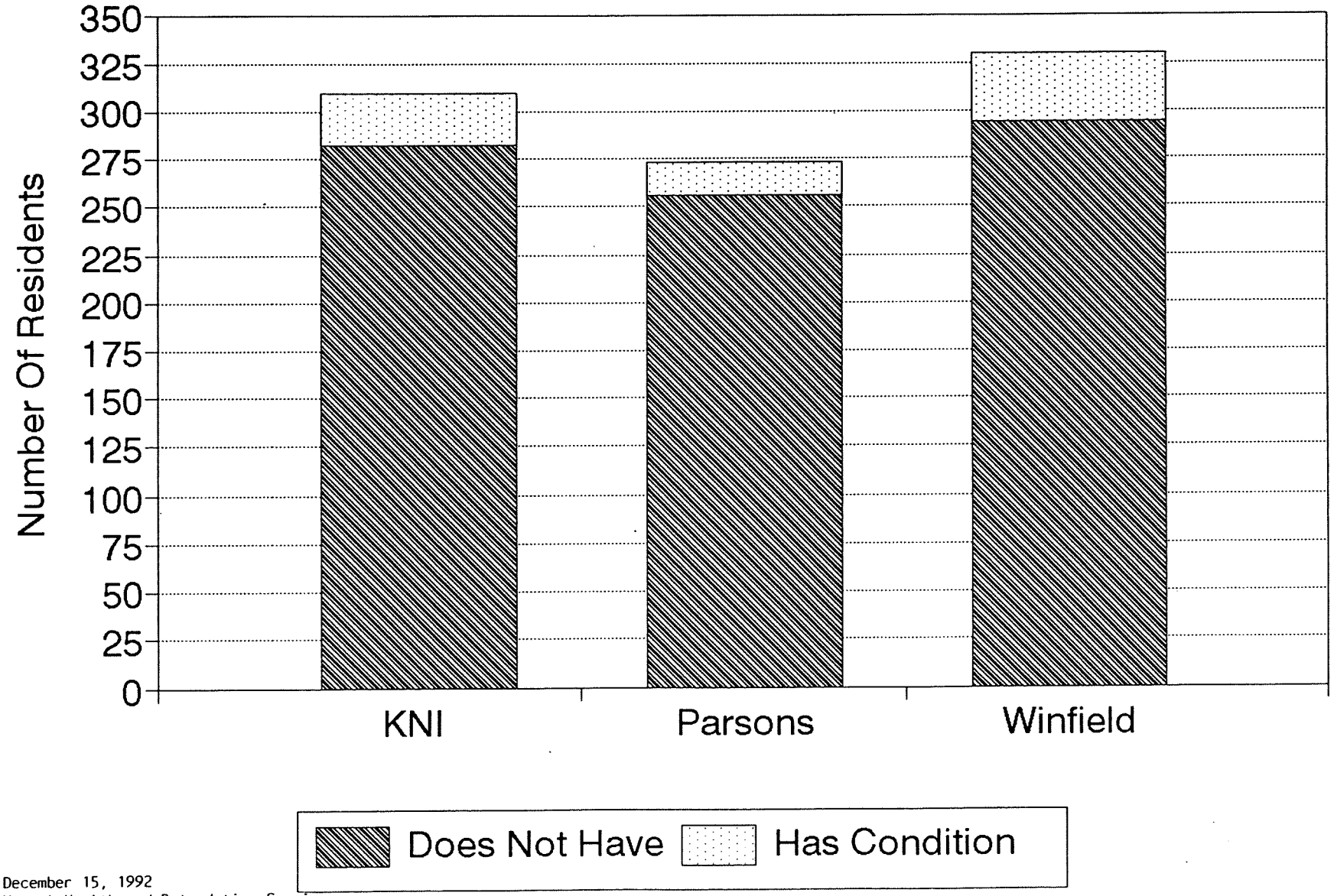


14-22

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Who Do Not Have A Cardiovascular Medical Condition

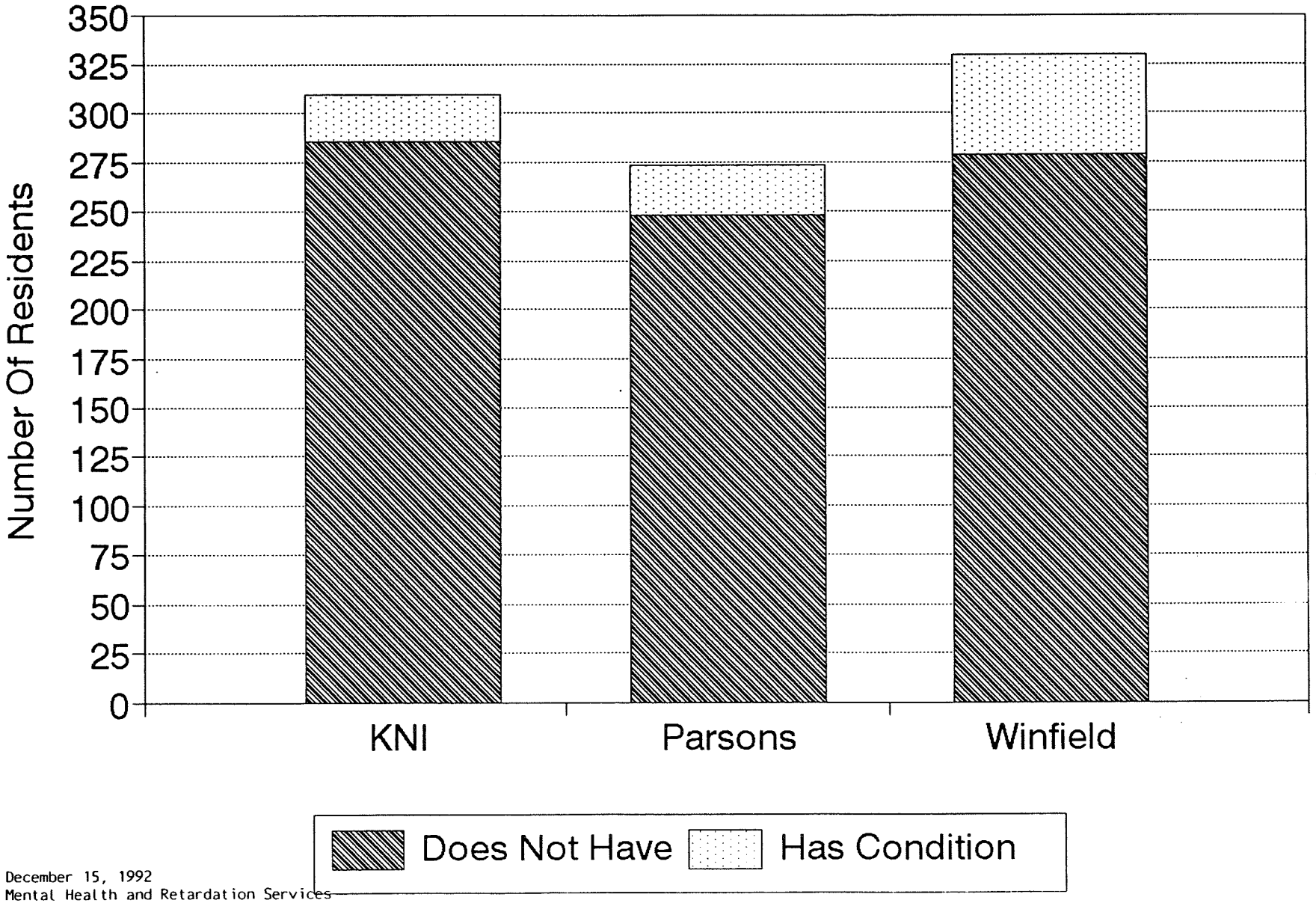


Date : December 15, 1992
Source: Mental Health and Retardation Services

#2-23

Kansas Mental Retardation Hospitals

Residents Who Do Not Have A Respiratory Medical Condition

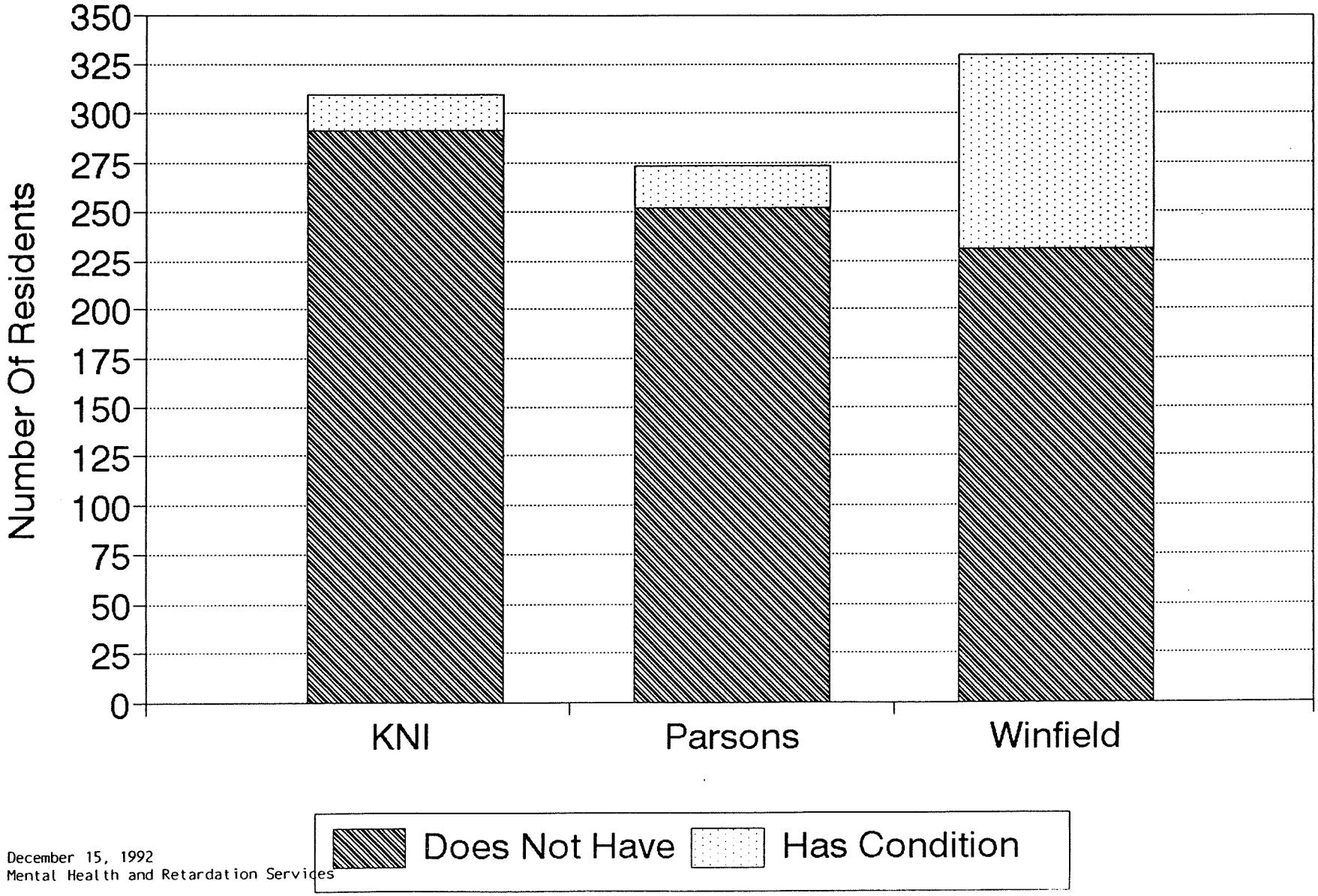


64-74

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Who Do Not Have A Gastro-Intestinal Medical Condition

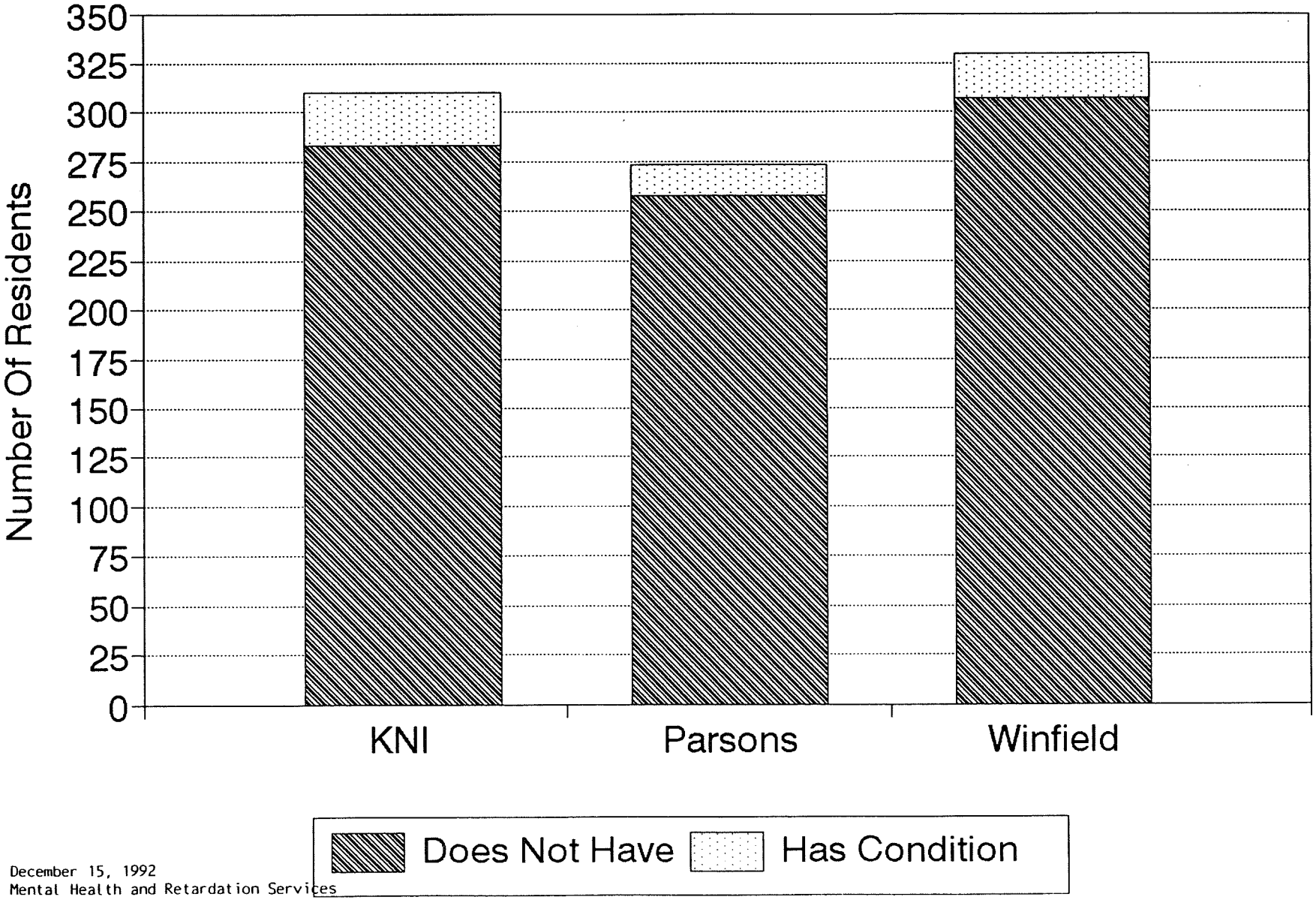


14-73

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Who Do Not Have A Genito-Urinary Medical Condition

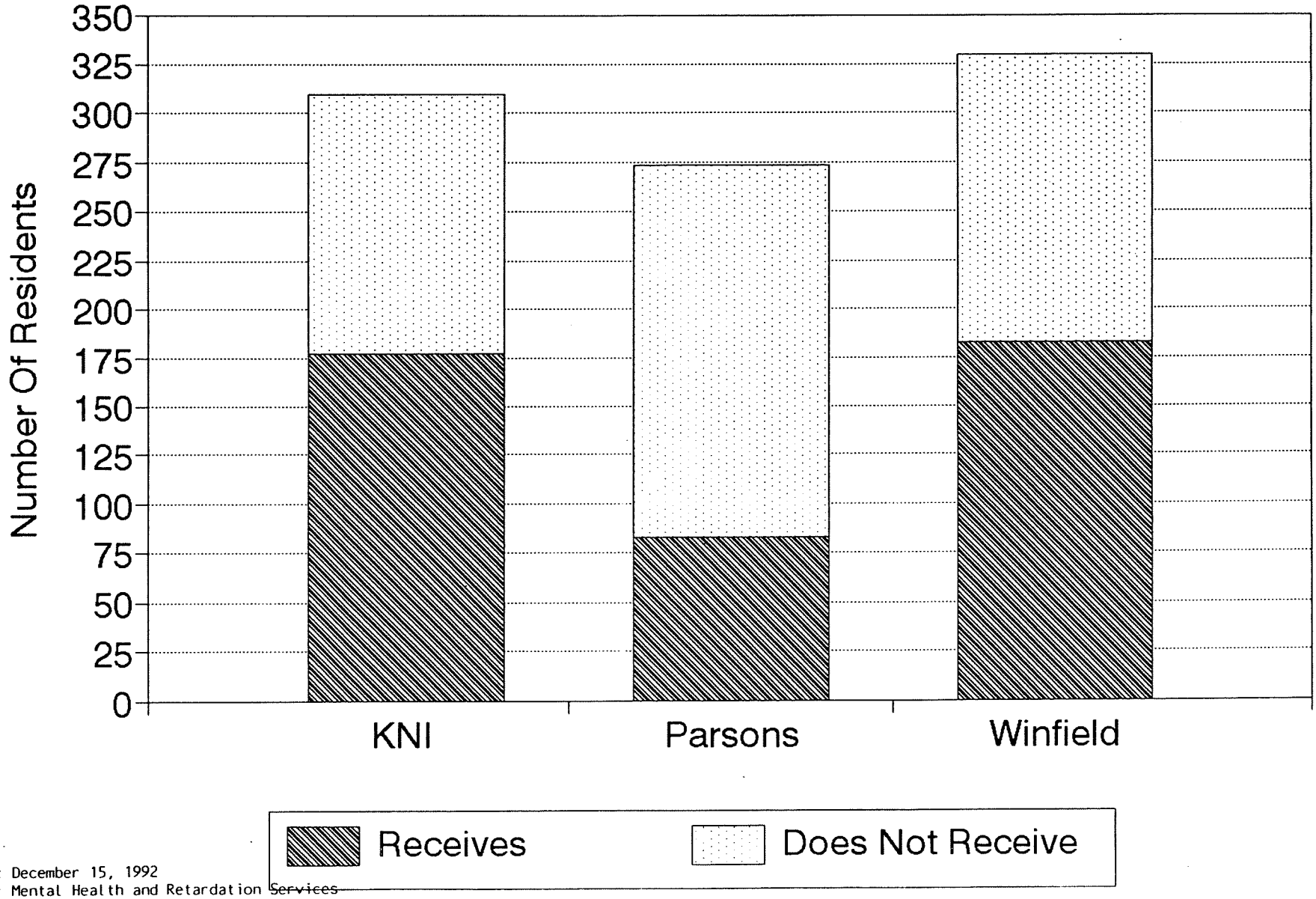


14-76

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Who Receive Anticonvulsant Medication(s) On An Ongoing Basis

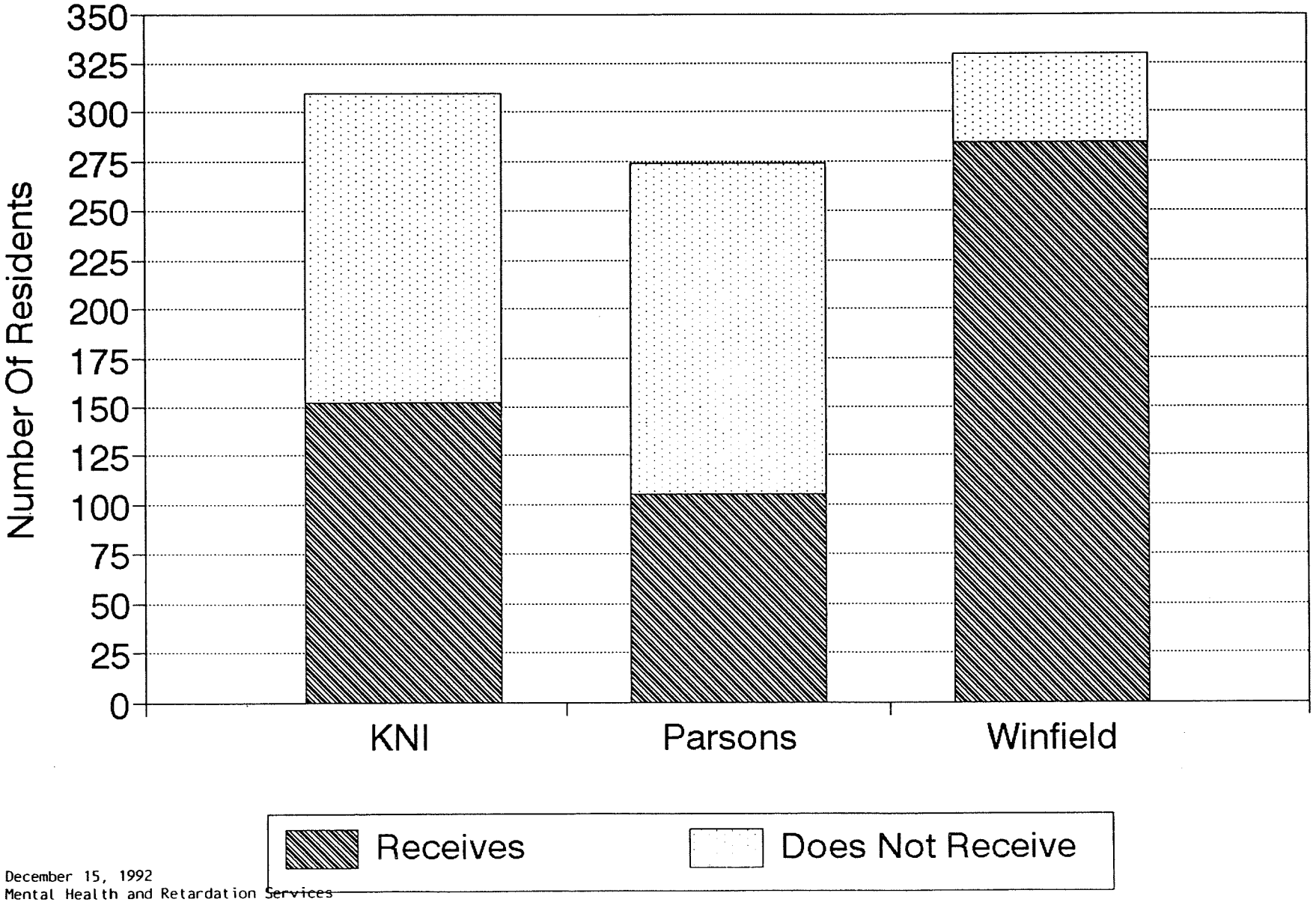


14-77

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

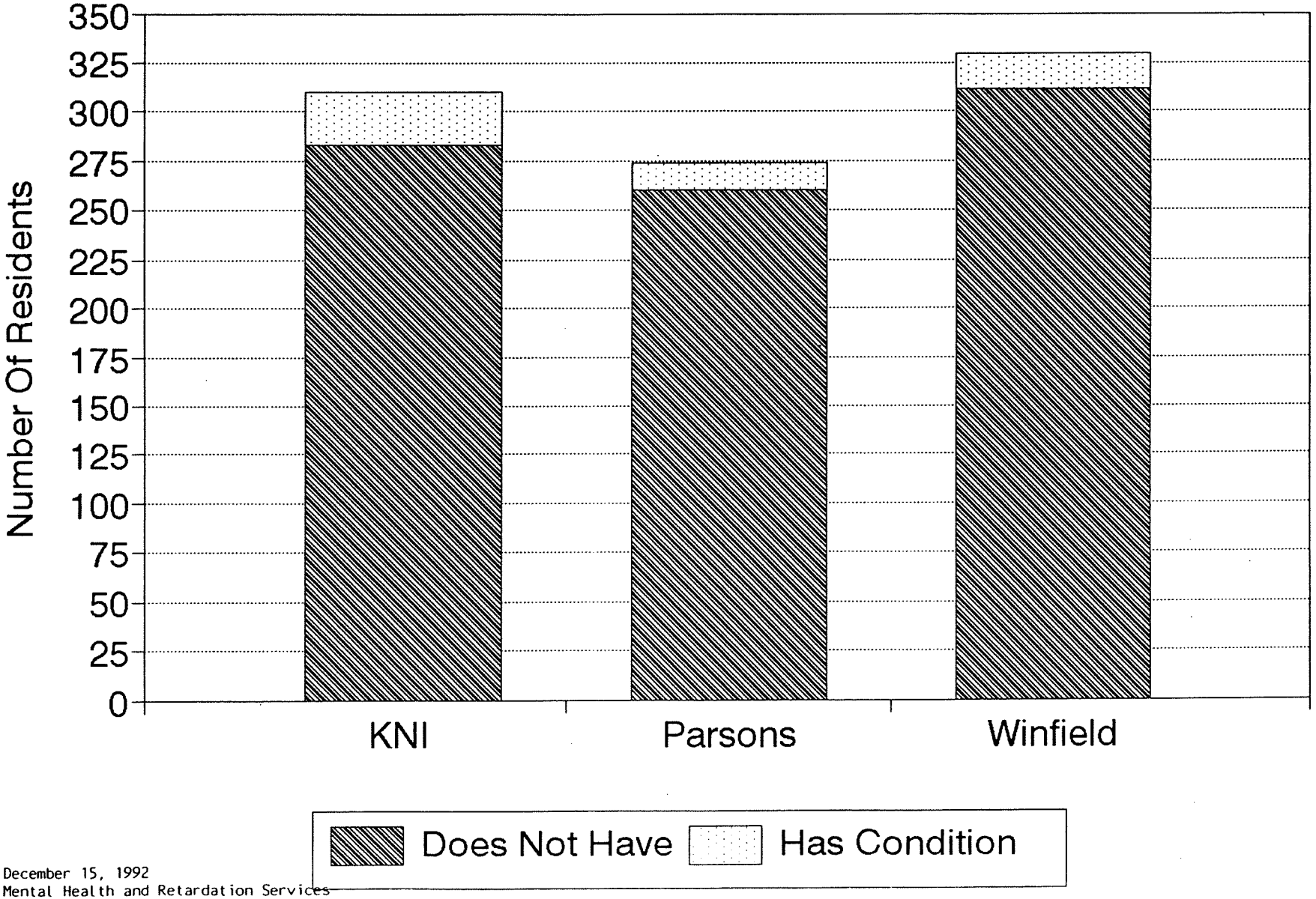
Residents Who Receive Maintenance Medication(s) On An Ongoing Basis



Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Residents Who Are Not A Hepatitis B Carrier

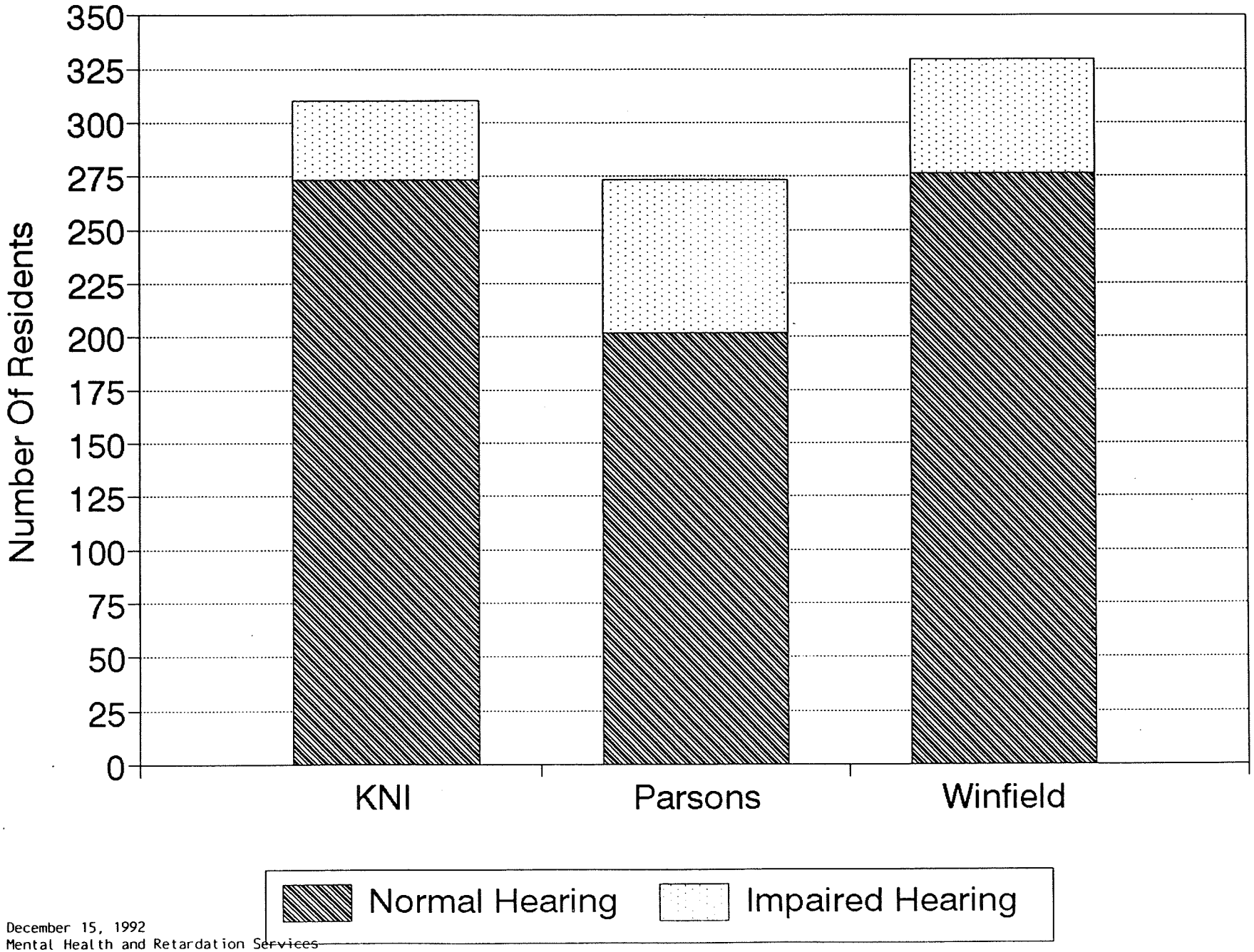


14-77

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

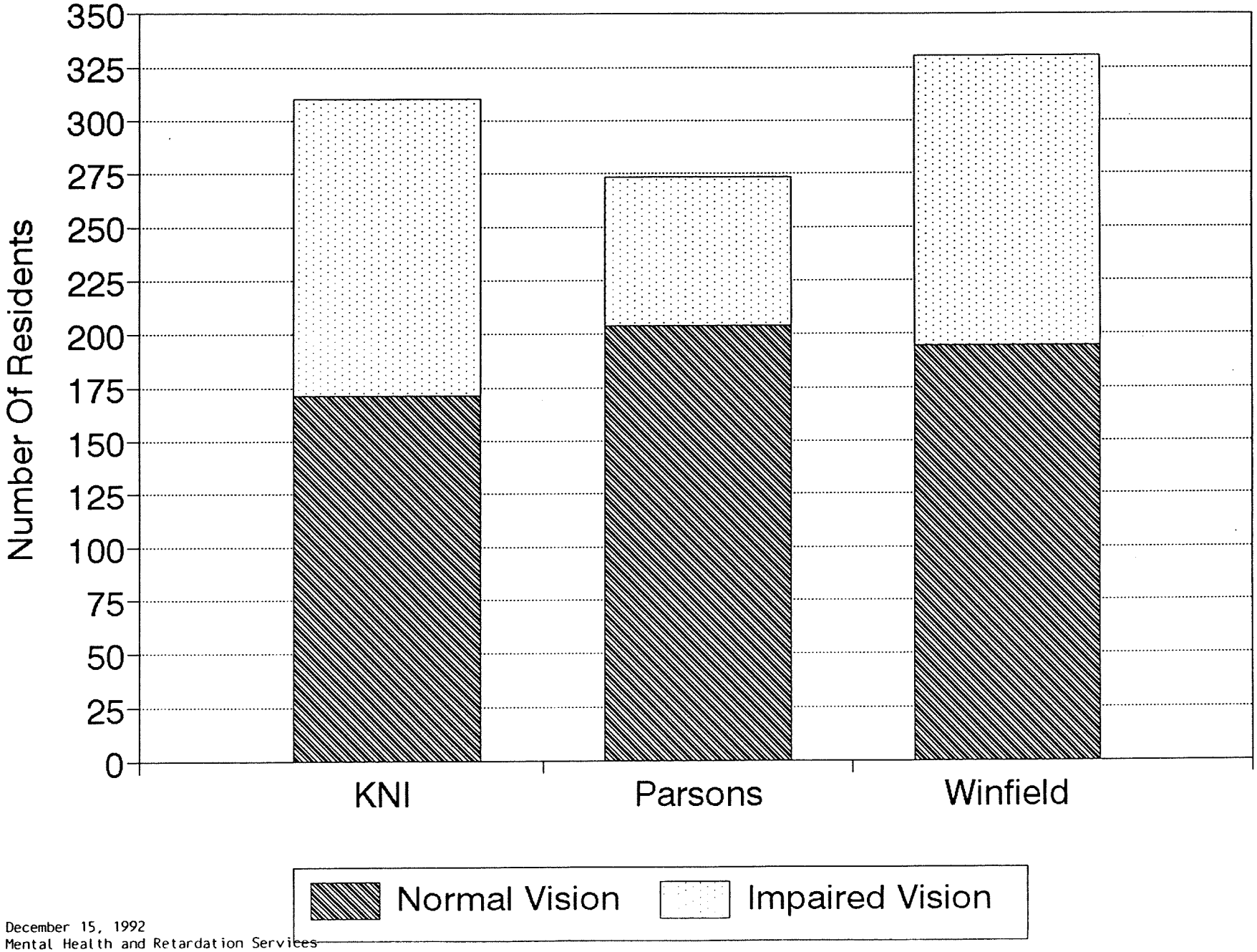
Hearing Ability Of Residents



08-41

Date : December 15, 1992
Source: Mental Health and Retardation Services

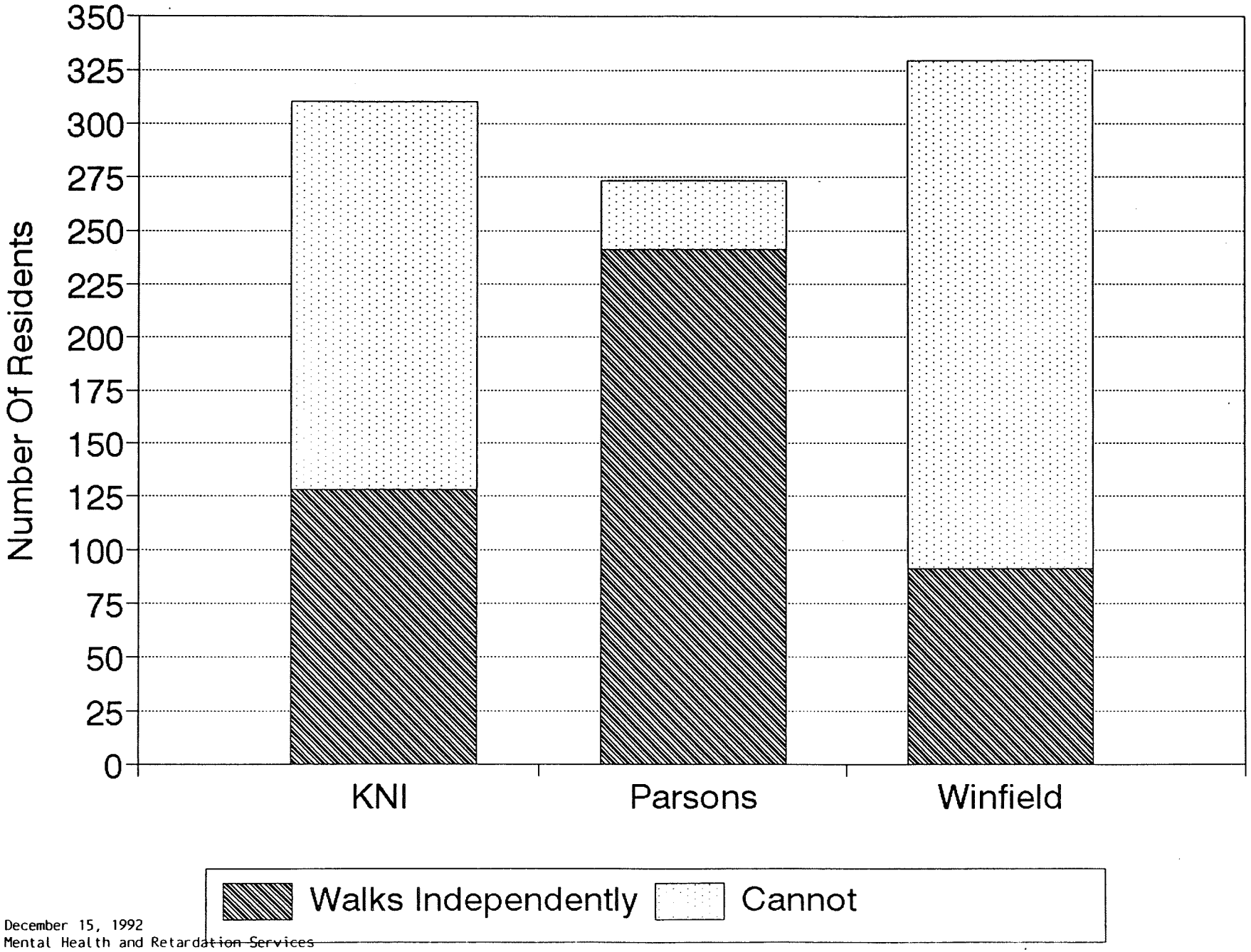
Kansas Mental Retardation Hospitals
Visual Ability Of Residents



18-41

Date : December 15, 1992
Source: Mental Health and Retardation Services

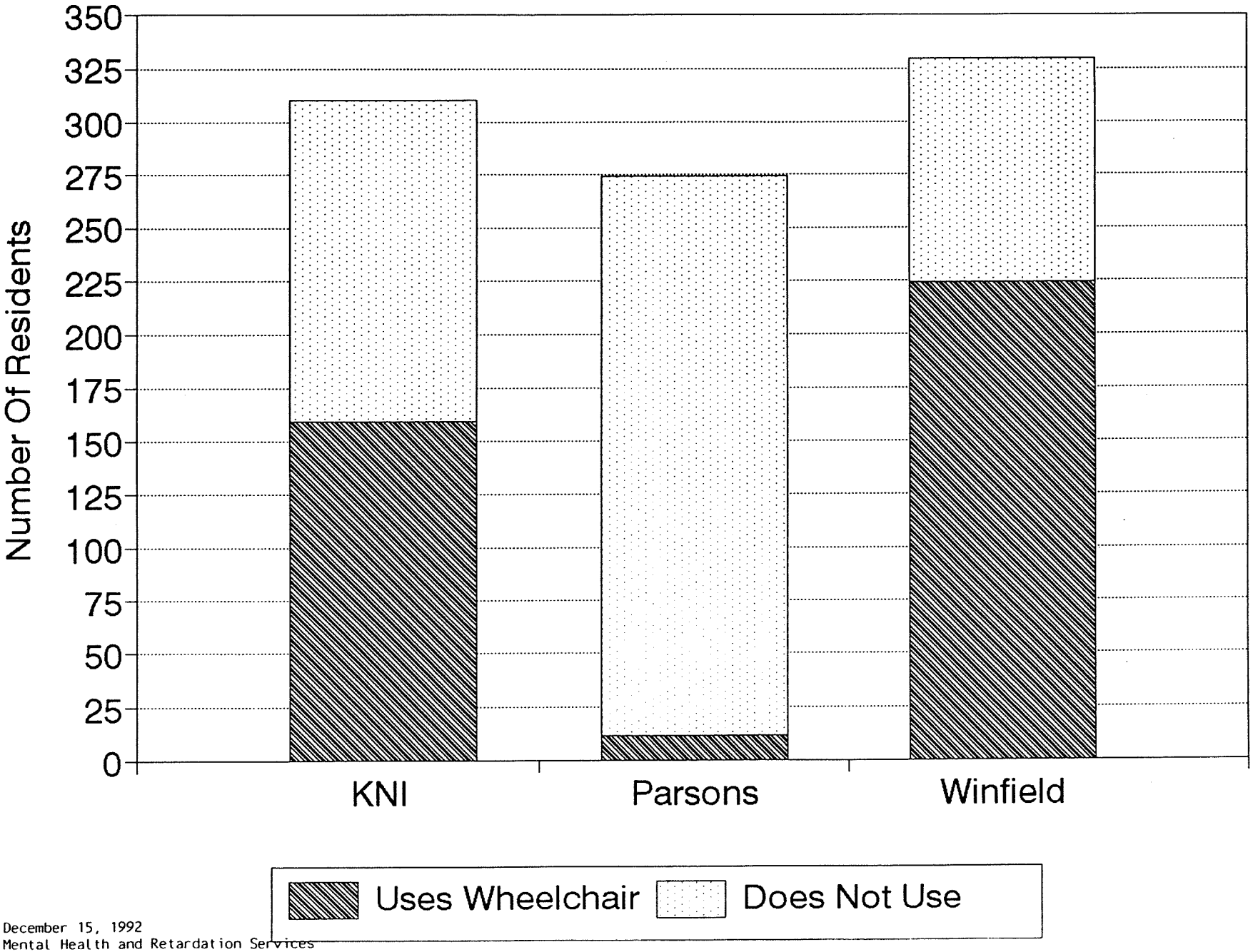
Kansas Mental Retardation Hospitals
Residents Who Can Walk Independently



14-83

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals
Residents Who Use A Wheelchair

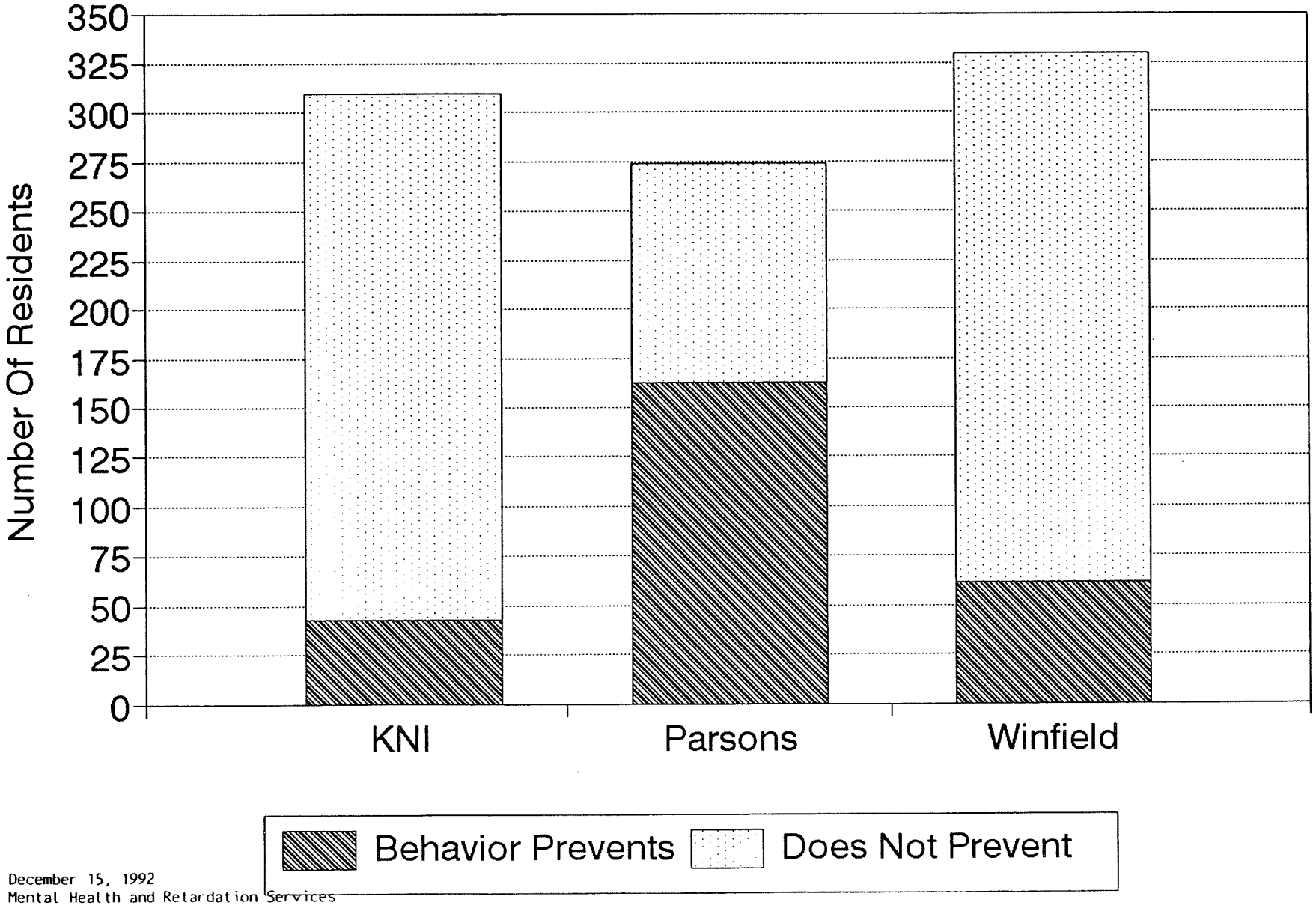


14 - 83

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Behavior Problems Prevent Residents Being Moved To Less Restricive Setting

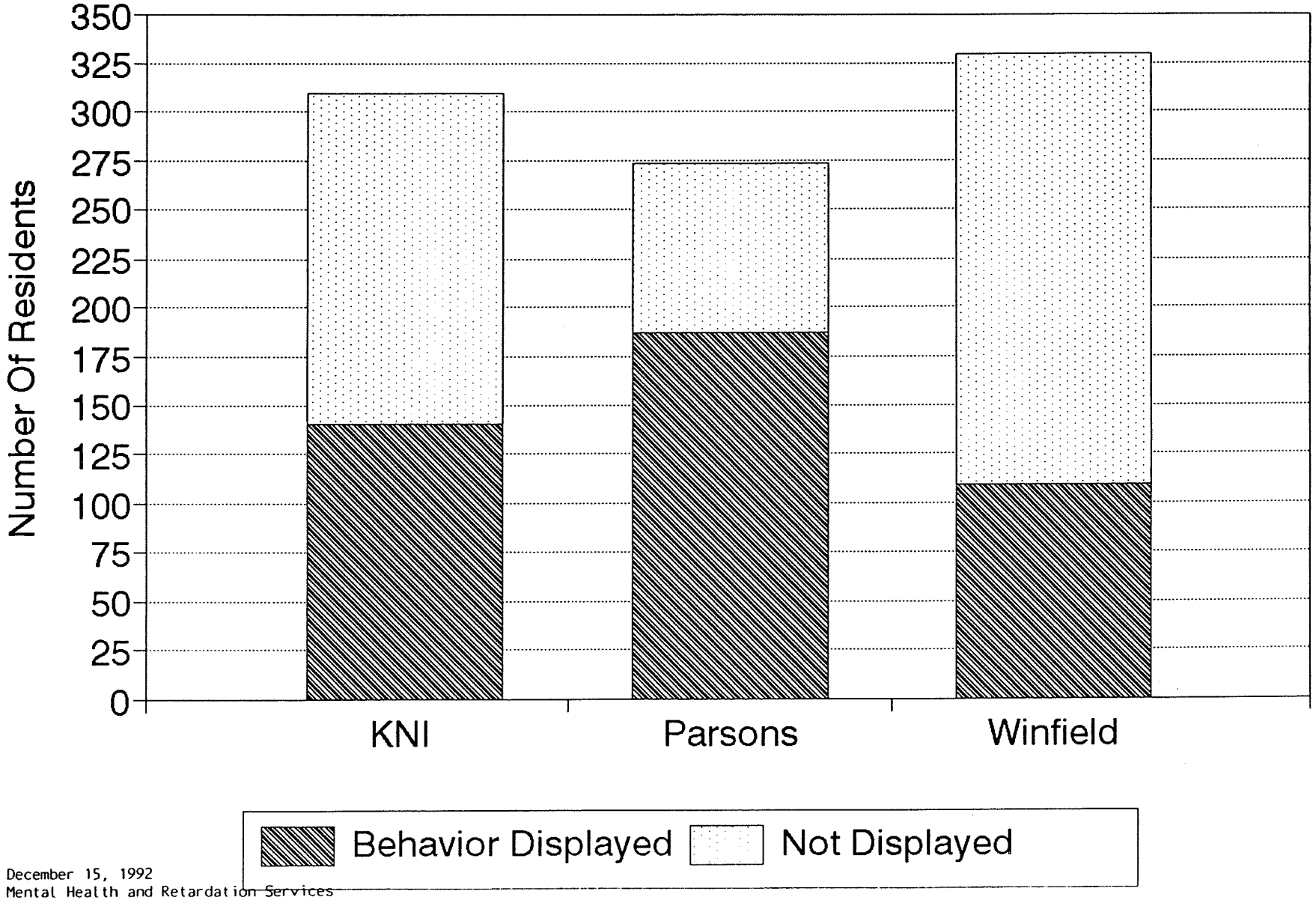


48-41

Date : December 15, 1992
Source: Mental Health and Retardation Services

Kansas Mental Retardation Hospitals

Behavior Problems Of Residents Requires Physical Intervention Of Staff



14-83

Date : December 15, 1992
Source: Mental Health and Retardation Services

APPENDIX

14-86

LIVING IN THE COMMUNITY:
WAYS PERSONS WITH MENTAL RETARDATION ARE BEING SERVED

Persons with mental retardation display deficits in both their behavior and their intelligence. There is a wide range of mental retardation, from mild to profound. Persons with mental retardation may also have some physical disabilities in addition to cognitive impairment. Mental retardation differs from mental illness in that it cannot be "cured" or treated as mental illness often can. People with mental retardation can be taught a variety of skills depending upon their level of retardation, but will always require some support to live in their communities. This support can vary from assistance in locating a job or managing money to 24 hour support and supervision. Some ways in which this level of support can be accomplished are listed in these examples of people with mental retardation being successfully included in their communities:

B. is a 13 year old boy who cannot dress, toilet, or bathe himself. He is deaf and blind. He cannot move, nor can he talk. B. lives with his parents in southeast Kansas. He is able to remain with his family because of the home and community-based services (HCBS) program which pays for a variety of in-home support services.

O. is a 41 year old man, who has spent the last 21 years in a state mental retardation hospital. He is in a wheelchair, and needs assistance with most of his daily activities. Although he cannot walk, and experiences seizures, he now lives in a house with two roommates, and is learning skills which will enable him to work in his south central community.

R. recently moved from his parents home to an apartment he shares with one roommate in his urban hometown. In spite of his wheelchair and severe, multiple disabilities, such as frequent seizures, asthma, and the inability to speak, he is able to participate in many activities which any young adult without disabilities enjoys, including the experience of moving away from home.

A.'s family reached a point where they were no longer able to support her in their home because of the intensive care she requires due to disabilities related to a head injury. She has lived in a state mental retardation hospital and a nursing facility for the elderly. Slightly over a year ago, this ten year old girl returned to her family home in central Kansas. Thanks to HCBS, she is a part of her family, attends school in her home district, and is included in her community.

N. is 62 years old, and has lived most of her life at a state mental retardation hospital. She uses a walker, cannot talk, and needs someone to help her accomplish most of her self-care activities. She now lives in a home with five other people in a small town in southeast Kansas, and participates in local recreational activities. She is able to enjoy the same opportunities to become a part of her community as any Kansan enjoys.

INSTITUTIONAL CLOSURES
BETWEEN 1987 AND JULY 1992

State	Facility	Year
Arizona	ATP at Phoenix	1988
Colorado	Pueblo Regional Center	1988
Connecticut	Waterbury Regional Center	1989
Connecticut	New Haven Regional Center	1992
District of Columbia	Forest Haven	1991
Illinois	Dixon Developmental Center	1987
Kansas	Norton State Hospital	1988
Maryland	Victor Cullen Center	1991
Michigan	Coldwater	1987
Michigan	Macomb-Oakland	1988
Michigan	Oakdale	1991
Missouri	Albany Regional Center	1991
Missouri	Hannibal Regional Center	1989
Missouri	Joplin Regional Center	1991
Missouri	Kirksville Regional Center	1988
Missouri	Springfield Regional Center	1990
New Hampshire	Laconia State School	1991
New York	Craig Developmental Center	1988
New York	Long Island	1991
New York	Rome Developmental Center	1989
New York	Staten Island (Willowbrook)	1988
New York	Westchester	1988
New York	Manhattan Developmental Center	1991
New York	Newark Developmental Center	1989
New York	Bronx Developmental Center	1991
North Dakota	Sanhaven	1987
Ohio	Cleveland	1988
Pennsylvania	Pennhurst	1987

Following the closures cited above, the District of Columbia and New Hampshire operate no large public facilities for persons with mental retardation/developmental disabilities.

Source: National Association of State Mental Retardation Program Directors
August 1992

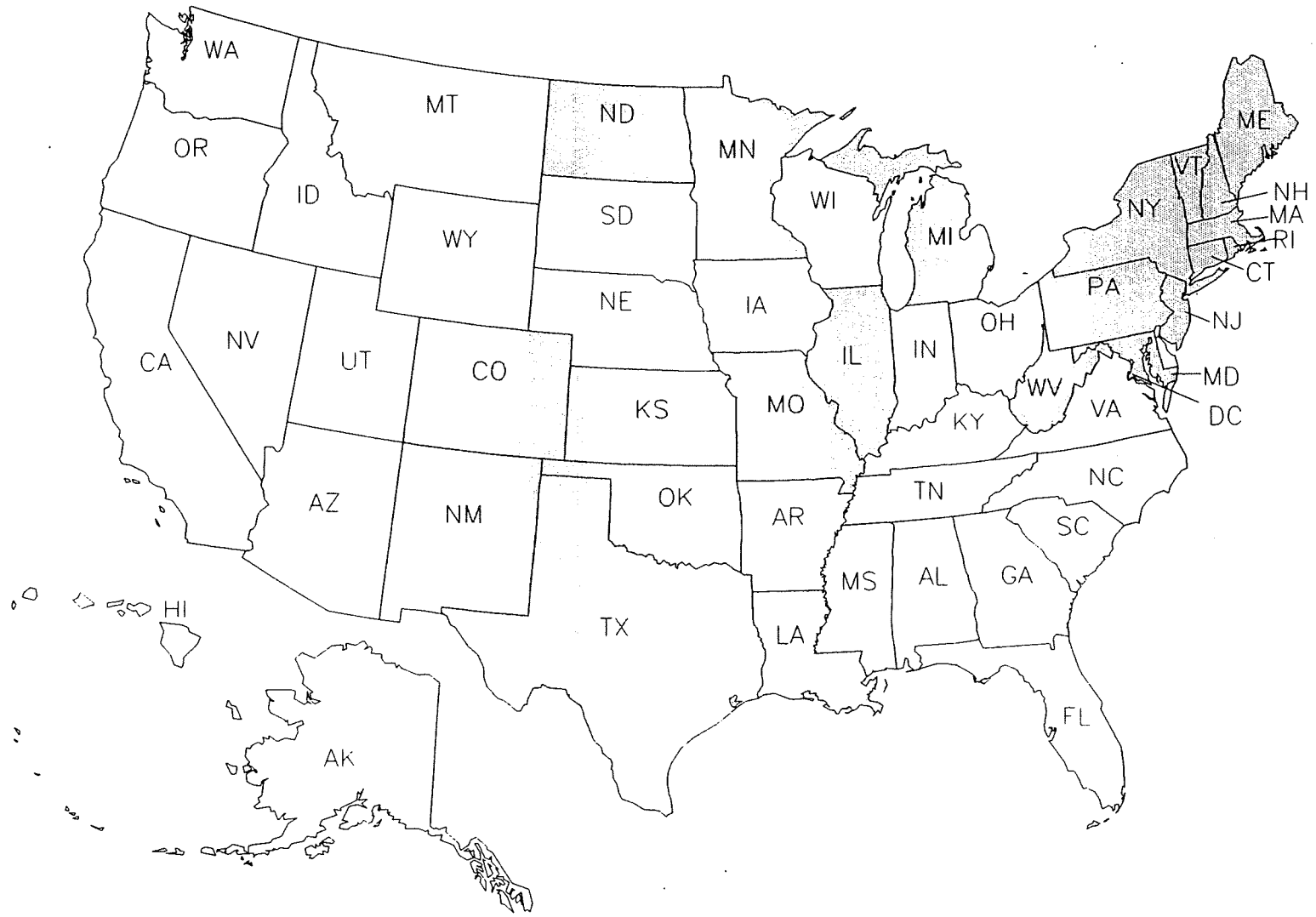
14-88

INSTITUTIONAL CLOSURES
PLANNED THROUGH 1995

State	Facility	Year
Connecticut	Mansfield Training School	1992 (Nov.)
Connecticut	Seaside Regional Center	
Illinois	Choate Mental Health & Dev. Center	
Louisiana	Leesville State School	
Maine	Pineland Center	1995
Massachusetts	Belchertown State School	1992
Massachusetts	Dever State School	1995
Michigan	Muskegon	1992 (Sept.)
Michigan	Newberry	1992 (Sept.)
Michigan	Caro	1994
Michigan	Mount Pleasant	1994
Michigan	Southgate	1994
Minnesota	Cambridge	1992
Minnesota	Fairbault	1995
New Jersey	Johnstone Center	1993
New Mexico	Fort Stanton	1995
New York	J.N. Adams	1992
New York	Wilton	1993
Ohio	Broadview	1992
Oklahoma	Hissom Memorial	1994
Rhode Island	Ladd Center	1992
Texas	Fort Worth	1995
Vermont	Brandon Training School	1993
West Virginia	Greenbrier Center	1993

The following states anticipate having no large public institutions in operation by 1995: Maine, Michigan, Rhode Island, and Vermont. New York anticipates closing all its large public facilities by the year 2000.

States With Planned Or Actual Institutional Closures 1987 to 1995



Date : August, 1992
Source: NASMRPD

States With Planned Institutional Closures Through 1995

14-91

Date : August, 1992
Source: NASMRPD

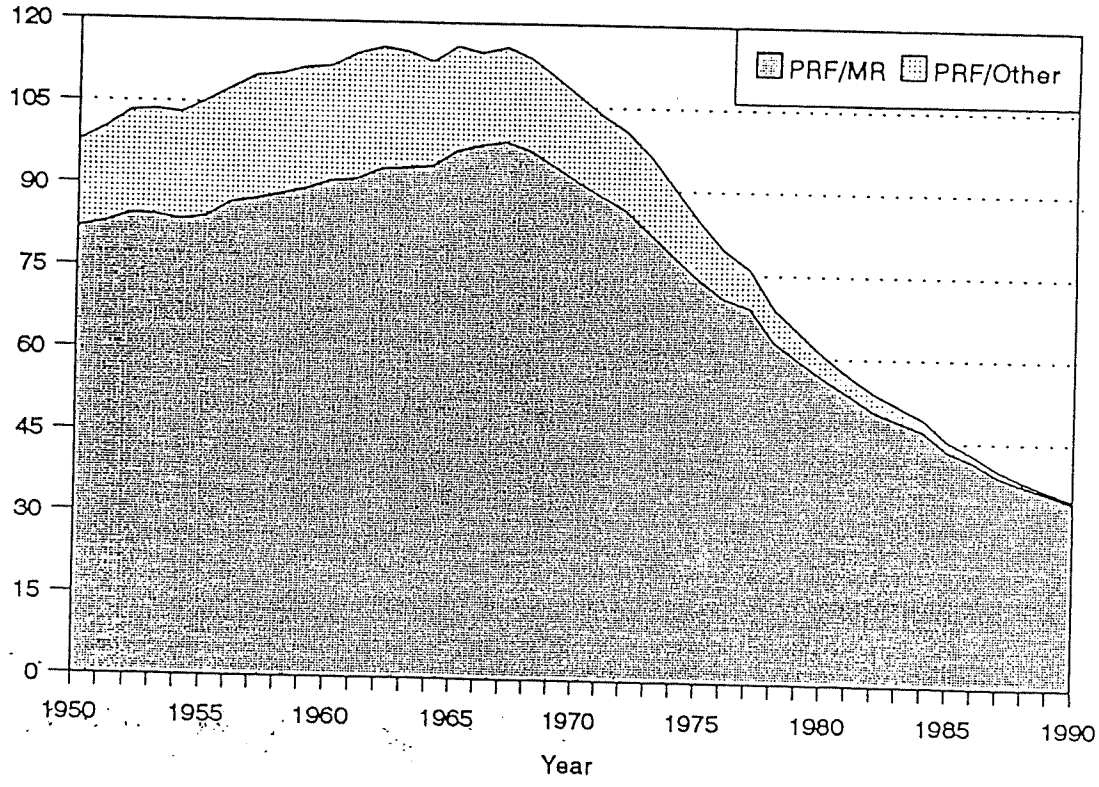
States With Institutional Closures
1987 to 1992

Date : August, 1992
Source: NASMRPD

Average Daily Population of Large State-Operated Mental Retardation Facilities per 100,000 of the General Population, 1950-1990

Year	U.S. Population in 100,000s on 7/1	PRF/MR	PRF/Other	Total
1950	1,518.68	81.85	15.74	97.59
1955	1,650.69	84.10	21.20	105.30
1960	1,799.79	90.97	20.91	111.88
1965	1,935.26	96.79	19.03	115.82
1967	1,974.57	98.58	17.14	115.72
1970	2,039.84	91.55	15.63	107.18
1973	2,113.57	82.22	14.31	96.53
1977	2,197.60	68.95	7.06	76.01
1980	2,272.36	56.35	4.14	60.49
1981	2,295.42	53.54	3.43	56.97
1982	2,318.22	50.54	3.39	53.93
1984	2,361.58	47.14	2.16	49.30
1985	2,382.91	43.49	1.90	45.39
1986	2,387.70	41.96	1.30	43.26
1987	2,433.05	38.92	1.17	40.09
1988	2,458.07	37.26	0.79	38.04
1989	2,482.43	35.73	0.65	36.38
1990	2,487.09	34.07	0.58	34.65

Average Daily Population of Large State-Operated
Mental Retardation Facilities per 100,000 of the General Population, 1950-1990



Source: Center for Residential Services and Community Living
Project Report 36
March 1992

Average Daily Population of Persons with Mental Retardation and Related Conditions in State-operated Residential Facilities per 100,000 of the General Population During Fiscal Year 1990 by State

State	7/1/90 State Pop.	Average Daily Residents: Total	Average Daily Residents per 100,000: Total	State-Operated Facilities: Large Total
AL	40.41	1,305	32.3	5
AK	5.50	60	10.9	2
AZ	36.65	360	9.8	3
AR	23.51	1,260	53.6	6
CA	297.60	7,111	23.9	7
CO	32.94	466	14.1	3
CT	32.87	1,898	57.7	18
DE	6.66	345	51.8	1
DC	6.07	309	50.9	3
FL	129.38	2,119	16.4	11
GA	64.78	2,087	32.2	12
HI	11.08	162	14.6	2
ID	10.07	210	20.9	1
IL	114.31	4,538	39.7	19
IN	55.44	1,940	35.0	9
IA	27.77	1,018	36.7	8
KS	24.78	1,017	41.0	3
KY	36.85	804	21.8	9
LA	42.20	2,622	62.1	9
ME	12.28	322	26.2	4
MD	47.81	1,289	27.0	6
MA	60.16	3,090	51.4	17
MI	92.95	1,137	12.2	6
MN	43.75	1,439	32.9	9
MS	25.73	1,498	58.2	5
MO	51.17	1,895	37.0	17
MT	7.99	244	30.5	3
NE	15.78	466	29.5	1
NV	12.02	170	14.1	2
NH	11.09	87	7.8	2
NJ	77.30	5,259	68.0	16
NM	15.15	500	33.0	2
NY	179.90	7,991	44.4	53
NC	66.29	2,767	41.7	10
ND	6.39	274	42.9	2
OH	108.47	2,665	24.6	19
OK	31.46	935	29.7	3
OR	28.42	838	29.5	2
PA	118.82	3,986	33.5	13
RI	10.03	236	23.5	2
SC	34.87	2,286	65.6	4
SD	6.96	403	57.9	3
TN	48.77	1,971	40.4	10
TX	169.87	7,320	43.1	17
UT	17.23	462	26.8	1
VT	5.63	180	32.0	1
VA	61.87	2,689	43.5	14
WA	48.67	1,782	36.6	8
WV	17.93	330	18.4	4
WI	48.92	1,710	35.0	5
WY	4.54	367	80.8	1
U.S.	2487.09	86,219	34.7	393

Source: Center for Residential Services and Community Living
Project Report 36
March 1992

14-94

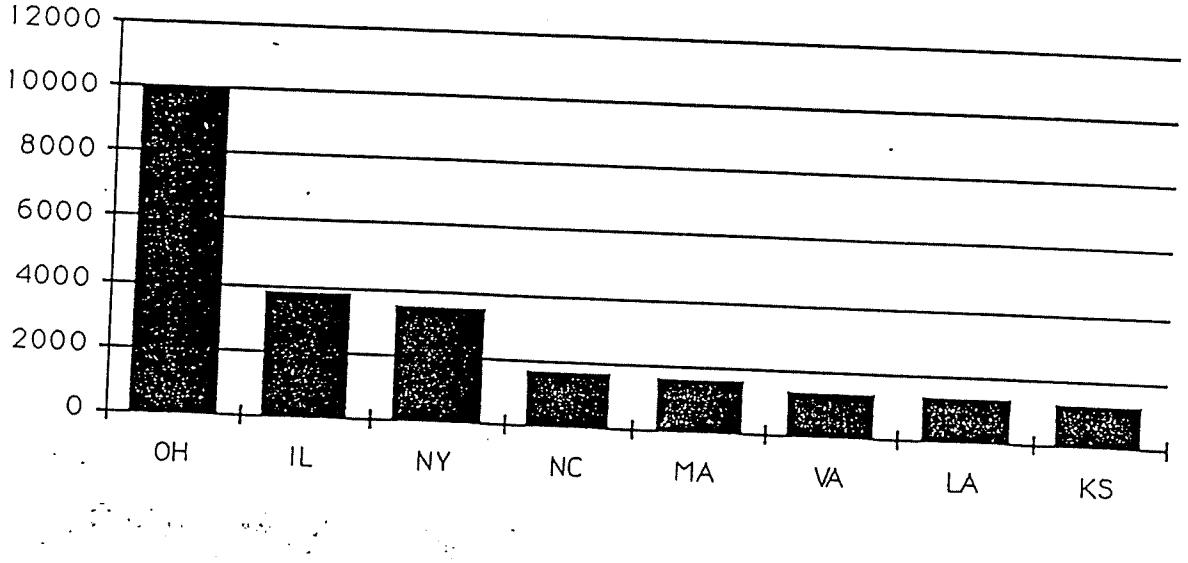
Kansas Placement Data

Jane Rhys

In an analysis of placement data Kansas does not fare well when compared with the other forty-nine states. Table AB1 in the *Thirteenth Annual Report to Congress* (1991), lists the percentage of students with disabilities, aged 3-21, served in different educational environments during the 1988-89 school year. Table AB2 lists the number of students with disabilities, aged 3-21, who were served in different educational environments during the 1988-89 school year. If the settings of public and private residential facilities are added together, Kansas ranks number eight out of all fifty states in sheer numbers of students placed in residential facilities. This puts Kansas in the same company with much more heavily populated states such as Ohio, Illinois, New York, North Carolina, Massachusetts, Virginia, and Louisiana. Kansas, with only one per cent of the total United States population, ranks thirty second out of the fifty states in population (1990 Census). Compared to New York (second), Ohio (seventh), Illinois (sixth), North Carolina (tenth) Massachusetts (thirteenth), Virginia (twelfth) and Louisiana (twenty-first), there can be very little justification for the numbers of students placed in residential facilities.

Table I

13th Annual Report to Congress - Highest Number of Students Placed in Residential Facilities



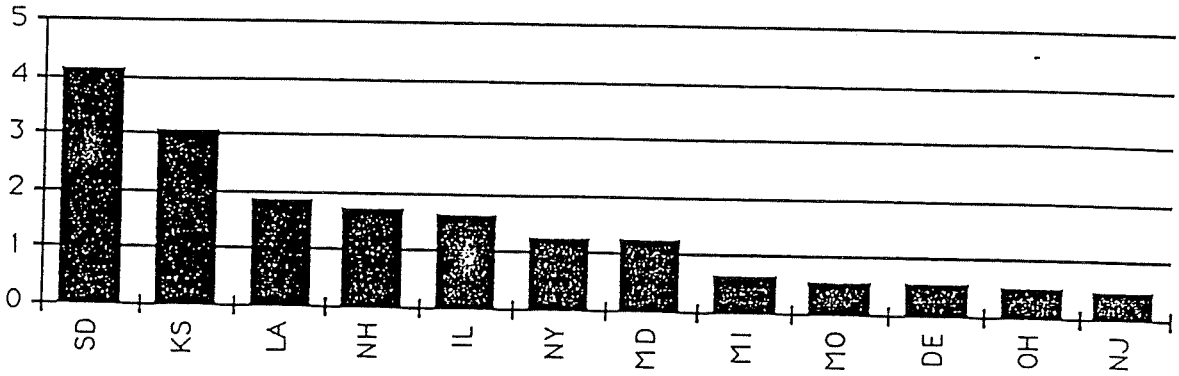
An examination of the percentage of total student population served in residential facilities for the 1988-89 school year shows Kansas ranks number two! Again, with the exception of South Dakota, Kansas is in with states who have much higher populations (see Table II). The

14-95

prevailing paradigm in Kansas has been, if a student has a severe disability and we do not know how to serve him, place him in an institution.

Table II

13th Annual Report to Congress - States with Highest % Residential Placement



The previous data documents that, although new laws and policy initiatives have been developed, Kansas has a long history of placing students with severe disabilities in residential settings.

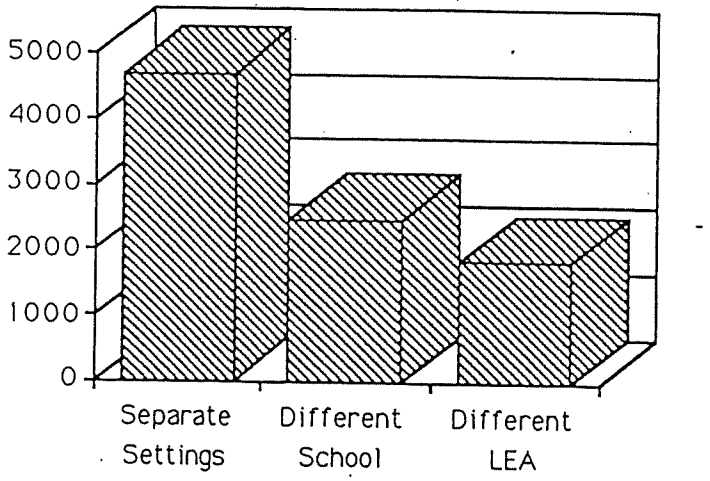
The 1991 December 1 count of students with disabilities was used to look at those students with severe disabilities who receive special education and related services for more than sixty per cent of their school day to determine how many received services in their local district, in their home school and what type of delivery model was used. This population includes students with severe multiple disabilities, students with deaf-blindness, students who have trainable level mental retardation, and students who have serious emotional disturbance who are placed for sixty per cent or more of their school day in special education services. Students who receive special education and related services for sixty per cent or more of their school day usually receive those services in a separate classroom, school, or residential facility. A small number of these students are in pilot programs and are fully included in a general education classroom setting but most are only with their nondisabled peers for non-academic activities. The remainder of the students may be receiving some instruction in community sites, but school inclusion is limited or nonexistent.

Table III indicates the numbers of students receiving services for sixty per cent or more of the day, who are not educated in their local district as well as the number who do not receive services in their home school.

14-96

Table III

Placement of Kansas Students with Severe Disabilities



As can be seen in the chart, a significant number of students with severe disabilities, those who have deaf-blindness, severe multiple disabilities, serious emotional disturbance, and autism, are not being educated in their home school or even in their local district. These students have very little opportunity for interaction with their nondisabled peers and those who do not attend school in their local school districts or even their home school have almost no opportunity to make neighborhood friends and continue these friendships at school and into their adult life.

14-97

COMMUNITY MENTAL RETARDATION CENTERS

PERSONS CURRENTLY SERVED

JANUARY 1, 1993

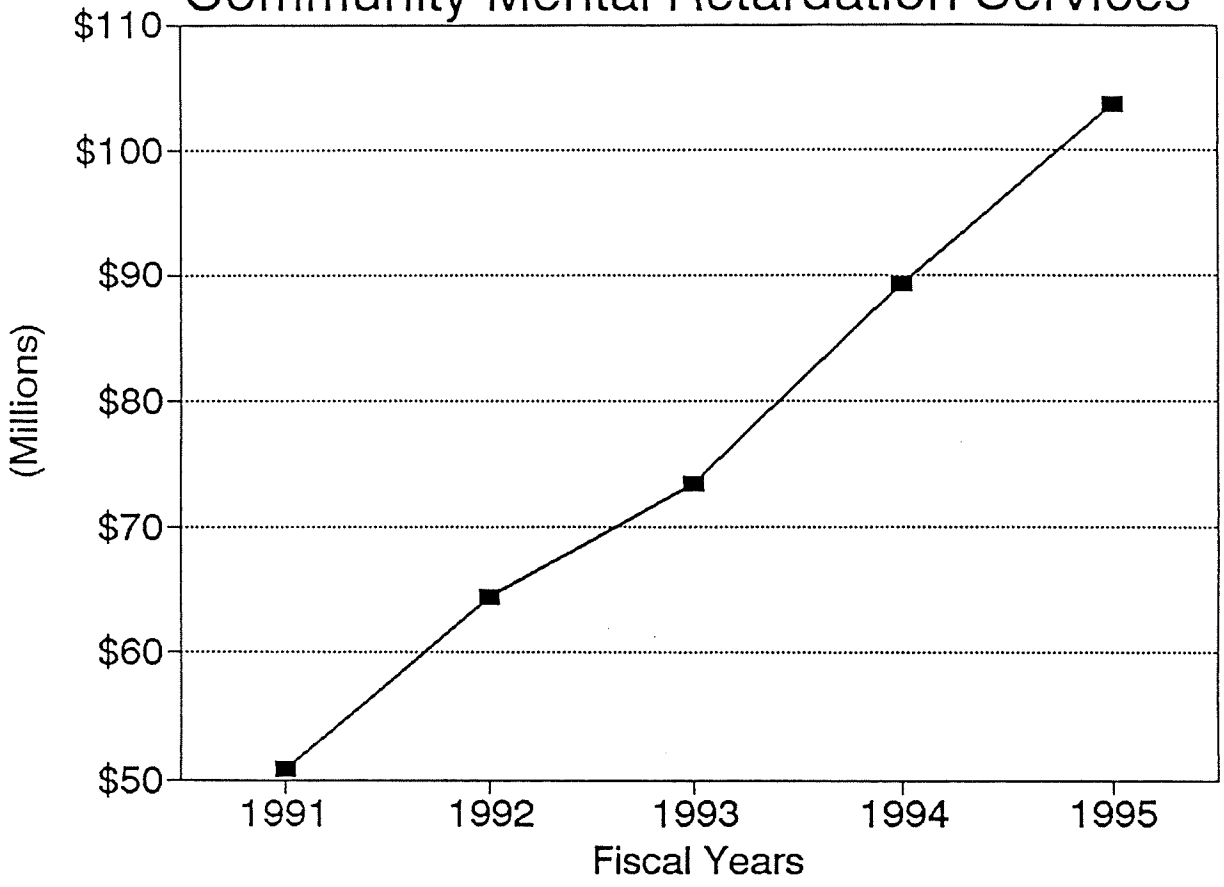
Community Mental Retardation Centers and Affiliates have reported to the SRS Kansas Rehabilitation Information System vital information regarding individuals who are currently being served in their facilities. The procedures used in obtaining this information required a standard set of data for identifying who is being served.

ADULTS	TOTAL SERVED
Private ICF/MR	976
Day Program Only	1757
Residential Only	466
Day & Residential	1900
Support	269
Adult Subtotal	5368
Children	342
Total	5710

Private ICFs/MR and CMRCs report 5710 individuals who are mentally retarded or developmentally disabled are being served in Kansas.

State Financial Support

Community Mental Retardation Services



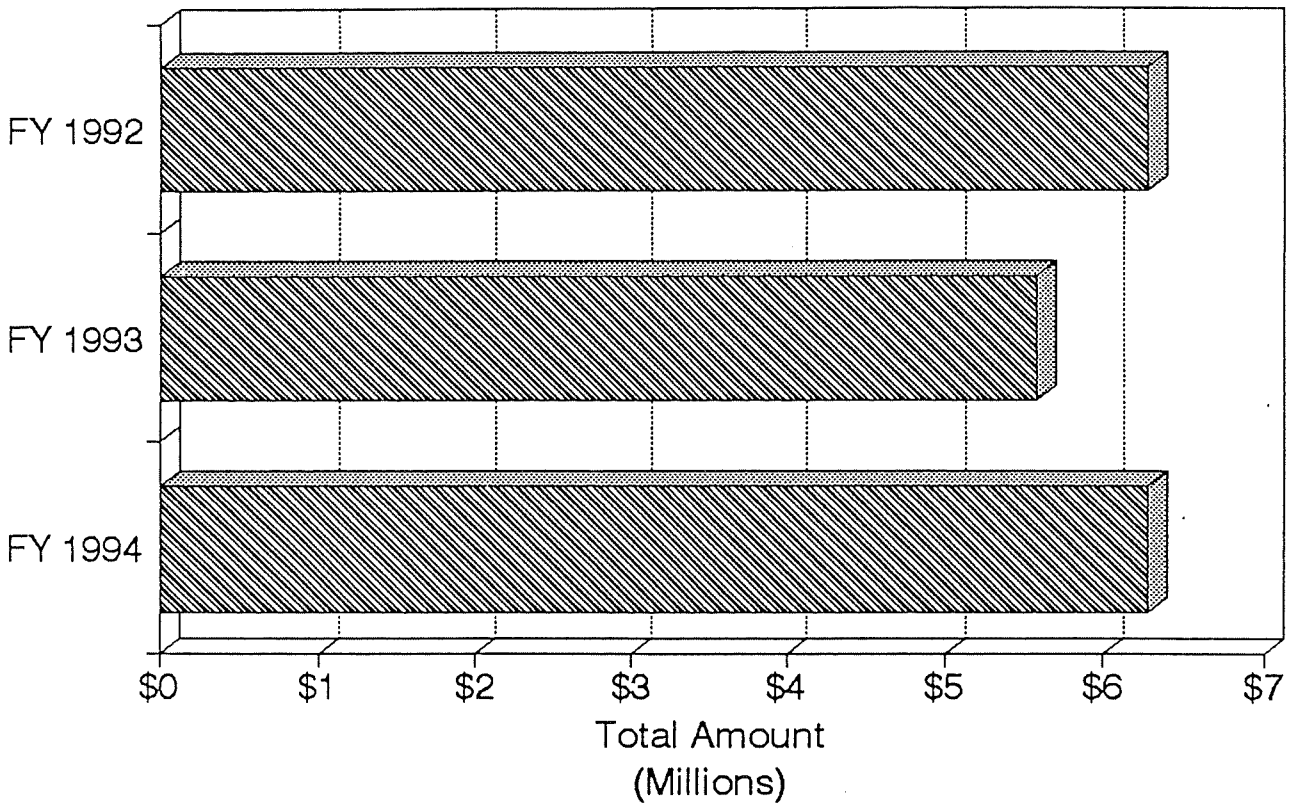
Funding Source	1991	1992	1993	1994 Est.	1995 Est.
Family Subsidy		$600,000	$792,000	$2,900,000	$3,600,000
Special Purpose	$11,872,793	$13,587,310	$13,842,117	$18,726,411	$20,198,911
State Aid	$5,963,771	$5,963,771	$5,963,771	$6,023,409	$6,023,409
Small Private ICF/MR *	$13,067,447	$15,626,102	$15,850,368	$16,936,810	$17,396,499
HCBS Waiver *	$9,681,773	$18,307,519	$26,560,450	$34,410,000	$46,000,000
SSBG Grants	$10,350,340	$10,350,340	$10,350,340	$10,350,340	$10,350,340
Totals	$50,936,124	$64,435,042	$73,359,046	$89,346,970	$103,569,159

* These are medicaid funds which include both state and federal funds. This is the source of funding for most community placements from state hospitals.

14-99

State Financial Support

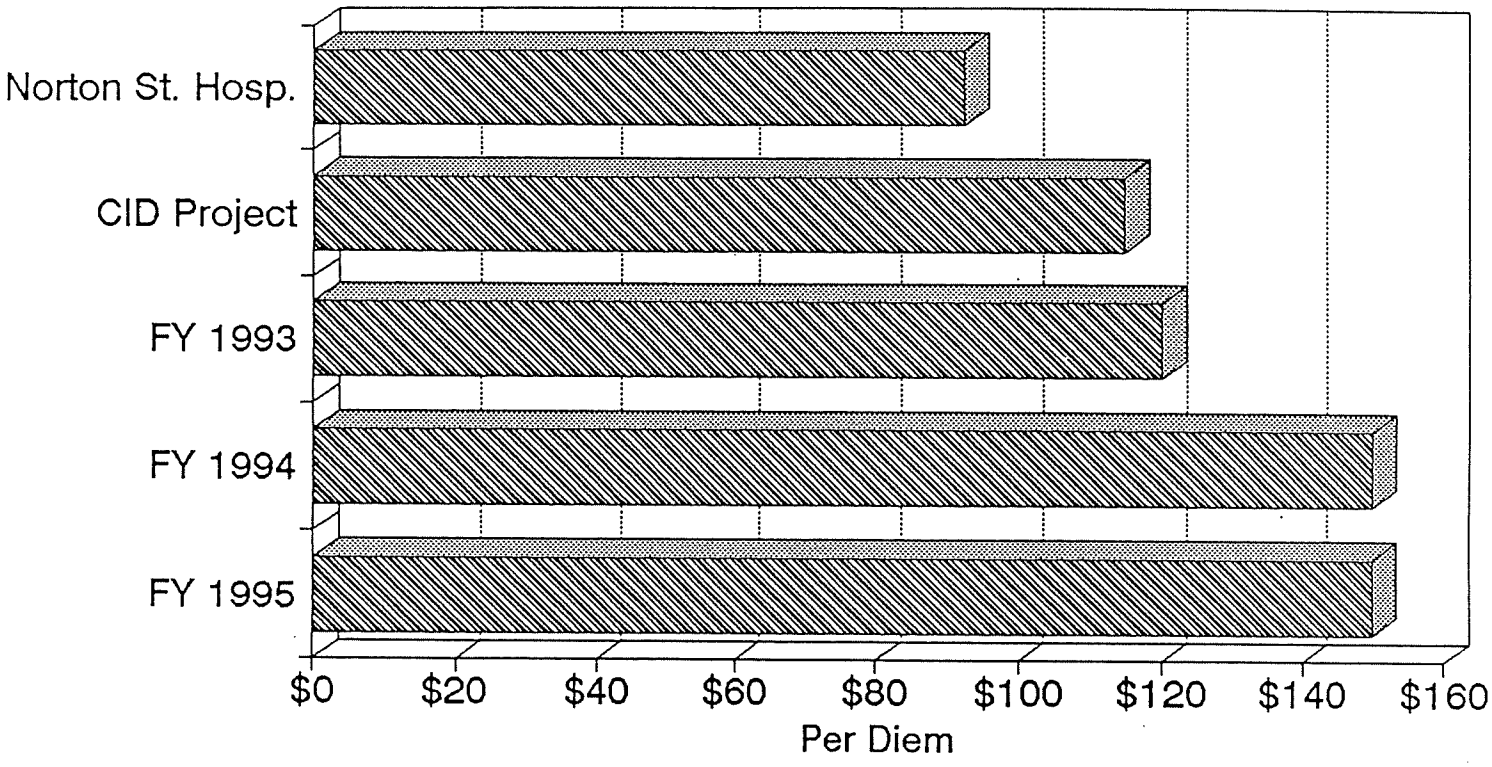
To Reduce the Community Waiting List



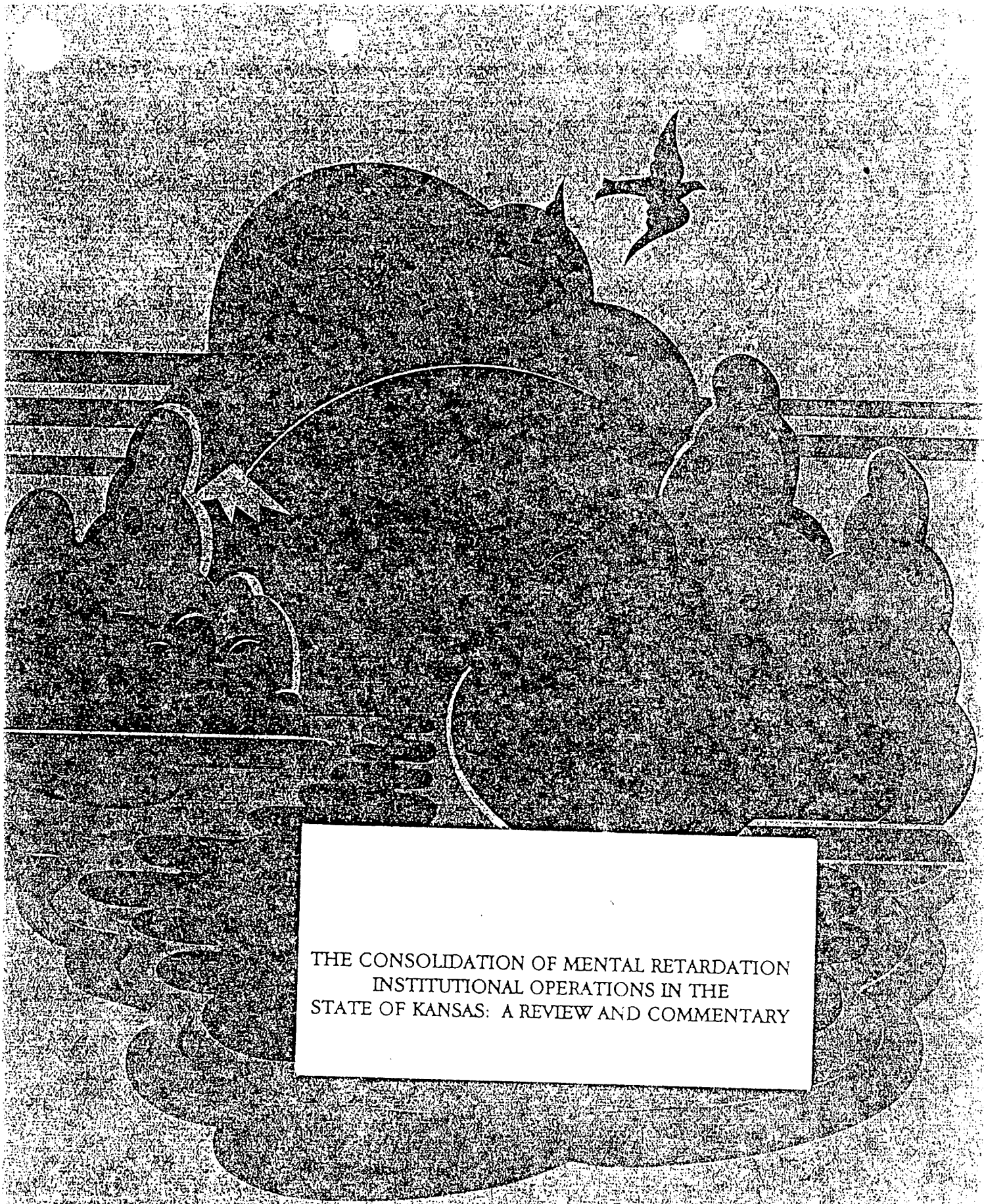
Fiscal Year	Number Of New People	Total Amount
FY 1992	310	$6,273,000
FY 1993	290	$5,583,500
FY 1994	310	$6,273,000

14700

State Financial Support
For State Hospital Placements



Placement Initiative	Number Of Placements	Average Per Diem
From Norton State Hospital	53	$92.26
CID Project	54	$114.82
Placements in FY 1993	84	$120.00
Placements in FY 1994 (Est)	84	$150.00
Placements in FY 1995 (Est)	84	$150.00



THE CONSOLIDATION OF MENTAL RETARDATION INSTITUTIONAL OPERATIONS IN THE STATE OF KANSAS: A REVIEW AND COMMENTARY

NATIONAL ASSOCIATION OF STATE MENTAL RETARDATION PROGRAM DIRECTORS, INC.

THE CONSOLIDATION OF MENTAL RETARDATION INSTITUTIONAL OPERATIONS IN THE STATE OF KANSAS: A REVIEW AND COMMENTARY

Lyn Rucker

and

Robert M. Gettings

June, 1992

This report was prepared in accordance with the terms of separate contracts between the authors and the Kansas Department of Social and Rehabilitation Services, Mental Health and Retardation Services (SRS/MH&RS), dated May 18, 1992. The views expressed in this report are those of the authors and do not necessarily represent the policies of SRS/MH&RS.

CONTENTS

Preface p. i

I. Background
- A. Legislative Mandated Study p. 1
- B. Mission of the Expert Team p. 4
- C. Limitations of the Expert Team's Analysis p. 5

II. Reactions to SRS/MR&RS' Closure Study
- A. Anticipated Individual Outcomes p. 7
- B. Review of the Process p. 10
- C. Key Factors Examined by MH&RS During its Closure Analysis p. 12
- D. Reactions Based on Visits to the Three State Hospitals p. 14
- E. MH&RS' Recommendations to Close a State Hospital and Training Center p. 19

III. Implementation Issues
- A. Maintaining the Quality and Appropriateness of Services in the Facility to be Closed p. 25
- B. Developing Community Capacity p. 28
- C. The Role of the Remaining Two State Hospitals p. 31
- D. State Level Planning, Implementation and Monitoring Activities p. 32

IV. Conclusion

Footnotes p. 37

PREFACE

Oliver Wendall Holmes was not necessarily reflecting on the responsibility of government officials when he wrote: "we must sail sometimes with the wind and sometimes against it -- but we must sail, and not drift, or lie at anchor." Nonetheless, in these few words he managed to capture the essence of successful public policymaking -- i.e., to carefully choose the basic direction in which policy should be headed and then ensure that all subsequent actions are consistent with this objective.

The State of Kansas currently is faced with a critical public policy choice with respect to assisting people with developmental disabilities. This choice involves the decision to close one of the State's three publicly-operated mental retardation hospitals as part of an ongoing effort to emphasize community-based services for individuals with severe, lifelong disabilities. At the direction of the Kansas Legislature, the authors of the current report were selected to review and comment on the process used by officials of the State Department of Social and Rehabilitation in determining which of the three facilities should be targeted for closure.

We wish to take this opportunity to express our sincere appreciation for the cooperation we received throughout the performance of this review. The staffs of the three State MR hospitals deserve a special word of thanks. They went to great lengths to show us the various facets of the operations of their respective facilities and responded patiently to our many questions. The fact that they managed to do so in a highly professional manner, despite the uncertainty and stress associated with the process, is a testament to their dedication and competence.

We also would be remiss if we failed to express our appreciation to Acting MH&RS Commissioner George Vega, his chief assistant for mental retardation/developmental disabilities services, Darvin Hirsch, and the other members of the MH&RS staff. Without their well-honed organizational skills and logistical support, it certainly would not have been possible to complete our review in the limited time that was available.

Finally, SRS Secretary Donna Whiteman was both gracious and supportive of our efforts to gather the information necessary to prepare this report. Without her strong commitment to a full and fair assessment of the closure study conducted by the MH&RS staff, our review could not have been completed.

While fully cognizant of the fact that Kansas faces a critical and controversial choice that will have far-reaching consequences for its citizens with developmental disabilities, we came away from our examination of the facility closure study with a high degree of optimism about the course the State is pursing. As Justice Holmes might put it, Kansans have set a visionary course and, while there may be rough sailing along the way, the State clearly is headed in a direction that promises a considerably brighter future for all citizens with developmental

disabilities. It is our hope that this report will make at least a small contribution to facilitating the State's journey along that path.

Lyn Rucker and Robert M. Gettings

June 26, 1992

I. BACKGROUND

The State of Kansas has made important strides over the past few years in expanding and improving residential services for people with mental retardation and other developmental disabilities. The community service system has developed the capacity to serve a wider range of individuals -- including persons with severe disabilities who were once thought to be in need of permanent institutionalization -- as the result of a continuing, collaborative effort to reduce the census of Kansas' three State-operated mental retardation hospitals. These census reductions, in turn, have led to marked improvements in the living environments and programmatic opportunities at all three state facilities.

As often occurs in the public policy arena, however, progress leads to new challenges. Among the new challenges that the State of Kansas now faces is how to reconfigure its existing State-operated residential facilities in a way that is fully supportive of the trend toward serving people with developmental disabilities in community-based settings. More specifically, Kansas is rapidly reaching the point where it makes less and less economic sense to continue to operate three separate state residential facilities for persons with mental retardation.

As will be discussed in further detail below, during its 1992 session the Kansas Legislature instructed the State Department of Social and Rehabilitation Services (SRS) to: (a) determine which of the three State-operated mental retardation hospitals should be closed, based on a set of legislatively articulated criteria; and (b) prepare and submit to the Legislature by January 1, 1993 a multi-year plan for carrying out this closure. The Legislature also directed SRS officials to retain an outside expert to assist them in determining which one of the three state MR facilities should be closed. The authors of the present report were asked by the Acting Commissioner of Mental Health and Retardation Services (MH&RS) to review and critique the methodology used by the MH&RS staff in reaching a preliminary determination, prior to making a formal recommendation on the facility closure question to the Secretary of Social and Rehabilitation Services.

The purpose of this report is to summarize the authors' findings regarding the facility closure analysis conducted by the MH&RS staff and to offer further suggestions regarding the closure process, as MH&RS/SRS officials begin to develop the implementation plan mandated by the Legislature. However, before turning to these topics, it is important that the reader understand the nature of the authors' (hereafter referred to as the expert team) assignment, the methods that were used, and the very real limitations associated with the type of short term analysis which the expert team was asked to perform.

A. Legislatively Mandated Study

During its past two sessions, the Kansas Legislature has taken a strong interest in systematically reducing the resident population of the three State-operated MR facilities -- Kansas Neurological Institute, Parsons State Hospital and Training Center, and Winfield State Hospital and Training Center. In 1990, the Legislature directed SRS' Mental Health

and Retardation Services to transfer 50 individuals from the state hospitals to community residential settings. In 1991, SRS/MH&RS, in response to a call for further depopulation issued by the House Appropriations Subcommittee No. 2 (Human Services), drew up a plan to reduce the census of the three state hospitals by an additional 137 individuals over a two year period.

Also during 1991, an interim legislative task force was established to study a number of critical SRS policy issues. This task force: (a) recommended that the number of State-operated MR hospitals be reduced from three to two in an effort to trim systemwide operating cost and promote community-based living alternatives; and (b) proposed that SRS/MH&RS establish its own study group to work out the details of effectuating this hospital consolidation.[1]

At the suggestion of the Legislature and the direction of the Governor, an Ad Hoc Committee on Hospital Consolidation was established in 1991 to study the need to maintain three state MR hospitals. This group, which was composed of staff representatives from the three hospitals, public employees, family members and other advocates for people with mental retardation and related conditions, reviewed the proposal that one of the existing MR hospitals be closed and agreed that such action could be taken without creating major dislocations or overburdening the community MR/DD service delivery system. The Committee also offered a number of suggestions regarding implementation of the proposed closure, including steps which could be taken to keep the process client- and family-centered.

Based on the recommendations of the Ad Hoc Committee and its own analysis of the situation, the House Appropriations Subcommittee No. 2 (Human Services) concluded earlier this year that:

> ... the current process of *downsizing* (i.e., closing beds) at all three institutions contemporaneously is a mistake. It serves, in the view of the Subcommittee, only to create insecurity among families of clients regarding the care for their loved ones, and creates a demoralizing uncertainty among state employees at the MR institutions with regard to the future of their jobs. Also, downsizing, unless done on a dramatic scale, does little to save money at the state institutions, and, in the short term, even increases costs per client-day.[2]

While acknowledging that the state hospitals "... offer [their residents] excellent care", the Subcommittee said community-based settings could "... offer care opportunities that are more client-centered, in which clients' families have more involvement in care decisions, and which, in the long-run, will prove much less expensive than residential care at the three mental retardation institutions." In light of these factors, the Subcommittee concluded that "... the time has come to build up the community-care system for people with mental retardation and developmental disabilities, and to consolidate the number of state MR institutions from three to two." Rather than designating the facility

which should be targeted for closure, however, the Subcommittee decided to leave the decision to SRS/MH&RS.3

The members of the Subcommittee emphasized that the decision regarding which facility should be closed "... should be driven by what is best for the system's clients" and directed SRS/MH&RS officials to take the following factors into account in making the closure decision:

- "The impact that the hospital's closing would have on the hospital's clients and their families.
- The availability of appropriate community-care settings and supports in the service area of each institution.
- The effect of closing an institution on the institution's staff, their families, and the institution's host community.
- The efficiency of the institution's operation.
- Employee availability and labor costs.
- The ability of the institution's home community to deal with the economic consequences of closure as determined by a financial-impact study...
- The savings to the State of Kansas that would be generated by closing the institution.
- The state of the institution's physical plant, and future capital costs that would be incurred by the state if the institution were kept open.[4]

In reaching a decision regarding which of the three state MR hospitals should be closed, SRS/MH&RS was instructed by the Subcommittee to "... work in close cooperation with a recognized outside expert." The Subcommittee also: (a) directed the Department to prepare and submit to the Legislature no later than January 1, 1993 a detailed facility closure plan; and (b) recommended that the placement and transfer of residents be spread over a four year period (i.e., at approximately the same pace (84 placements per year) as facility downsizing efforts over the past two fiscal years), in order to ensure adequate time for advanced person-centered planning and necessary accommodations by the receiving facilities/programs.[5]

Although the recommendations of the House Subcommittee were not formally incorporated in the FY 1992-93 appropriations measure, the Subcommittee's view were referenced favorably at subsequent stages of the legislative process and, therefore, were recognized by MH&RS/SRS as a clear statement of legislative intent. Based on the findings and recommendations of the Ad Hoc Advisory Committee on Hospital Consolidation, which were submitted

to the Legislature and the Governor in March, 1992, MH&RS officials prepared a draft report in April-June, 1992 analyzing the differential impacts of closing each of the three state MR hospitals, in accordance with the criteria outlined by the Legislature.[6]

In conformance with the stated wishes of the Legislature, MH&RS officials selected a two member team of outside experts, Robert M. Gettings and Lyn Rucker, to review and critique the agency's draft report, entitled Creating Choices, Providing Options: One Person at a Time. In addition to sharing with members of the expert team a copy of this draft report plus two other supplementary analyses prepared under contract by an economist at Kansas State University.[7,8] MH&RS officials arranged to have the team members visit each of the State MR hospitals. The purpose of these visits, which took place on June 8-10, 1992, were to give the expert team an opportunity to observe, first hand, the unique aspects of each facility's resident population and programs and, thus, gain a better understanding of the special challenges and opportunities associated with carrying out the legislative mandate to close one of these facilities.

B. Mission of the Expert Team

The contractual agreements between MH&RS/SRS and the two members of the expert team specified that Mr. Gettings and Ms. Rucker were to:

"1) Review information and data compiled in a study by the Agency [MH&RS/SRS] regarding the closure of one of Kansas' three state-operated facilities for people with mental retardation.

2) Conduct an on-site visit of Parsons State Hospital and Training Center, Winfield State Hospital and Training Center, and Kansas Neurological Institute.

3) On the basis of independent professional judgment summarize findings, conclusions and recommendations as to [the] appropriateness of proposed agency action in a brief written report including at a minimum:

   a) Comments on the Agency's study's content and recommendations concerning the aims and procedures to be followed as part of the closure initiative as to validity of [the] issues included for decision making and inform the Agency if any critical areas have been excluded.

   b) Comment on ecological impressions -- positive or otherwise -- of any of the three institutions which would contribute to the decision on closure based on the best interests of the residents served.

4) Conduct by telephone discussion of the submitted report under the schedule and arrangement of MH&RS.

It is important to note that the expert team's assignment was not to advise State officials on whether MR institutional operations should be consolidated or, if so, to recommend which of the three facilities should be closed. Instead, the team was asked to review the process and procedures which MH&RS officials used to assure that all variables were studied. This distinction is highlighted here because it became evident during the June 8-10 site visits that many staff members, parents and friends of the three State MR hospitals had an inaccurate perception of the expert team's mission. As noted above, the Legislature left the closure decision to the Secretary of SRS, based on the advice of MH&RS officials. While seeking input from an objective outside expert was viewed as a necessary and appropriate part of the decisionmaking process, it was never intended that the duly empowered officials of the Department would delegate responsibility for making such a critical decision to a non-accountable third party, no matter how impressive the credentials of the party or parties involved.

C. Limitations of the Expert Team's Analysis

A short term review of this type has a number of inherent limitations. It is important that the reader understand these limitations in evaluating the findings of the expert team, as summarized in this report.

First, it is impossible to gain a complete, well-rounded understanding of a complex organizational setting such as a large, multi-purpose state MR institution without spending weeks, if not months, studying the various facets of its operations. The expert team's tour of each of the three State MR hospitals was limited to three to four hours per facility. Despite the extensive familiarity of the team members with the operations of similar facilities across the country, it was not possible in the limited time available to obtain anything more than general impressions regarding the operating environment of each of the three facilities. The fact that the team was exposed to as many aspects of each facility's programs as they were is a credit to the careful advanced planning by each facility superintendent and his executive staff as well as the dedication and openness of all staff members with whom the team members came into contact during their brief visits.

Second, due the nature of the expert team's assignment, no attempt was made to complete a structured assessment of each facility's performance. The expert team's findings, therefore, should not be viewed as an attempt to objectively critique any of the three facilities' programs or rank order them in terms of their overall performance. That was not the purpose of the team's visits. Instead, the expert team was attempting to gather information and impressions that might be of assistance to MH&RS/SRS officials in: (a) deciding which of the three facilities should be closed; and, once this decision was made, (b) determining the best approach to organizing the closure initiative.

Third, due to time and resource constraints, no attempt was made by the expert team to examine the capabilities of the community developmental disabilities service delivery system in Kansas, although clearly the success of the proposed facility consolidation initiative will rest to a large extent on the ability of community agencies to appropriately serve

individuals who are scheduled for placement out of State MR hospitals over the next four-five years. Several key members of the State hospitals' staffs, as well as parents of institutional residents, expressed the view that most community MR/DD agencies in Kansas currently lack the resources and expertise necessary to serve the more severely disabled and/or behaviorally challenged residents who will have to be placed in community settings in order for the hospital consolidation initiative to be a success. To the extent that these perceptions are accurate, MH&RS officials obviously will need to devote major attention to shoring up weaknesses in the existing community MR/DD service system as part of its overall strategy for implementing a facility consolidation plan (see further discussion under III-B below). On the other hand, the argument that the community lacks the capability to serve the types of clients that will have to be placed has a certain "chicken and egg" ring to it. It is unrealistic to expect that community agencies will acquire new capabilities until they are challenged to assume additional responsibilities. The experience in Kansas as well as all of the other states with which the expert team is familiar is that, with appropriate assistance and support from responsible state officials, the majority of community agencies are quite capable of accepting such new challenges. "Community readiness", therefore, should not be used as an excuse for inaction.

Finally, the two members of the expert team collectively have had over 40 years of experience in the organization and delivery of services to people with mental retardation and other developmental disabilities. While having no personal stake or preconceived views regarding the outcome of the present decisionmaking process (and, in this sense, qualified to offer objective advice), the members of the expert team bring to the present assignment strongly held views regarding the best methods of serving people with developmental disabilities, which have been shaped by their own diverse, wide-ranging experiences in the field. It is, therefore, quite conceivable that other, equally qualified experts might very well reach different conclusions and offer contradictory advice.

In preparing this report, the expert team has tried to remain conscious of the above limitations of the analysis and restrict its findings and recommendations to areas that are directly relevant to the decisions MH&RS/SRS must make and the actions it must take to comply with the Legislature's institutional closure mandate.

II. REACTIONS TO SRS/MR&RS' CLOSURE STUDY

One of the overriding challenges which permeates both individual and systemic planning activities when a state decides to reduce its reliance on one service modality and emphasize another is defining the outcomes expected for the individual. What is the anticipated impact on the individual? What is or will be done to safeguard the person's immediate and long-term interests before, during and after the transition? These concerns, then, should become the starting point and central focus of a state's planning and problem-solving efforts. Accordingly, we being our review of SRS/MH&RS' closure study by focusing on the individual.

A. Anticipated Individual Outcomes

All too frequently when considering the best means of supporting and assisting persons with developmental disabilities the solutions focus simplistically on "where" the individual lives. Often this approach originates and culminates in the "institution vs. community placement" debate. We have found that the more successful leaders in the provision of services and supports to persons with developmental disabilities focus first on the outcome expectations desired for the individual. By articulating a clear set of person-centered *values* which are to *drive the accomplishment of the expected outcomes, success can be achieved, person by person and move by move.*

Evidence of SRS' commitment to person-centered outcomes for individuals with developmental disabilities can be found in a recent study entitled, A Report On Consolidation Of Institutional Services From Three to Two Facilities, published in March, 1992 by SRS Secretary Donna Whiteman and Acting MH&RS Commissioner George Vega. This study begins with the following statement (format emphasis added):

> "All Kansans, including those with mental retardation and other developmental disabilities have the right and should have the opportunity:
>
> - to participate and
> - be integrated into the life of their community,
> - to exercise options,
> - to choose where and with whom they live and work,
> - to participate in preferred leisure activities,
> - to be educated in schools of their choice in their neighborhoods, and
> - to maintain relationships with family and friends."[9]

This is one of several documents which sets forth the "person centered" emphasis of those many constituents who have been involved in considering the future of community supports and services for persons with mental retardation and other developmental disabilities in Kansas. For example, the report of the Task Force on Social and Rehabilitation Services of the 1991 interim legislative study commission endorsed the above statement of principles and expanded on the desired direction of future State policy. The general conclusion section of the Task Force's report begins with the following statement:

> "The Subcommittee believes that decisions must be made for the ultimate benefit of the client and notes that the trend, nationwide, is to place as many individuals into community settings as possible...
>
> A comprehensive array of support and direct services should be developed in Kansas which provides the greatest possible degree of integrated service options to mentally retarded or otherwise developmentally disabled people. This array of services shall be enhanced in partnership with individuals served, their parents, advocates, service providers, and federal, state and local governments.
>
> The system of services [for] Kansans with mental retardation and developmental disabilities must be flexible and based on individual needs...
>
> Decisions should be based on future planning for individuals rather than "slots" in the system..."[10]

Additional emphasis is given to individualizing services and supports in the 1992 report of House Appropriations Subcommittee No. 2 (Human Services). In assigning SRS responsibility for determining which MR institution should be closed, the Subcommittee stressed that the first factor to be considered is, "the impact that the hospital's closing would have on the hospital's clients and their families."[11]

Actions count more than words, of course, and Kansas officials have begun to translate this new service philosophy into operational terms. The Community Integration Demonstration (CID) project, launched last year by MH&RS, is designed to, "address the concerns regarding placement of individuals out of state mental retardation hospitals." This project is reported to have moved values into practice. Forty-two persons have been placed out of two State hospitals (Winfield and KNI) into fully integrated community settings. As of March, 1992, none had been reinstitutionalized. The goals of CID are to:

- Provide individuals living in state mental retardation hospitals and their families a choice of whether they participate in community placement;

- Design person-centered plans for serving individuals who do choose to be placed out of state mental retardation hospitals;

- Monitor CMRCs to be certain that quality services are provided; and

- Develop and maintain necessary services in state mental retardation hospitals to meet the needs of individuals who have particularly severe disabilities and cannot at present benefit from placement in existing community programs.

Building on the experience gained from the CID project, MH&RS officials have concluded that there will be no difficulty in finding an adequate number of individuals/families interested in moving from a State hospital to the community. As of earlier this year, over 125 individuals had expressed an interest in community placement, according to MH&RS officials. In an effort to expand on this individually centered approach, MH&RS dedicated two sections of its draft report entitled, Creating Choices, Providing Options: One Person At A Time, to providing details on how State officials intend to move individuals from institutional to community-based services with a minimum of dislocations to the persons involved. Section IV of MH&RS' report, entitled "Principles of Placing Individuals", makes it clear that people living in the state mental retardation hospitals will be given the choice of whether to move or remain in an institutional setting. As a result, individuals will move from and within all three hospitals. Section V of this same report again emphasizes the importance of planning services around the individual rather than placing people into existing slots or service models.

While the temptation is strong to judge success by the numbers of persons moved, Kansas has underscored its intent to assess progress in terms of the ability of each participant in the placement process to EXERCISE CHOICE REGARDING WHERE AND WITH WHOM HE/SHE LIVES AND WORKS, LEISURE ACTIVITIES, NEIGHBORHOOD SCHOOLS, PERSONAL RELATIONSHIPS AND LEVEL OF COMMUNITY PARTICIPATION AND INTEGRATION. The expert team strongly commends this emphasis and encourages state officials as well as all other involved parties to adhere to these principles throughout the transition process.

Kansas officials began the process of deciding which State MR hospital should be closed by articulating outcome expectations for affected individuals and their families. Building on these expectations, the initiation of the CID project provided an opportunity to test and fine-tune the "person centered, lifestyle planning" process. By taking these critical first steps, Kansas has joined the ranks of those states which have committed themselves to supporting people with developmental disabilities in community settings and managing service costs in a thoughtful, individually focused manner. The expert team congratulates the staff of the state hospitals, the CMRC staff and MH&RS officials on the development of such strong guidelines for managing the transition of institutionalized individuals to community settings.

Without exception, the primary focus of all those with whom the expert team interacted (state leaders, facility administrators and staff, union representatives, community business executives, related support personnel, family members and advocates) was the impact that the hospital closure will have on the individual consumer and his/her family. Given the complex nature of the issues to be considered, along with the personal and emotional investment of the various constituencies, the *consistent focus on the welfare of the individual and his/her family is deserving of note, respect and applauses.* All other considerations were assigned a secondary priority in the final determination and, in the opinion of the expert team, quite rightfully so.

B. Review Of The Process

When examining the process used in making the decision as to which of the hospitals to close, the expert team sought information about the following areas:

- *Who was involved?* In considering a public policy decision of this magnitude, one would expect that those most directly affected would be initially and continuously consulted as to their views, recommendations and hesitations. More specifically, attention needs to be given to the nature of the involvement of persons with mental retardation/ developmental disabilities and their family and friends. Furthermore, the involvement of those who have to implement the hospital closure initiative, as well as those who must expand the capacity of generic and specialized community provider agencies, is essential. If additional expertise was required in technical areas, was it obtained? Finally, those decisionmakers, elected and administrative, who are responsible for planning, funding and systemwide accountability must be involved at every step of the decisionmaking process if the ultimate goal is to be achieved effectively and economically.

- *How were these individuals involved?* Insights regarding the breadth and richness of the process can be gained by understanding the ways individuals were engaged during the process. Did people have the opportunity to ask questions, offer their viewpoints on issues and recommendations, voice concerns and exchange views from a variety of differing perspectives?

- *Was the time allotted for the review adequate?* Did responsible State officials give all affected parties sufficient time to weigh the available options, consider the likely consequences and fully express their respective views (keeping in mind that no matter how much time was allotted, not everyone was likely to be satisfied with the final decision)?

- *What did they produce?* Naturally, even the best process can produce an unsatisfactory analysis and final decision. A review of the documents produced by the various constituencies, therefore, is very helpful.

The introductory section of this report provides the reader with the essential background information on this legislatively mandated hospital consolidation effort. The authors will not repeat that information here. However, the following chronological summary of the process demonstrates the lengths to which Kansas officials have gone to interject constituent participation, thoroughness and objectivity into the decisionmaking process.

1990 Legislature:	Directed MH&RS to transfer 50 individuals from state hospitals to community settings. In addition, the Task Force on Social and Rehabilitation Services was first established by the Legislative Coordinating Council and directed to prepare a report and recommendations to the Legislature based on the work of four (4) subcommittees.
1991 Legislature:	During the 1991 interim period, the Task Force on SRS was divided into four (4) subcommittees: mental health and retardation services; financing; prevention and medical services and long-term care. The subcommittees met each month to receive information and develop recommendations in their respective subject areas. In some cases, the subcommittees visited community facilities. An Ad Hoc Committee on Hospital Consolidation was established by SRS in 1991 to study the need to maintain three MR hospitals. The Committee was composed of family members, advocates, state agency employees, staff representatives from the three hospitals, union and provider representatives and a representative from the Governor's Office.
February, 1991:	Initial discussions began regarding the implementation of the Community Integration Demonstration (CID) project which was aimed at transitioning WSH and KNI residents to community settings.
July, 1991:	The staff of the State hospitals, in collaboration with CMRC personnel, began to develop the first personal transition plans for CID participants who would be moving from a State hospital to the community.

December, 1991:	The four subcommittees made reports to the full legislative Task Force on SRS. The Task Force consisted of 17 members of the Legislature and seven public members.
January, 1992:	The Task Force on SRS filed its final report with the Legislature. It included a recommendation that the number of state-operated MR hospitals be reduced from three to two over a five year period.
March, 1992:	The SRS Ad Hoc Committee on Hospital Consolidation filed its final report entitled, A Report on Consolidation of Institutional Services From Three to Two Facilities.
May, 1992:	A draft economic impact analysis on the proposed closure of Kansas Neurological Institute, Parsons, and Winfield State Hospitals was completed by Fayez Tayyem, Ph.D., an economist at Kansas State University.
June, 1992:	A draft economic impact analysis of relocating mentally handicapped patients to their home communities was completed by Dr. Tayyem.
	An expert team, consisting of Robert M. Gettings an Lyn Rucker, toured Parsons, Winfield and KNI to review and critique SRS/MH&RS' draft report entitled, Creating Choices, Providing Options: One Person at a Time.

C. Key Factors Examined by MH&RS During Its Closure Analysis

In keeping with its assigned mission, the expert team reviewed information and data compiled in the draft SRS/MH&RS report entitled, Creating Choices, Providing Options: One Person At A Time as well as the two supplementary analysis of the potential economic impacts of the planned hospital closure initiative.

As evidenced by these reports, Kansas officials have gone to great lengths to examine the needs of individuals at each hospital in comparison to the personnel and facilities available. In addition, SRS/MH&RS has taken care to review the local financial and employment implications of eliminating one hospital and, conversely, the economic advantages of placing individuals in local communities across Kansas.

Our charge was not to debate the conclusions drawn by these various studies -- which, like any studies, obviously are subject to interpretation -- but rather to comment on the breadth of the information gathered and reviewed.

The following subsections provide a brief overview of the types of information gathered and reported for each of the three institutions (WSH, Parsons & KNI).

1. *Individual Needs*: Presently 960 Kansans with developmental disabilities reside in the three State MR hospitals. Of these individuals, 85 percent have severe to profound disabilities. Approximately 50 percent of the individuals living in the State mental retardation hospitals are described as having some form of serious aberrant behavior, such as aggression or self-injury.[12] In MH&RS' analysis, the following dimensions of the hospital populations were examined:

   - *Level of needs compared to access to specialized services*: Individuals who have extensive medical needs and those with behavioral challenges were identified as the most difficult to serve. However, those with extensive medical needs have more difficulty receiving consistent and regular access to specialized care (see subsection II-E below).

   - *Distances families must travel to see their family member*: On average, families must travel farther to PSH (166.5 miles) than to KNI (74.5 miles) or WSHTC (102.3 miles).

   - *Personnel Related Issues (reported for fiscal year 1990 through 1992)*: Particular attention was given to turnover rates (especially for medical and direct care positions), absenteeism (particularly sick leave), recruitment of professional and direct care staff (according to the length of time it takes to recruit and hire, as well as those positions which can not be filled).

2. *Efficiency of Operations*: During Fiscal Year 1992, more than $150 million, excluding education funds, were spent by the State of Kansas on services for persons with developmental disabilities. Almost half of this total went to support operations at the three MR hospitals which serve 960 persons compared to the more than 3,000 individuals served by community agencies.[13] Indicators of efficiency include the daily costs (per diem expenses), administrative costs (as a percentage of total costs), staff training costs, overtime expenditures, preliminary estimates of a ten year capital improvement plan and the costs of professional staff in terms of numbers and gross wages (see highlights of findings in II-E below).

3. *Economic Impact of Relocating Hospital Residents*: A study was commissioned which gathered information regarding the positive economic impacts of relocating individuals from State hospitals to their home communities. The study projected that two new direct care jobs would be created for every individual placed in the community and estimated the hourly wage/salary rate for these positions in the probable areas of relocation. The local economic

impact study also estimated the number of supervisory positions that would be created as a proportion of the number of direct care staff person hired. That led to a review of the overall impact of creating jobs on the unemployment rate in selected counties/cities into which individuals would be moved, the impact of these additional jobs on personal income and economic wealth and the costs and benefits to the business sector as well as municipal and county governments where such individuals were scheduled to be relocated.

4. *Economic Impact of Consolidation*: MH&RS also commissioned a separate study to review the role each hospital plays as an employer in its local geographic area, how the results compare with other sectors of the local economy, the ability of the hospital to generate income, economic wealth, personal income (in terms of both primary and secondary income) as well as personal income costs. The study went on to consider the distribution of economic "linkages and leakages", business benefits/costs, municipal expenditures to maintain the hospital, county revenue benefits derived from the hospital, school district impacts and the net impact on the county of having (or losing) the hospital. The findings indicate that the greatest financial impact to the town and surrounding county of closing a facility would occur if KNI were to be shut down ($73.9 million), followed by Winfield ($47.3 million) and Parsons ($33.6 million). However, KNI's share of personal income and employment represents only about one percent of the county's totals, while both WSHTC and PSHTC play much more important roles in their respective counties' local economies, ranging between 4.0 and 5.5 percent.

In the opinion of the expert team, MH&RS officials have analyzed and summarized the key areas which significantly influence the consolidation decision. This information has been assembled in a clear and concise manner. Primary consideration was given to the impact on individuals who live in the respective State hospitals. The unique needs of the population, compared to the ease or difficulty in securing and maintaining specialized professional and para-professional staff is an overriding concern. Additional attention was given to the general, specialized, and family needs of the individuals who live at each hospital. Specific, detailed information was gathered on the impacts a closure decision would have on the local communities in which the respective state MR hospitals are located as well as the surrounding county. This attention to the implications of consolidation for the broader community is laudable. Finally, facility renovation costs were estimated in order to provide policymakers with a full and complete picture of the long range fiscal consequences for the State of a decision to keep each of the three facilities in operation.

D. Reactions Based on Visits to the Three State Hospitals

The expert team, accompanied by Dr. Darvin Hirsch, Director of Mental Retardation/Developmental Disabilities Services within SRS, toured the three State hospitals on June 8-10, 1992. In preparation for these tours, the three facility superintendents were given complete freedom to

provide information, conduct tours, demonstrate areas of specialty or schedule public forums. Without exception, the expert team felt its time at each facility was used to maximum benefit.

In completing its brief review of current institutional services in Kansas, the expert team was enormously impressed by the sense of dedication and commitment displayed by the staffs of all three state mental retardation hospitals. While it was quite clear that each of the centers has its own distinctive capabilities and operating milieu, it was equally clear that each in its own way has made important strides over the past few years toward improving both the quality and accessibility of services to its residents. These improvements obviously make the choice of which facility to close much more difficult than it might have been in past years. Nevertheless, several observations ought to be made, based on the teams overall impressions.

1. *Numbers of Institutionalized Children*: Kansas presently has over 200 children residing in the three State-operated MR hospitals, a number that far exceeds comparable figures in the institutions of other states. According to data collected by the University of Minnesota's Center for Residential and Community Living, the national median percentage of children (0-21 years of age) residing in public mental retardation facilities as of June 30, 1989 was 9.6, compared to 25.0 percent in Kansas.[14] Kansas had about 1.0 percent of the nation's children and 3.3 percent of all children living in state MR institutions, or more than three times the predicted rate. Only Nevada and Oklahoma had a higher percentage of institutionalized children and youth at the time. The comparison between Kansas and states with well-developed programs for creating non-institutional service options for children with severe disabilities is even more striking. At the end of fiscal year 1991, for example, Michigan, a state with more than three and a half times the population base of Kansas, had only 13 children living in its public MR facilities.[15] Similarly, Minnesota presently serves only three children in its State-operated regional treatment centers.[16]

   In developing a community placement strategy, one area that clearly needs to be given top priority is the creation of the capacity to serve children in community-based settings. Not only is an institutional setting an inappropriate environment in which to raise a child, but the potential lifetime costs of furnishing institutional care when a resident is admitted during childhood or adolescence will probably exceed $8 million, when the effects of inflation are taken into account. By any standard, that is a heavy burden to ask the taxpayers of the State to bear, especially when other states have clearly demonstrated that it is possible to develop various types of family and surrogate family living arrangements where children with severe, lifelong disabilities can be served at considerably less cost.

   The expert team was told during its June 8-10 visits that the reason for the high proportion of children residing in State

hospitals was that SRS/MH&RS and the CMRCs historically have focused on serving adults with developmental disabilities and the generic child welfare/foster care system has lacked the resources and expertise necessary to serve youngsters with severe medical and behavioral problems. While this historical background is helpful in gaining an understanding of the origins of the State's present dilemma, it should not be used as an excuse for failing to vigorously address this obvious service gap in the context of the planned facility closure/consolidation initiative.

Some will argue that the service challenges posed by many of the children who currently reside in State MR hospitals are beyond the capabilities of most, if not all, CMRCs, based on their existing service capabilities. Indeed, in some instances, this presently may be the case. We note, however, that one of the recommendations in Creating Choices is that "medically challenging persons should be consolidated in one of the two remaining hospitals" and, therefore, assume, that the State may find it necessary to transfer at least selected children to another State hospital (hopefully for a time-limited stay) until appropriate community resources can be developed. But, based on the limited observations of the expert team, we would judge that the number of such inter-facility transfers can be held to a minimum. Certainly, we observed a large number of children and adolescents at all three facilities who appeared to be excellent candidates for community placement, including residents of one cottage for adolescents with behavioral challenges at Parsons who, in our opinion, probably never should been admitted to a state residential facility.

2. *Providing Resources Throughout The State*: One of the many positive aspects of the services we observed in each of the facilities is the extent to which the State hospitals receive specialty supports and assistance from institutions of higher education, especially through the Kansas University Affiliated Program. For example, the members of the expert team have never seen an equally well-equipped video studio on the grounds of a state MR facility (Parsons).

As referenced several times throughout this document, the expertise and funding made available to provide dental services, adaptive equipment, therapy, behavioral supports, on-going physical support and monitoring, is substantial. As is done currently, these resources need to be shared with the CMRCs. Certainly, the need for support and staff training to follow individuals into the community will increase as the populations of the State hospitals continue to decrease. These technical resources should also be made available to generic service providers so that the expertise currently available throughout Kansas can grow beyond the State MR/DD system.

Some states have used a facility closure as an opportunity to transfer such expertise into other areas of the state (usually rural areas), which have no such resource upon which to draw. A "clinic" approach, which is made available to everyone in the community (not just persons with developmental disabilities) on

specified days, often has been used. This approach has been particularly successful in the case of dentists, therapists, adaptive equipment, accessibility modifications and mental health counseling. Private as well as public sources of revenue (Division of Rehabilitation Services, Medicaid, insurance, services to the elderly, etc.) can be accessed to stretch limited resources.

States have also found creative ways to facilitate the hiring of current state hospital staff by generic and specialized community services providers, or to assist such individuals to become community service providers themselves. The end result of such an emphasis would be the continued expansion of the capacity of generic providers, CMRCs and Kansas communities to assist people with developmental disabilities.

3. *Development of Segregated Specialized Services*: While visiting Winfield State Hospital and Training Center, the expert team was informed that consideration was being given to establishing a specialized forensic facility for criminal offenders with mental retardation on the grounds. We would encourage State officials to exercise great caution when considering the development of segregated, facility-based, services for "special populations" of people with developmental disabilities. Certainly, it is important to focus attention on the unique needs of individuals who pose special challenges. But it also is extremely valuable to learn from the successful strategies which have been used to integrate individuals who have behavioral challenges, involvement with the criminal justice system and other relatively unique needs.

   While a few states have or are in the process of developing special facilities for individuals who have such needs, often these facilities duplicate services and expertise already available in a state, segregate an already isolated population, divert scarce resources and impede the spread of the technical learning and experience within the community.

4. *Facility Environment*: The staff of all three State hospitals are to be commended for their efforts to make institutional facilities appear more home-like. Extensive attempts have been made to provide wall decorations, bedspreads, and curtains which reflect some individualization and warmth, especially within resident bedrooms. In addition, the common living areas generally reflected an effort to make them less spartan. However, great challenges remain, especially at KNI and WSHTC, because these facilities were originally constructed along more traditional institutional lines with long corridors and large day rooms of cement block construction. KNI has converted some nursing stations to kitchens with refrigerators, a dining table, stoves and cabinet space, so that residents can learn to prepare their own meals. WSHTC has gone to enormous lengths to make large, sterile environments into smaller, cosier areas with more decorations in living areas and on kitchen walls.

While laudable, these improvements do not fully compensate for the essential institutional character of the environment and, in some cases, mask more significant problems. For example, one staff person expressed concerns about resident safety in reference to "F" building at Winfield. This three story building houses the day hospital and the most physically/medically involved individuals on campus. In addition, the school program for 65-70 children occurs within this building. We understand that the State Department of Education periodically surveys the building as part of its process of certifying the school program at Winfield. It is important to note that no safety deficiencies have been cited during recent surveys of Building F. However, a number of non-ambulatory school age children are on the second floor for extended periods of the day. We must assume that special attention is being given to the numbers of staff required to evacuate the building in case of an emergency. Nevertheless, we raise this issue to point out the inherent limitations of the physical plants of the three state MR hospitals -- especially Winfield -- which were built years ago to serve a significantly different population than reside in them today.

Concerns about overcrowding and lack of adequate training space also were voiced by the staff and observed by the expert team at KNI. The administration of the facility is quite aware of this problem and has identified space once used as dining areas for conversion to an additional workshop area. It appears, then, that some corrective steps are underway.

We would confirm, through our observations, some crowded and noisy training rooms at KNI. If individuals are to be transferred to KNI as part of the closure/consolidation initiative, plans will have to be made for additional individuals to move out of KNI or alternative programmatic space will have to be created.

5. *Community Integration*: Finally, we would compliment the staffs of all three hospitals -- particularly KNI -- on the work they have done to facilitate increased interaction between facility residents and the local community. KNI reported that 27 residents were placed in community jobs last year. In addition, we learned that the Community Outreach Program at KNI has been assigned the task of preventing admissions to the facility. This program supports 18 children in supported family living (therapeutic foster care) and has intervened to prevent four children from being admitted to the facility. [N.B., They were placed on paper only.] The cost of this program is $33.00 per day vs. $209.56 per day for inpatient care at KNI. Moreover, twenty-two (22) KNI residents have been successfully placed in the community as a result of the person-centered planning effort currently underway.

The PSH staff has worked extensively with local education officials and, as a result, 20 children from Parsons are attending integrated classes in the local middle school or high school for at least two to three hours per day. We also were told that eight (8) children currently attend the public schools in Winfield. Obviously, a great deal more needs to be

done to move towards classroom integration. However, we highlight these positive achievements to date.

The State hospitals which remain open, for what ever period of time, should be charged with the continued responsibility of supporting individuals in the community where they live, so permanent admissions to the hospital do not occur. It makes no sense for the State to promote continued downsizing and consolidation of its institutional operations without simultaneously taking steps to prevent new admissions, except under the most extenuating of circumstances. In addition, the staffs of the remaining state hospitals must be fully committed to moving current residents into integrated community employment and living settings. It is absolutely critical that they view as a part of their mission reaching out to the community, with the clear aim of eventually "putting the facility out of business".

E. The Recommendation to Close a State Hospital and Training Center

The decision to phase out a large, complex government agency, such as a state mental retardation facility, is a traumatic undertaking, even under the most favorable circumstances. Inevitably, the lives of several thousand individuals will be affected, including facility residents, their families, staff members, and local residents of the community, who directly or indirectly benefit from the commerce the facility generates. But one also has to weigh the consequences of failing to act decisively.

Kansas, like many other states, has experienced a gradual but steady decline in the census at each of its state mental retardation hospitals. This trend is virtually certain to continue, given the growing commitment to improving and enhancing community developmental disabilities services across the State. In the absence of a decision to close one of the public MR hospitals now and proceed to phase out operations in an orderly manner over the next few years, each of the State hospitals is likely to experience a rapid, upward spiral in per capita expenditures as fixed operating costs are spread across a dwindling resident population base. The net effect would be to erode the State's capacity to serve the rapidly increasing number of individuals who are on waiting lists for community services. At some point, if other states' experiences are any guide, Kansas policymakers may find themselves forced to close one or more of the public MR hospitals anyway, but on a crisis basis instead of in a well planned, carefully sequenced manner in which potentially negative consequences can be minimized. Obviously, this latter scenario would benefit no one, least of all the residents and staff of the facility(ies) eventually targeted for closure.

Indeed, Kansas experienced the negative side effects of a rapid facility closure several years ago when Norton State Hospital was shut down. State officials should draw the appropriate lessons from the Norton closure and plan a more orderly phase out process this time.

No matter which facility ultimately is chosen for closure, the State's decision no doubt will be interpreted by some as an indictment of the targeted facility's performance. In the opinion of the expert team, this

interpretation is not only inaccurate but also ignores the central aim of the closure initiative. The fact is that, in the judgement of the Kansas Legislature and most qualified professionals and interested citizen leaders in the State, operating three, separate state residential facilities is no longer programmatically necessary or economically feasible, especially given the diseconomies of scale involved in supporting the enormous infrastructure necessary to maintain a state facility that serves fewer and fewer residents. Once one accepts the fiscal and programmatic imperatives involved in the decision, the critical question is: on which two campuses should the State's existing institutional operations be consolidated. A variety of factors must be weighed in arriving at this decision, not all of which are readily quantifiable.

Under the circumstances, we believe that the staff of SRS' Mental Health and Retardation Services (MH&RS) has made a conscientious effort to examine these factors. Some of the key findings from MH&RS' analysis, as described in subsection II-C above, are highlighted below.

- WSHTC Residents, On Average, Have More Extensive Medical Needs and Greater Difficulty in Accessing Qualified Personnel: WSHTC serves a larger number of residents with severe, chronic medical conditions than either KNI or PSHTC. This conclusion is affirmed by the health index scores on the Developmental Disabilities Profile (DDP) as well as our own on-site observations. As a result of these specialized individual needs, accessibility to essential medical personnel becomes a key factor when considering which facility to close.

  The MH&RS draft report entitled, Creating Choices..., provides information which is particularly relevant to this issue, noting that: "While any large agency must deal with turnover, absenteeism, and recruitment, these areas have been particularly troublesome for WSH."

  WSHTC was reported to have considerable problems with turnover. If we focus particularly on medical positions, the reported turnover rate for FY 1990 was 43 percent; for the first six months of FY 1992, it was 10 percent. The average turnover percentage for WSHTC medical positions over a 30-month period (July, 1989 to December, 1991) was 22 percent, compared to 11 percent at PSHTC and 17 percent at KNI.

  Although KNI normally can fill vacant professional positions in three weeks, it was reported to take six to eight weeks to fill vacant professional positions at both PSHTC and WSHTC. Due to the historic difficulty in recruiting and training professional medical personnel, WSHTC has been forced to contract with Liberty Health Care, a proprietary vendor of health services for persons with developmental disabilities,

to furnish certain essential professional services (i.e., physical therapists, occupational therapists, and a medical director). The cost of this contract during FY 1992 was $1,213,067. WSHTC, as of March, 1992, had been operating without a medical director for approximately six (6) months. Both PSHTC and KNI have been able to recruit professional personnel without reliance of an outside contract agency.

The expert team learned that the problem of recruiting and retaining professional staff at WSHTC is compounded by the fact that local physicians in the Winfield area reportedly are reluctant to treat individuals at WSHTC. Assuming this information is accurate, the facility is left without a readily available back up medical system. While WSHTC currently has a medical director, the long term probability of maintaining qualified medical personnel continues to be a concern to State MH&RS officials.

Clearly, not all individuals who reside at WSHTC have challenging medical needs. However, for those who do, the question of their health and safety is a very legitimate concern.

WSHTC has the Highest Utilization of Sick Leave: Sick leave results in additional operating costs when the usual complement of staff is not available or must be "covered" by alternative staff or overtime authorizations. The following hours of sick leave were used between January 18, 1991 and January 17, 1992 at the three State MR hospitals.

WSHTC	86,563	for 953 Authorized FTE
KNI	68,152	for 860 Authorized FTE
PSHTC	44,986	for 563 Authorized FTE

As these figures indicate, WSHTC had the highest per capita rate of sick leave utilization (90.83 hours per staff on average) followed by PSHTC (an average of 79.90 hours) and KNI (79.24 hours).

WSHTC has a Higher Direct Care Staff Turnover Rate: Concurrent with the highest medical personnel turnover rate, WSHTC has experienced much higher direct care staff turnover rates (14 percent compared to 9 percent at KNI and 6 percent at PSHTC). WSHTC is also reported to take up to four weeks to fill direct care positions.

The bottomline issue is clearly one of access to necessary training, supervision and professional care. Winfield appears to experience more difficulty in each of these areas than the other two State facilities. With the difficulty experienced in attracting and retaining qualified professional staff (especially medical personnel), higher staff turnover, utilization of sick leave per FTE, and higher

direct care staff turnover than the other two facilities, Winfield naturally moves to the top of the list when considering which facility to close.

- WSHTC has the Highest Per Diem and Overtime Costs: The average daily census is reported to be 322 at KNI, 336 at WSHTC and 270 at PSHTC. In terms of client population (need level and size) WSHTC and KNI are more comparable. Again, the following information is extracted from MH&RS' report entitled, Creating Choices...:

Per diem costs:	WSHTC	$245.10
	KNI	209.56
	PSHTC	179.76
Overtime costs:	WSHTC	$483,513
	KNI	12,798
	PSHTC	2,969

- WSHTC Has the Highest Projected Capital Outlays: Large, old facilities are enormously expensive to operate and maintain. Consequently, Kansas officials must weigh the relative costs of upgrading the physical plants of the existing State MR hospitals in determining which of the three facilities should be closed. Not surprisingly, Winfield State Hospital and Training Center, as the oldest of the three facilities, is expected to be the most costly to upgrade -- an estimated $34.7 million over the next ten years. Meeting accessibility requirements, attempting to create a more home-like environment and complying with Medicaid and fire safety standards all contribute to these cost projections. The same holds true for PSHTC, with projected ten year capital outlays of $32.2 million and KNI, with $21.5 million worth of renovations/improvements projected.

Overall, in the opinion of the expert team, *the process used to consider the implications of consolidating the State's three state MR hospitals was done in a responsible, participatory and comprehensive manner.* The examination of the implications and resources necessary to ensure a smooth transition for individuals with developmental disabilities and the staff who work with them began over two years ago and continues today. Participants in this process included individuals representing a broad spectrum of interests and opinions. Family members, advocates, state employees, union representatives, community providers and elected officials have formed a partnership dedicated to fully exploring the implications of the consolidation question. Recommendations have been made by such groups, individually and collaboratively. State officials attempted, in several ways, to involve various constituencies in the decisionmaking process. For example, interested individuals were given opportunities to participate through legislative and administrative hearings, ad hoc committees, parent, union, community leadership and provider meetings, interviews, letters, etc.

We would be remiss, however, if we did not point out the obvious lack of involvement by those most directly impacted by this decision -- i.e., individuals with mental retardation/developmental disabilities who currently live in the three state hospitals. The expert team was provided with an abundance of evidence of the involvement of parents and siblings in the decisionmaking process, which, as indicated earlier, is commendable. However, we received no evidence of attempts to obtain feedback from individuals or groups of direct consumers regarding the consolidation issue. This apparent oversight still can be rectified by providing information and assistance to affected consumers so that they are able to participate and make recommendations regarding the closure and transition process.

Having participated in similar closure initiatives elsewhere, it is the experience of the expert team that many consumers are quite aware of pending closure discussions. Lack of information and rumors increase their anxiety and frustrations. They feel left out of the process. It also is a great loss to decisionmakers if the insights, desires and recommendations of direct consumers are ignored.

III. IMPLEMENTATION ISSUES

A recent survey conducted by the Center for Residential Services and Community Living (CRSCL) at the University of Minnesota found that 24 states closed a total of 67 large (16 beds or more), publicly-operated mental retardation facilities between 1960 and 1990. This CRSCL survey also revealed that 18 states plan to shut down 34 additional public MR facilities between January 1, 1991 and June 30, 1995.[17] If there is one common lesson that can be drawn from the experiences of states which have closed public MR residential facilities in recent years, it is that shutting down a facility of this type is a complex undertaking that necessitates careful advanced planning and continuous, high level management oversight throughout the process.

In laying plans for a facility closure/consolidation similar to the one that is contemplated in Kansas, state officials need to develop strategies that take into account at least the following major areas of impact:

- The effects on the facility that is scheduled to be shut down, including the ways in which various constituencies served by the facility are likely to be impacted (i.e., the residents, their families and friends, the facility's staff and their families, and other individual/entities in the surrounding community that benefit, either directly or indirectly, from the operation of the facility);

- The effects on the community developmental disabilities agencies (especially the 27 designated Community Mental Retardation Centers (CMRCs)) that will be expected to establish appropriate services and supports for the estimated 330 individuals who will need to be placed out of the three state MR hospitals over the next five year in order to make it possible to close one of the State hospitals; and

- The effects on the State agency (MH&RS/SRS) that will be responsible for assuring that the various facets of the closure/consolidation plan are properly orchestrated and carried out efficiently and with a minimum of negative consequences.

Each of these topics is discussed in further detail in the succeeding subsections of the report. The purpose of this discussion is simply to point out some of the key areas that Kansas officials will want to take into consideration in designing the facility closure/consolidation plan requested by the State Legislature. Specific recommendations on how State officials should handle various components of the plan, however, are beyond the scope of the present analysis.

Before discussing particular closure implementation issues, the expert team wishes to make two general points about the planning/ implementation process. First, we would strongly advise responsible State officials to adopt an open, highly interactive process of planning

and executing the closure/consolidation initiative. All involved parties should be given an opportunity to have their views heard and considered before any final decisions are made. Traditional hierarchical decisionmaking tends to breed distrust, backbiting and recriminations which can very quickly undermine implementation efforts, especially when the objective is as inherently divisive as closing a state residential facility. Maintaining an open, participatory process helps to avoid factionalism, treat all parties as part of the decisionmaking team and keep everyone focused on performing the mutually reinforcing tasks necessary to bring the facility closure/consolidation initiative to fruition.

Second, given the growing number of MR facility closures that have occurred across the country in recent years, there is a significant body of materials now available which describe how various states have attempted to deal with particular issues that arise during the closure process. These materials can be helpful, as Kansas officials and other involved citizens begin to weigh the options available and design an implementation plan. At the same time, it would be a mistake to lean too heavily on solutions developed by other states, without first critically examining how they might work given the situation and circumstances that Kansas now faces. The types of resources and capabilities available vary considerably from state to state, as do the specific short range and longer term aims of a closure initiative. Therefore, while it makes sense to attempt to learn from the experiences (both positive and negative) of other states, in the final analysis it is usually best to rely on "home grown" solutions that are tailored to the unique circumstances that must be addressed and in which local parties have a clear sense of ownership. Similarly, the expert team would advise against an over-reliance on outside consultants to design and execute key elements of the closure/consolidation plan, although the State may decide to retain outside experts to provide advice at critical junctures or to perform specific, clearly delineated implementation tasks.

A. Maintaining the Quality and Appropriateness of Services in the Facility to be Closed.

One of the major challenges that State officials are likely to face in their efforts to implement a closure/consolidation plan is to sustain the quality and appropriateness of services to residents of the facility which is targeted for closure. Quite understandably, the staff of the facility is likely to view the announcement of the closure decision as a signal to begin searching for alternative employment. As a result, State officials should plan to spell out immediately the steps that will be taken to ensure continuity of employment opportunities during and following the transition process. Preferably the major initiatives that will be taken in this area should be announced simultaneously with the release of the Secretary's decision regarding the facility that will be targeted for closure. As quickly thereafter as possible, a series of question and answer sessions should be held for all affected facility employees.

Unless the State moves swiftly and decisively to explain the steps that will be taken to minimize the negative impacts on the facility's work force and enlist the staff's cooperation in carrying out the closure plan, the normal anxieties and uncertainties surrounding the process will begin to escalate as rumors spread and more and more staff seek other jobs or become distracted from performing their usual duties by worries of imminent unemployment. Obviously, a work environment of this type can lead rapidly to a sharp deterioration in the quality of services provided to facility residents if State officials do not remand vigilant and prepared to take immediate corrective steps when the situation dictates. The retention of highly skilled professional clinicians may be a particularly knotty problem for the State, since such individuals are vital to maintaining the facility's certification but also in high demand and very difficult to replace.

A high turnover rate, especially in key professional and para-professional positions, would make it very difficult to maintain the facility's Medicaid certification status. Loss of Title XIX certification, of course, would lead to the withdrawal of federal financial participation, which currently makes up over 55 percent of the operating budgets of Kansas' three State MR hospitals. Should the targeted facility lose its Medicaid certification, obviously the fiscal viability of the overall closure/consolidation initiative would be seriously jeopardized. Clearly, every effort must be made to avoid this eventuality. That is why it is so vitally important that, before formally announcing the facility closure initiative, responsible officials carefully think through the commitments the State is prepared to make to minimize employment dislocations for personnel at the facility targeted for closure.

Quite aside from the importance of retaining qualified staff during the phase down period, the State has a clear moral obligation to make every effort to assist employees of the targeted facility, many of whom have devoted a significant portion of their work careers to assisting people with developmental disabilities, to secure alternative employment of their choice. Without attempting to analyze the various options State officials may wish to consider, the expert team wishes to stress that it is absolutely essential that these efforts be perceived of by all parties as fair and equitable. Otherwise, serious morale problems are likely to arise, which, again, will complicate the already difficult task of maintaining the quality and appropriateness of resident services.

The experiences and skills of the facility's work force should be viewed as a highly valued resource to be nurtured and developed. Extensive efforts, therefore, should be directed toward retaining as many qualified and capable staff in service to people with developmental disabilities as possible -- either through transfers to other State civil service positions or, where such transfers are not feasible, to positions in the private sector where their skills can be fully utilized. The Legislature should be prepared to

earmark funds to carry out this critical component of the closure/consolidation initiative, in recognition of the fact that such expenditures represent an important ingredient in the overall success of the venture as well as a vital investment in the future of MR/DD services in the State.

One key to a successful facility closure initiative is to have a management team in place at the targeted hospital that is wholeheartedly committed to the task at hand. If the facility superintendent and/or key member of his/her management team harbor doubts about the wisdom of the State's decision to shut down the facility, they can sabotage the closure initiative in a thousand direct or indirect ways. The Commissioner of Mental Health and Retardation Services, therefore, must be absolutely certain that the front line management team is totally committed to closing the facility and positively conveys this message to all facility employees on a consist and regular basis throughout the transition process.

Ideally, the existing management team can remain in place throughout the downsizing and closure process, since, as pointed out earlier, these individuals are already familiar with the organizational milieu and have a proven track record in effectively managing the facility. However, if at any point in the process, the MH&RS Commissioner concludes that any member of the facility's executive staff is ineffective or less than fully committed to the closure/consolidation initiative, he should be prepared to replace him/her without delay.

Another key to a successful facility closure is that the targeted facility's staff must receive strong, ongoing support from central office personnel. Again, if the experiences of other states are used as a guide, it will be necessary to make numerous exceptions to standard State procurement and personnel policies in order to carry out the closure initiative effectively, efficiently and in a timely manner. Therefore, the MH&RS/SRS central office staff will have to be prepared to respond in a flexible and expeditious manner as new needs emerge (see additional discussion of central office organizational issues under III-D below).

Of equal importance, the MH&RS central office staff will need to enlist the management team of the targeted facility as full participants in the implementation process. This means that the facility staff should have significant input at all stages of the closure planning and implementation process, rather than simply being told by Topeka the actions that they will be expected to carry out. It should be clear to all parties that are involved in the closure/consolidation process (residents, parents, State hospital personnel, community provider agencies, etc.) that the staff of the target facility have a vital role to play if the overall venture is to be a success. The central office staff of MH&RS/SRS, therefore, should reinforce this message, by both their actions and their words, throughout the transition period.

B. Developing Community Capacity

The desired outcome of person-centered planning is the successful integration of the individual into the basic fabric of his/her community. The "success" of a community placement, therefore, needs to be defined by the individual in terms of the surrounding cultural lifestyles of similarly situated peers. The perpetual challenge for the service delivery system will be to provide only those supports necessary to accomplish this goal and no more.

There is a tendency during a state facility closure process to focus narrowly on the actions which the institutional staff and community service providers must take to "get someone moved". Indeed, as indicated in the preceding subsection, one major focus of the closure initiative must be on maintaining supportive and efficient operations at the institution. However, there must be an equally urgent focus on the steps that are necessary to ensure that each individual's community placement is successful. That is not to say that "everything must be in place in the community before people begin to move", but rather that the essential supports which are needed by a specific individual must be available when the individual moves into his or her new place of residence. Consequently, creativity in the utilization of existing community resources is a must.

To this end, the following approaches might be incorporated in the State's rapidly expanding menu of successful community placement strategies that have been evolved through the Community Integration Project:

- *Foster the development and use generic providers*. Generic providers are those agencies/individual practitioners to whom one would turn for particular services if he or she were not mentally retarded or otherwise developmentally disabled (i.e., taxi companies, local acute care hospitals, schools, dentists, grocery stores, retail outlets, churches, public housing projects, senior citizen centers, etc.). The yellow pages of the phone book can serve as your "service directory".

  The aim should be to develop collaborative strategies to pool the existing resources of the staff of state MR hospitals, CMRCs and generic agencies in order to expand the capacity of the community to provide services and support for individuals with developmental disabilities and develop new technologies where necessary. These strategies might include the utilization of existing:

  - local health maintenance organizations (HMOs), physicians, retired RN/LPN registers, dentists, etc.;

  - local acute care hospitals by tapping into health prevention activities available to the entire community

(exercise, weight rooms, diet, nutrition, jazzercise, mental health services, etc.);

- public schools as community resource centers for families (e.g., to provide space for SRS offices where families can apply for and receive public benefits and to furnish technical resources to families that are caring for a child with disabilities at home); and

- state hospital personnel to supply speciality services in local communities where such expertise is currently lacking (medical, dental, durable medical equipment, adaptive equipment modifications, etc.). [N.B., A significant amount of such outreach activities was reported during the expert team's June 8-10 visits to the three state hospitals but these efforts need to be expanded further as part of the facility closure/consolidation initiative.]

- *Develop marketing strategies*: Efforts should be directed toward helping those individuals who will be central to the transition process (case managers, CMRCs, etc.) develop marketing strategies to attract and retain generic providers or create new speciality agencies. As individuals with increasing needs continue to move into the community, new providers may be needed. Building on existing programs and creating new incentives, recognitions and awards to help stimulate and retain providers is helpful.

- *Incorporate community leaders*: Approaches which involve community businesses (realtors, grocers, newspaper), chambers of commerce, religious and health groups as part of the training and integration of individuals moving into their community can pay rich dividends. There are enormous financial incentives for small rural communities to want new programs and supports to enter their community. Whether one person or five people move into a town, houses are rented, people hired, groceries purchased, churches contributed to and the overall economy improved. Rural communities have a reason to want these individuals to move in and this fact needs to be clearly articulated to community leaders.

- *Work with employers/employment agencies*: Attempts should be made to build on existing alliances with local and state agencies to access employment opportunities for individuals who will be moving into the community as part of the facility closure/consolidation process. Some existing employers and business leaders will need assistance in expanding their expectations of persons with developmental disabilities as employees. They may also need assistance in task analyzing a job, modifying a work environment or adapting equipment in order to put someone with disabilities to work.

Businesses of all sizes will have a product to sell, but may not have much money to pay employees and purchase technology. Some MR/DD systems have the manpower and computers but not the production needs required to put people to work. Partnerships between MR/DD officials who know task analysis with businesses that are looking for ways to streamline and make their operations more efficient can be of enormous benefit to potential workers with developmental disabilities.

- *Developing an incentive program for those individuals/ providers who create exemplary supports and services for people identified as the most difficult to serve.*

- *Addressing risk management and liability issues*: In the litigious environment of the 1990s, individual practitioners and agency providers of services to persons with mental retardation/developmental disabilities are faced with enormous potential legal liabilities. Often it is quite difficult for such providers to furnish critically needed services because they simply cannot afford the insurance premiums. One means of reducing the costs of liability insurance is to arrange a shared risk pool. Some states have passed legislation which creates a "risk pool" for providers of a wide range of human services under which participants in the pool must be insured by a legislatively created insurance provider. The rates are lower and training is provided in claims management. Both contracting state agencies and providers sit on the board of directors of the insurance pool.

- *Accessing internal and external media*: Attention should be given to promoting and sharing success stories by seeking local and statewide media coverage. Many individuals can recite the appropriate philosophical goals (i.e., person centered planning, community participation, choices for those with the most severe handicaps, etc.). Unfortunately, while many staff hear their administrators talk about "doing it right", they are hard pressed to articulate the desired results in individual terms. It is so important, therefore, for stories to be told about individuals who have moved and are living successfully in the community, participating in hobbies and clubs, making choices, etc. The first time we heard the word normalization, none of us knew what it meant. The philosophy had to be put into practice for us to understand and be able to visualize and, therefore, work towards making it a reality for those in need of our assistance. Tell your success stories from the point of view of the person with developmental disabilities, so that staff, parents and others can see that "this really works".

- *Setting priorities:* With the many projects which are underway in Kansas, attention needs to be given to establishing clear priorities. We highlight this issue as it

may become necessary to clarify initiatives in order of urgency for the CMRC and state hospital staffs.

C. The Role of the Remaining Two State Hospitals.

The two State MR hospitals which will remain open after the closure/consolidation initiative is completed also must play integral roles in the process. The effects on these facilities will be felt in two ways. First, MH&RS officials expect to transfer to the remaining two State MR hospitals those residents of the facility targeted for closure who are not deemed to be immediate candidates for community placement. And, second, in order to make space for the former residents, the remaining two State facilities will be expected to develop community placements for an equivalent number of existing residents.

The task of planning and carrying out the intended inter-facility transfers will have to be executed very carefully, since: (a) some of the residents are expected to have extensive medical support needs and, consequently, will require a high degree of continuity of care; and (b) the receiving facilities may not serve a similar population (i.e., individuals with extensive medical needs) and, consequently, will need time and assistance to develop this capacity. Under the circumstances, Kansas officials would be well advised to ensure that all of the necessary staff supports and equipment are in place at the receiving facility and fully operational before any resident is transferred. In addition, transfers to the new facility(ies) should be phased-in over a sufficient period of time to allow the receiving facility to absorb a new resident into a unit's routine (e.g., to prepare and refine an individualized set of program services and an activity schedule for each new resident). This process may necessitate additional expenditures, since, to some extent duplicate staffing and equipment will have to be maintained in the sending and receiving facility for at least a short period of time. But, the alternative -- a hasty and poorly thought-out transfer process -- is far too dangerous, especially in the case of residents who require extensive medical supports. The institutional closure literature is replete with examples of what often is referred to as "transfer trauma" (i.e., an increased death rate and other highly undesirable side effects of closing or phasing down the population of public and private facilities serving vulnerable populations). These possible side effects can be counteracted, as the experiences of dozens of states that have closed public MR facilities over the past few years tend to demonstrate. However, it takes a strong commitment to careful advanced planning and an implementation process that gives primacy to the interests of the people to be transferred, rather than an arbitrary set of budgetary objectives or placement schedules.

With respect to the task of making space within the two receiving facilities for the individuals to be transferred, the expert team is convinced, even based on its rather cursory review of the three State MR hospitals, that there is no lack of residents who would be appropriate candidates for placement in the community. It is important to recognize, however, that the CMRCs will be asked to develop simultaneously placement options for individuals leaving the State hospital that is scheduled to be closed, one or both of the remaining two facility, and also

accommodate individuals in the community who are on waiting lists for residential, day and support services. Furthermore, in many cases (particularly with respect to the State hospital placements), they will be expected to assume responsibility for individuals with types and degrees of disabilities that they have little or no prior experience in serving. Indeed, each of the facility superintendents told the members of the expert team that they already are experiencing a growing backlog of placeable residents due to the inability or unwillingness of CMRCs to develop and sustain appropriate community living/programming settings for such individuals.

As emphasized in subsection III-B above, MH&RS/SRS will have to make a significant investment in upgrading the capabilities of the CMRCs to serve the types of individuals who are expected to be placed out of the State MR hospitals over the next five years if the closure initiative is to be successful. Readers are asked to keep in mind that if there are logjams at any point in the placement/transfer chain, the entire process will bog down. Thus, for example, if the two facilities that are scheduled to accept transfers from the State hospital which is targeted for closure are unable to meet their outplacement objectives, the transfers will have to be delayed until appropriate space is available to accept them. As a result, the entire closure/consolidation initiative will fall behind schedule and overall implementation costs will increase accordingly. Again, this is why it is so important that the State of Kansas adopt a holistic, interactive planning and implementation process to carry out this important multi-year initiative.

D. State Level Planning, Implementation and Monitoring Activities

As indicated earlier, the consolidation of state institutional operations is a very complex undertaking, which, of necessity, must involve many interested parties, all of whom have a significant stake in the outcome. A project management approach to organizing and sequencing such tasks, therefore, is virtually essential. Careful and detailed planning also is necessary. Unfortunately, not all issues can be anticipated in advance. Therefore, the mechanisms a state puts into place to complement the project management approach become further safeguards in the identification and problem resolution process. In preparing a strategy for managing the facility closure/consolidation initiative, the expert team offers the following suggestions:

- *Manage expectations*: Any major initiative carries with it mixed expectations, depending on the individual's perspective. It is important that all messages are clear and that outcome objectives are conservatively stated. Broken promises, obviously, make individuals, families and staff more anxious and less confident that the closure plan will be carried out in an effective and timely manner.

- *Create clear channels and methods of communication*: Regular internal and external channels of communication need to be established. As mentioned previously, rumors will abound and become aggravated in the already emotionally charged

environment, if there is no mechanism for conveying reliable information. It is very helpful if lines of communication get established early. For example, who will communicate information to the staff and families about the closure/consolidation initiative and at what intervals? From whom can such parties expect to receive answers to their questions? The same issues apply to communications to and from the central office of MH&RS and the Secretary's office.

- *Clarification of roles and responsibilities*: Again, a facility closure is a complex task. Everyone (CMRCs, the State hospitals and central office staff of MH&RS, the placement coordination teams, community development staff, etc.) need to know:

  - who is responsible for completing various facets of the implementation plan?
  - what is expected of them?
  - what are the deadlines for completing the particular tasks they have been assigned?
  - how they will be held accountable; and
  - how they can obtain help if problems are encountered.

- *Mechanisms to eliminate barriers*: There are some issues that can be easily anticipated. For example:

  - *Personnel*: When state employees of mental retardation institutions face potential unemployment, personnel questions can be expected to abound. If the state is prepared to be creative and respond swiftly, morale will improve and confidence increase. Many staff members will have questions regarding the transfer of benefits and wages to community provider agencies, should they move. Others will have questions concerning the effects of transferring from one hospital to another. Hopefully, some state staff will choose to become providers themselves. State personnel officials can be an enormously positive resource if they are properly prepared and authorized to respond in a flexible manner.

  - *Employee morale/information*: State officials should expect to deal with employee morale issues throughout the closure process. The experiences of other states indicate that certain proactive measures can be taken to limit the extent to which employees react to uncertain conditions. Employee advisory committees, the preparation of "individual career plans" for facility employees, regular and direct communications

with key central office personnel as well as other activities have proven to be very helpful in curbing rumors and keeping uncertainty to a minimum.

- *Provider contracting/procurement issues*: As person-centered planning expands, many contract and payment issues are likely to arise. Contract amendments and the need for new and previously unused contractors will increase. Hospital staff, who choose to become community service providers, will need to be assisted through the start-up process. Previously routine answers to administrative inquiries may need to be changed to assist in expanding the existing generic and CMRCs provider network.

- *Funding and rate settings*: Issues will have to be addressed and responded to quickly as they arise. If an individual needs a complex package of services, will payments be handled entirely through the State's existing Medicaid home and community-based waiver program? How will a provider know which agency is responsible to pay for particular types of services and supports and how to bill the appropriate funding source for them?

- *Quality assurance/reporting*: While small, individually designed living arrangements and day supports are clearly desirable, questions naturally will arise concerning the locus of accountability and oversight. How will consumers be involved in evaluating the appropriateness of services they are offered? How will the results of licensing/monitoring, consumer feedback, grievances, spontaneous complaints, budgeting, contracting, etc. all fit together as a "system" of quality safeguards?

  Quality assurance and enhancement is a very complex policy area which will require the attention of community providers, State officials, parents and persons with developmental disabilities. Striving for high quality is an ongoing and continuous process that requires early, detailed and comprehensive solutions that are tailored to the service delivery environment of Kansas.

- *Employee training (for CMRS staff, generic providers and facility staff)*: Before anyone is moved out of a State MR hospital, issues regarding the responsibility for furnishing staff training, as well as when and how it will be provided, will have to be resolved. Once the individual is placed, these questions can be expected to continue based on the individual's changing needs, staff turnover, and improvements in the "state-of-the-art" of service delivery. Training is key. How community colleges, the Kansas University

Affiliated Program, agency training staff and others fit into the overall training component of the closure/consolidation implementation plan are questions that require clear answers. Given the fact that training resources are likely to be limited, it will be essential as well to develop a strategy which ensures that the State achieves the greatest possible return from the dollars invested in training.

This list of issues certainly will be expanded during the implementation process. The key is how will Kansas choose to organize and manage the various tasks so that the successes and problems encountered during the closure process can be swiftly and accurately addressed with all of the appropriate participants kept fully informed.

IV. CONCLUSION

The authors of this report were asked by the Acting Commissioner of Mental Health and Retardation Services in Kansas to review the procedures used to recommend the closure of one of the three State MR hospitals. The State's analysis was conducted in accordance with detailed criteria set forth in legislative report language.

Having reviewed the studies and analyses performed during the course of MH&RS' review and visited each of the three State MR hospitals, the authors of the current report find MH&RS' closure plan both well thought out and defensible. It is the fervent hope of the present authors that all affected parties accept a decision and do their respective parts to bring this new initiative to fruition. We are convinced that the citizens of Kansas with developmental disabilities will be the ultimate beneficiaries of this initiative.

Least there be any doubt, we wish to make it clear that the decision to close one of Kansas' three state MR hospitals is totally consistent with the mainstream of thinking in the developmental disabilities field today. As noted earlier in this report, 24 states have shut down a total of 67 large state mental retardation facilities since 1960 and 34 additional facilities are scheduled to be closed in 18 states by June 30, 1995. Since last year, New Hampshire and the District of Columbia have been operating successfully without a public MR institution, after shutting down the last units in their respective public MR facilities. Michigan has recent announced plans to close its remaining six State developmental centers over the next three fiscal years. Governor Coumo of New York established a goal of closing all of the State's 16 remaining developmental centers by the year 2000 in his 1991 State of the State Message. Other states as well are in the midst of major downsizing or closure initiatives, including Connecticut, Maine, Massachusetts, Minnesota, Montana, New Mexico, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Vermont, Washington State, West Virginia and Wyoming.

Restricting the scope of institutional operations does not represent a solution to all of the continuing problems that plague state MR/DD service delivery systems. But often it is a necessary precondition to taking the next logical step toward developing a system of services and supports that is centered in local communities. In the opinion of the authors of this report, Kansas is at the point where the closure of one of its three state MR hospitals, as difficult as this action may be for some parties, represents a logical and necessary step in this direction. We also believe that, with careful advanced planning and a lot of hard work on the part of everyone who is involved, this initiative can be carried out with a minimum of dislocations and to the ultimate benefit of hundreds of individuals with developmental disabilities across the State.

FOOTNOTES

1. Task Force on Social and Rehabilitation Services, Report on Kansas Legislative Interim Studies to the 1992 Legislature, January, 1992, pp. 9-10.

2. Kansas House of Representatives, Appropriations Subcommittee No. 2 (Human Services), "State Mental Retardation Institutions Systemwide Recommendations", 92-1699/TC.

3. Kansas House of Representatives, Appropriations Subcommittee No. 2, Ibid.

4. Ibid.

5. Ibid.

6. Kansas Department of Social and Rehabilitation Services, Mental Health and Retardation Services, Creating Choices, Providing Options: One Person At A Time, June, 1992.

7. Tayyem, Fayez, "An Economic Impact Analysis of Kansas Neurological Institute, Parsons, and Winfield State Hospitals", May 6, 1992.

8. Tayyem, Fayez, "An Economic Impact Analysis of Relocating Mentally Handicapped Patients to their Communities", June 5, 1992.

9. Whiteman, Donna and George Vega, A Report on Consolidation of Institutional Services From Three to Two Facilities, Kansas Department of Social and Rehabilitation Services, March, 1992.

10. Task Force on Social and Rehabilitation Services, Ibid.

11. Kansas House of Representatives, House Subcommittee No. 2 (Human Services), Ibid.

12. Creating Choices, Providing Options..., Ibid.

13. Ibid.

14. Unpublished data collected by the staff of the Center for Residential Services and Community Living, University of Minnesota and furnished to the authors, June 19, 1992.

15. "Permanency Planning Program: Executive Report (FY 1991)", Michigan Department of Mental Health, undated.

16. Personal communication with K. Charlie Lakin, Director of the Center for Residential Services and Community Living at the University of Minnesota, June 18, 1992.

17. White, Carolyn C. Robert W. Prouty, K. Charlie Lakin and Ellen M. Blake, Persons with Mental Retardation and Related Conditions in State-Operated Residential Facilities: Year Ending June 30, 1990 with Longitudinal Trends from 1950 to 1990. Minneapolis: University of Minnesota, Center on Residential Services and Community Living/Institute on Community Integration, March, 1992.

SUMMARY AND CONCLUSIONS

FROM

An Economic Impact Analysis of Kansas Neurological Institute, Parsons, and Winfield State Hospitals

Fayez Tayyem, Ph.D.

May 6, 1992

IV. Summary and Conclusions

This study examines the economic impact of three state hospitals for the mentally retarded in Kansas, namely; Kansas Neurological Institute, Parsons State Hospital, and Winfield State Hospital. The study examines the costs and benefits of each hospital by tracing its linkages to the business sector, the municipal and county government sectors, and the school districts. It shows the income and employment multiplier effects of each hospital and estimates the overall net impact on the community in which the hospital is located and two other neighboring communities.

Comparing the results of the three hospitals indicate that KNI has the strongest impact on the community in absolute terms. However, WSH and PSH have relatively more important roles in their prospective county's economies. While KNI's share of total personal income and total employment is approximately one percent for each, it ranges between 4 to 5.5 percent for the other two hospitals. One important difference among the three is that while KNI's impact is largely limited to Shawnee county, there is some leakage from the other two counties. This is due to the relatively strong business sector in Shawnee county and its ability at maintaining retail trade activity in the county.

One particular important observation which clearly illustrates the point is that while KNI and WSH employ approximately the same number of people, the total impact of the hospitals on the prospective counties is different. It is higher in the case of KNI ($73.9 million vs. $47.3 million for WSH). The difference between

the two estimates is due to the economic leakage from Cowley county. The county's pull factor for the calendar year March 1991 through February 1992 is 0.76, while Shawnee county's pull factor for the same period is 1.23. This implies that Cowley county captures only three quarters of its potential retail trade relative to the State, while Shawnee county captures all of its potential trade activity and attracts retail trade from surrounding communities. By a rough estimate, if $47.5 million is 76 percent of total impact, then the full impact would be $58.28 million. The $14 million difference still is due to the multiplier effect.

It is also worth noting that the shares of the two hospitals in the total personal income of their counties is 1 percent for KNI and 4.8 percent for WSH. This implies that WSH plays a relatively more important role in generating income in Cowley county.

Furthermore, if we isolate the impact of WSH on the city of Winfield, the impact would be higher than that when weighted by the state pull factor. This is because the 1991 pull factor for the city of Winfield is 1.21 which indicates that the city captures all of its potential retail trade activity. The case for Arkansas City is the same. The 1991 pull factor for Arkansas city is 1.29 which is relatively high. In fact, the total personal income impact on Winfield (not weighed by the state) is approximately $20.8 million (vs. $18.6 million with county average) and on Arkansas City is $8.3 million (vs. $6.2 million).

The case is similar for PSH. The Labette county pull factor for the period March 91 through February 92 is 0.69. This implies that the county captures about 69 percent of potential retail trade

and loses 31 percent as a leakage to surrounding communities outside the county. The impact of the hospital on the county is, therefore, about 69 percent of the total impact. The impact of the hospital on Parsons alone cannot be assessed because the city did not have sales tax collection during the fiscal year July 1990 through June 1991.

On the other hand, estimating the impact of a hospital on other counties is extremely difficult since it requires information about how many people shop outside the county, where they shop, and how much they spend in each location.

SUMMARY AND CONCLUSIONS

FROM

An Economic Impact Analysis of Relocating
Mentally Retarded Persons
to their Communities

Prepared by

Fayez Tayyem, Ph.D.

for

Kansas Department of Social and Rehabilitation Services
Mental Health and Retardation

June 29, 1992

V. Summary and Conclusions

This study examines the economic impact of placing mentally retarded individuals in their communities rather than at mental health institutions. It shows the costs and benefits to each community by tracing consumption and income linkages to the business sector, the municipal and county government sectors. It also shows the income and employment multiplier effects and estimates the overall net impact on the county. Table 2 and Figures 2-6 summarize the results for all counties.

The largest income effect is in Johnson and Sedgwick (Table 2, Figure 3), while the smallest is in Labette, Crawford and Cowley counties.

The employment impact depends on the number of clients. Each patient creates 2.1 jobs on average, therefore the larger the number of clients, the larger the number of jobs created.

The largest net economic impact per client is in Johnson, Saline, and Sedgwick counties, while the smallest net economic impact is in Crawford and Labette counties. Table 2 suggests the following descending rank ordering of counties according to the net economic impact per person ($ thousands):

	Total Impact	Average Impact Per Person
(1) Johnson	$928.9	$309.6
(2) Saline	$568.4	$284.2
(3) Sedgwick	$1,065.7	$266.4
(4) Ford	$501.9	$251.0
(5) Douglas	$487.0	$243.5
(6) Shawnee	$472.5	$236.3
(7) Wyandotte	$419.9	$209.9
(8) Cowley	$617.8	$205.9
(9) Crawford	$400.9	$200.4
(10) Labette	$322.8	$161.4

Table 2
A Summary of The Economic Impact of
Relocating Mentally Retarded Persons (Per Person)

County/City	Employ -ment	Total Income ($000)	Business Benefit ($000)	Municp. Revenue	Municp. Expend.	County Revenue	County Expend.	Net Impact ($000)
Cowley	422	102.6	102.8			248	238	205.9
Winfield		121.3	153.9	2,237	1,291			276.2
Ark. City		109.2	117.8	1,911	1,307			227.7
Crawford	211	102.6	97.00			927	288	200.4
Pittsburg		126.7	118.8	1,539	567			231.5
Douglas	195	122.8	120.2			179	158	243.5
Lawrence		137.0	147.1	1,828	770			285.1
Ford	8	124.9	125.3			892	316	251.0
Dodge City		155.7	186.7	1,704	472			343.6
Johnson	202	151.6	177.2			1,170	367	309.6
Over. Park		193.9	246.9	1,978	421			442.4
Olathe		150.1	139.6	1,772	972			290.5
Labette	166	89.5	71.6			851	881	161.4
Parsons		98.6	97.1	1,265	501			196.5
Saline	35	140.5	142.4			1,294	379	284.2
Salina		162.5	184.8	2,244	567			349.0
Sedgwick	891	130.7	134.7			2,123	326	266.4
Wichita		183.0	252.9	2,858	838			438.0
Derby		117.3	105.4	1,197	780			223.1
Mulvane		109.6	89.9	1,023	751			204.9
Shawnee	357	118.6	116.9			488	286	236.3
Topeka		158.2	199.5	2,279	849			359.1
Wyandotte	290	109.3	99.5			862	262	210.0
K.C./KS		120.9	125.3	2,744	994			247.9
Total (County)	2,777	1,193.1	1,169.6			9,034	3,501	2,368.5

Figure 2

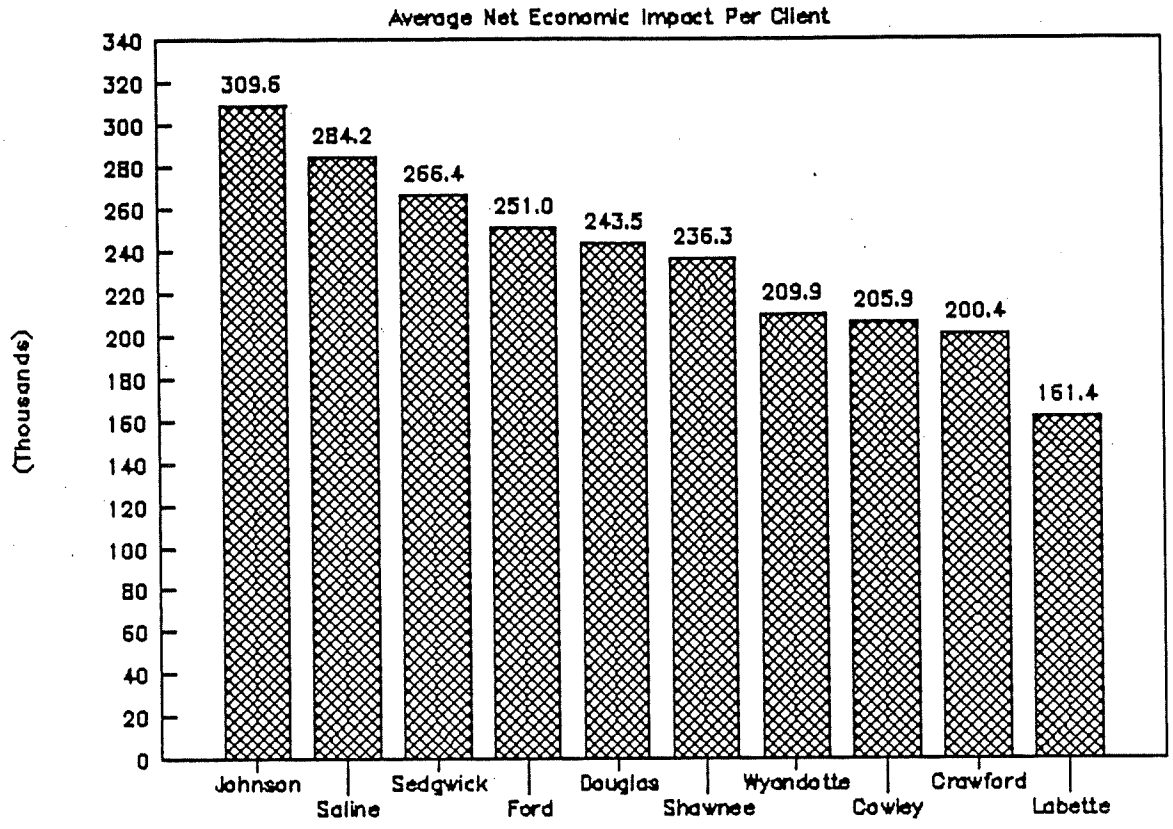

Average Net Economic Impact Per Client
(Thousands)
340
320
300
280
260
240
220
200
180
160
140
120
100
80
60
40
20
0
309.6
284.2
266.4
251.0
243.5
236.3
209.9
205.9
200.4
161.4
Johnson
Saline
Sedgwick
Ford
Douglas
Shawnee
Wyandotte
Cowley
Crawford
Labette

Figure 3

Average Income Impact Per Client

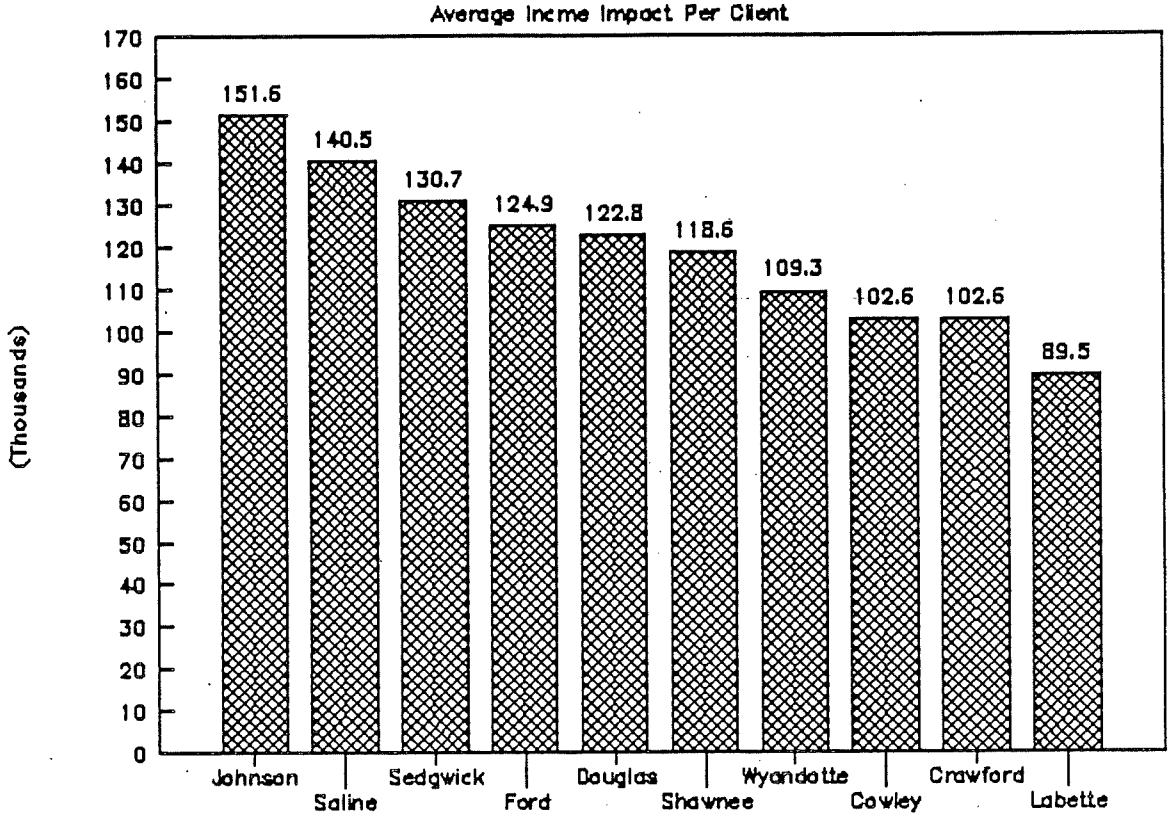


Figure 4

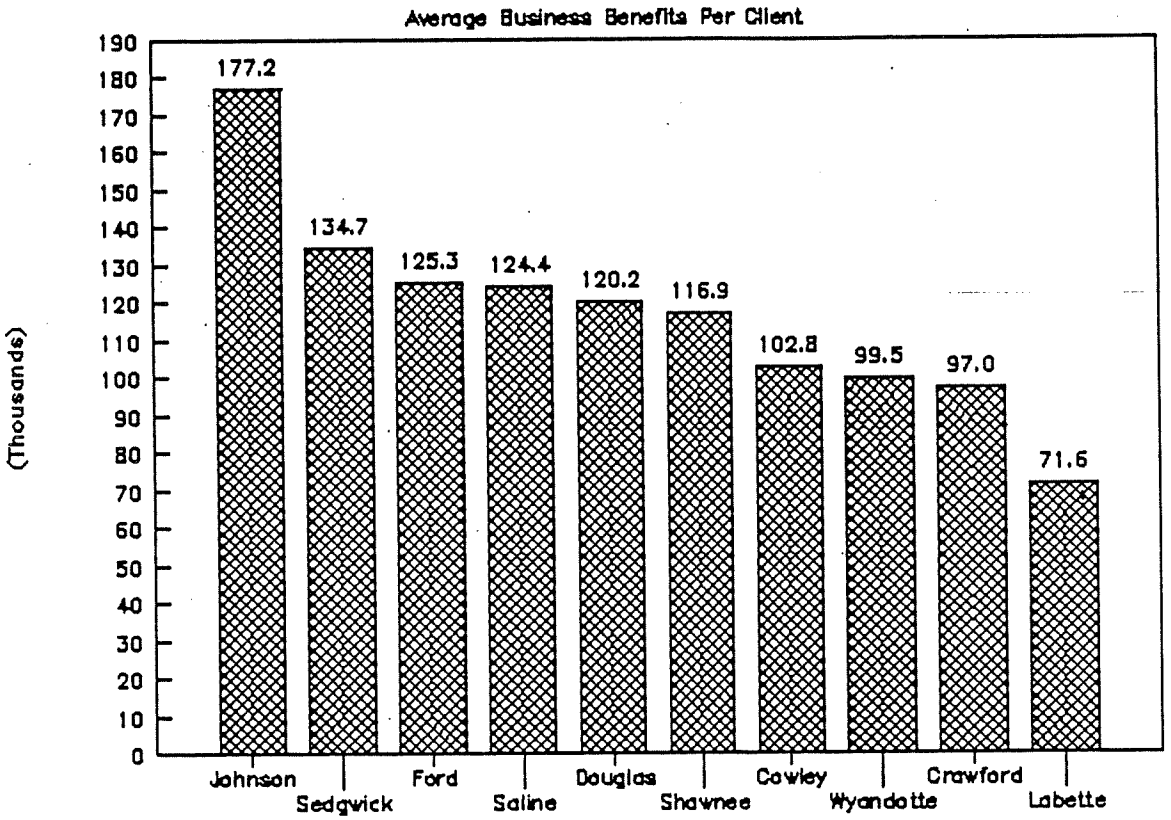

Average Business Benefits Per Client
(Thousands)
190
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
177.2
134.7
125.3
124.4
120.2
116.9
102.8
99.5
97.0
71.6
Johnson
Sedgwick
Ford
Saline
Douglas
Shawnee
Cowley
Wyandotte
Crawford
Labette

Figure 5

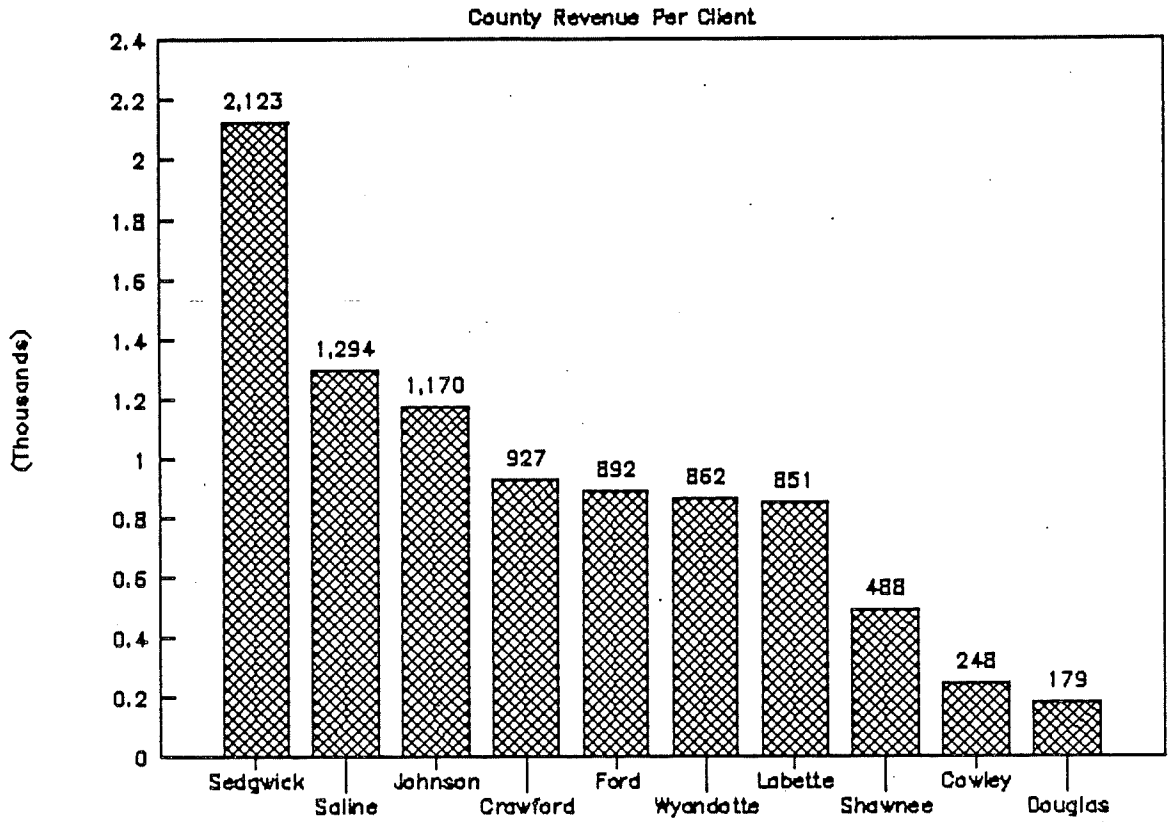
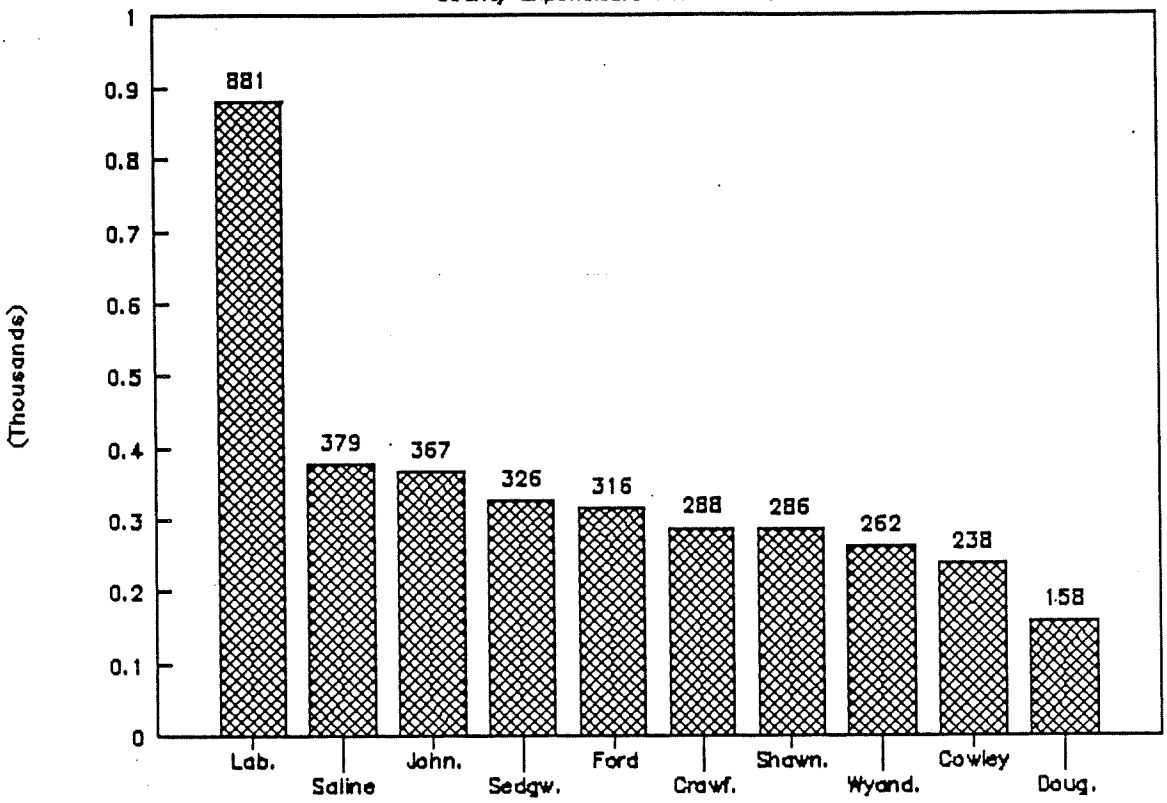

County Revenue Per Client
(Thousands)
2.4
2.2
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
2,123
1,294
1,170
927
892
862
851
488
248
179
Sedgwick
Saline
Johnson
Crawford
Ford
Wyandotte
Labette
Shawnee
Cowley
Douglas

Figure 6

County Expenditure Per Patient



SUPPORTING

KANSANS WITH

DEVELOPMENTAL DISABILITIES

STATE OF KANSAS
DEPARTMENT OF SOCIAL & REHABILITATION SERVICES
DONNA WHITEMAN, J.D., SECRETARY

MENTAL HEALTH & RETARDATION SERVICES COMMISSION
GEORGE D. VEGA, ACTING COMMISSIONER

Original
October, 1991

Update
January, 1992

As William Allen White wrote in The Nation (April 19, 1922), Kansans are:

> *"a people neighbor minded in the Golden Rule, a people neighbor bound by ties of duty, by a sense of obligation, by a belief in the social compact ....."*

These values placed Kansas at the forefront of social progress. I believe the ideas presented here are very much in keeping with this tradition.

This report is about people who need society's help, some temporarily, and some for a lifetime..... People who are and want to be our neighbors.

My vision for Kansas is to have a system of services that, once again, ranks among the leaders of our nation. The key ideas presented in this report would make a difference for all Kansans with developmental disabilities. I hope you will give them your thoughtful consideration and support.

Sincerely,

George D. Vega

George D. Vega
Acting Commissioner
Mental Health & Retardation Services

14-15

WHAT PEOPLE WANT

CHOICE	in daily decisions about job, friends, recreation, and residence
CITIZENSHIP	as a part of the community. Having interdependence and partnership. Exercising decisions affecting oneself.
ECONOMIC OPPORTUNITY	to work, to contribute, to have options for success
FREEDOM	of movement. Freedom from stigma
INDIVIDUALITY	by having a name and a personal history in the community and the opportunity to choose with whom to live with dignity and status
A VOICE REGARDING	money, transportation, services, medications, and resources
PERMANENCY	of a stable life in the community without fear of return to an institution. To be with family and friends.
PRIVACY	of records, files, and histories
RECOGNITION	of abilities, capacities, and gifts
RELATIONSHIPS	with family, friends, and partners
SECURITY	and protection from harm in environments where risk is controlled. To have safety and to receive competent services.

KEY INFLUENCES

RESOURCES

* Relationships in the system are driven economically

* Money spent on services creates jobs, has economic impact on communities, and creates pressures on legislators and policy makers to preserve formalized structures

* Direct care workers are generally underpaid, with high turnover rates, creating inconsistency in service delivery

* There are shortages of many licensed professionals in health care and other services, especially in rural areas

* Groups not historically competing for services to persons with mental retardation have emerged in open competition for scarce funding resources

ADVOCACY

* When there is cooperation, the work of parents, self-advocates, providers, and advocacy groups can provide movement toward common goals.

EXPANSION

* Rapid expansion has taxed the system and the people working in it, even though many people still do not receive services

TRENDS

* Community based integrated services will replace institutional and segregated settings

* Variety, choice, and consumer control will become more important

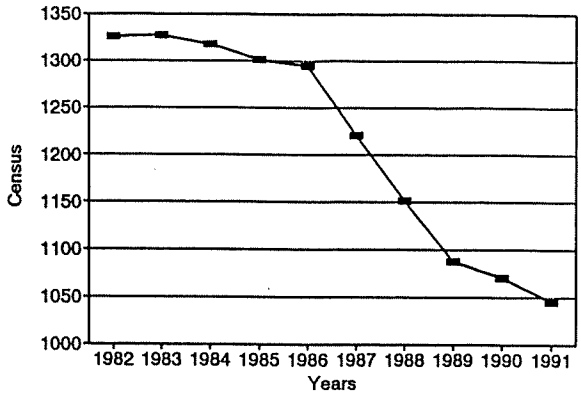
* Inclusion will lead to community acceptance

* Census reduction in large state institutions is becoming a reality

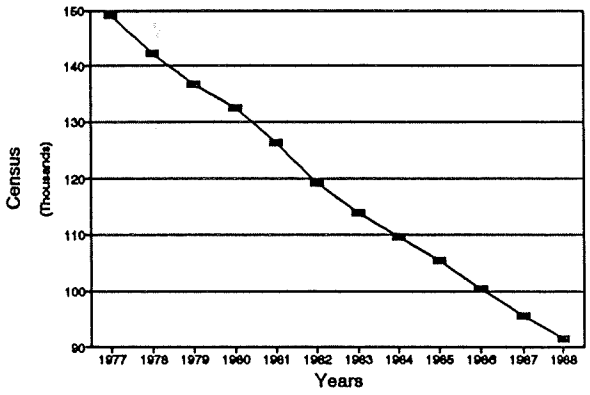
* More generic community services are being used (local health care, community activities, recreational, and transportation)

* Quality of service issues are drawing more attention, particularly how those services address individual needs and preferences

Census (State MR Hospitals)
Kansas 1982-1991



Institutional Residents in the U.S.
1977 through 1988



* There has been a real increase in the number of persons served, as the mix of funding changed (State Aid, Title XX Social Service Block Grant, Special Purpose Grants, and Home & Community Based Services Waiver), and as community services capacity building became a priority

* Workforce issues must be addressed

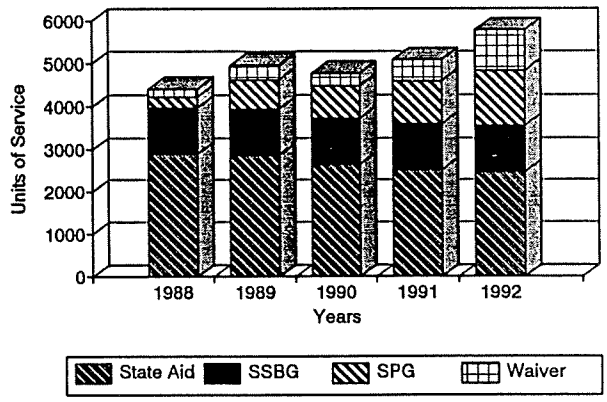
* Training issues for community service providers must be addressed

* Nationally, institutional census reduction has outpaced Kansas (Braddock, State of States In DD, 1990)

* Persons with complex medical and service needs must be considered and included in community services

* Services must be stabilized economically

Community Based Units of Service
in Kansas 1988-1992



FY	State Aid Dollars	SSBG Dollars	SPG Dollars	Waiver Dollars
1988	$5,255,408	$9,229,888	$1,976,691	$818,750
1989	$5,780,949	$9,929,870	$6,605,585	$2,460,979
1990	$6,069,996	$10,171,550	$7,465,807	$3,420,000
1991	$5,963,771	$10,350,340	$11,076,009	$5,500,000
1992	$5,963,771	$10,350,340	$13,587,310	$15,265,960

* Unit = serving one person in day or residential services
** Units are unduplicated

14-160

WHAT TO DO

There is, of course, a large gap between the vision of what persons with MR/DD want and need and the current type and adequacy of services available in Kansas. Over the past two decades the Kansas Department of Social and Rehabilitation Services (SRS) Division of Mental Health and Retardation Services (MHRS) has produced several planning documents. These include five year plans (1986 - 1991), annual budgets, as well as action documents; Home and Community Based Services (HCBS) Waiver, etc., which have established goals, objectives, and outcomes. The most recent document resulting from the agency's planning effort is the 1990 service plan outline developed by the MR/DD Advisory Council covering the 1991-1995 period. Common threads among these documents include values, mission, and principles of service provision.

VALUES

Kansans with mental retardation or developmental disabilities should have the opportunity to be included and integrated in the life of their community. They should be able to exercise options to choose where and with whom they live, where to work, to participate in preferred leisure activities, to be educated in schools in their neighborhoods and to build and maintain relationships with family and friends.

MISSION

A comprehensive array of support and direct services should be developed in Kansas which provides the greatest degree of integrated service options to the person who is mentally retarded or otherwise developmentally disabled. This array of services should be enhanced in partnership with individuals served, their parents, advocates, providers of service, federal, state and local governments.

PRINCIPLES OF SERVICE PROVISION

The system of services to Kansans with mental retardation and developmental disabilities must be flexible and based on individual needs. Services should be offered at a time and place which does not segregate or stigmatize individuals, in a way which provides diverse service options based on the following minimum principles:

1. It is the responsibility of service providers to justify separate, nongeneric or more restrictive services - whether in special education, living arrangements, leisure opportunities or work.
2. All individuals have the right to due process.

3. All individuals and/or their guardians should have opportunities to make choices including, but not limited to, where to live, work and play. They should select and keep possessions, be treated with respect and live in surroundings that provide individuality and privacy.

4. All individuals should be dealt with in an equitable manner.

5. Each individual should receive services tailored to address their unique personal strengths and needs rather than based on the availability of services.

6. Individuals should have the opportunity to have a safe, clean and healthy environment.

7. All services should continually meet at least minimum quality standards.

8. Services and the administration, management and oversight of services should be provided in the most cost effective manner possible.

9. All individuals and agencies should advocate for resources and services which are in keeping with these principles. This advocacy effort should be guided by individuals who are mentally retarded or otherwise developmentally disabled, their family, friends and guardians and include service agencies, county, state and federal agencies, elected officials and the general public.

WHAT IS NEEDED

* Embrace new ideas

  a) Base decisions on futures planning for individuals rather than slots in the system. Then, train service coordinators to implement such strategies.
  b) Pay nuclear and surrogate families to make a home for children as an alternative to public and private institutions
  c) Rework the way money is allocated by providing funds to wrap services around the individual based on level of need, rather than funding facilities, programs, or services
  d) Embrace a people first value system which considers people before disabilities, facilities, systems, or bureaucracies, and which encourages use of generic services rather than segregated specialized services

* Reconfigure services for adults and children to reflect their values

  a) For children, develop natural supports and family supports
  b) For adults, reinforce the preference for individual supports rather than facility

based services (eg; home/apartment or supported living rather than segregated group home; supported employment rather than programs based on the "readiness" model)

c) build no more group homes
d) look to other uses for segregated work activity and day activity centers

* Establish service capacity to provide full community integrated services

a) Eliminate the community waiting list by 1995
b) Reduce state MR hospital census to 675 by 1995
c) Serve all children including the 200 currently in state MR hospitals by 1995
d) Eliminate all large ICFs/MR by the year 2000 by reducing their census by 67 persons per year
e) Develop a service coordination mechanism independent of service provision to serve 9,000 persons by 1995

* Develop a solid, high quality service infrastructure

a) Rename CMRCs to Community Developmental Centers and establish a full service mandate to be available in each service area
b) Establish a list of core services which must be available in each service area
c) Set minimally acceptable standards for knowledge and performance competencies of paraprofessional and professional personnel who serve persons in the developmental service system
d) Establish a state wide, state level presence in area SRS offices to validate the mechanisms and monitor service provision, service quality, and service planning
e) Establish quality enhancement processes and procedures which go beyond minimally acceptable standards and which are led by consumers and parents
f) Establish a minimum wage for community provider staff
g) Establish reimbursement levels that are tied to the level of individual need rather than funding services based on labels and categories. For example, design model contracts which provide funding for people, not programs

WHAT DO WE NEED FROM OUR COMMUNITY AGENCIES?

* Commitment to

a) supporting individuals rather than facilities
b) developing coordinating and providing family supports for children and adults
c) bringing all persons back home from public and private institutions
d) quality enhancement
e) training through inclusionary rather than medical or educational models
f) tolerance for vacancies in and conversion of existing facilities

g) leadership and participation in cooperative service development and implementation
h) focus on increased financial support at the local level
i) serve all types of persons with developmental disabilities (eg; cerebral palsy, autism, etc.) and all age groups

WHAT DO WE NEED FROM OUR STATE AGENCIES?

* Support for

a) local planning and coordination
b) self advocacy
c) monitoring and validating local efforts rather than directing and sanctioning
d) provider staff training
e) raising wages of staff in community programs
f) merging legislative appropriations for institutional and community services
g) flexibility and accountability in the use of funds

WHAT DO WE NEED FROM THE LEGISLATURE?

* Fiscal and Policy Resources

a) Establish a minimum local funding base
b) Authorize MHRS to establish standards for Community Development Centers, core services, quality assurance, and quality enhancement
c) Establish an appropriations process that merges state hospital and community provider funding
d) Modify current law governing CMRCs and MHRS to broaden the mission to cover persons with developmental disabilities.
e) Authorize MHRS to establish minimum knowledge and performance competencies for professional and paraprofessional personnel in community developmental services and fund a mechanism to achieve these
f) Modify current statutes to reflect a mission which includes persons with developmental disabilities
g) Pass legislation which mandates development of training and delegation of non-invasive medical procedures to be available in all community settings serving persons with developmental disabilities

WHAT WILL IT COST?

The development of a full service system responsive to the needs of all persons with mental retardation and other developmental disabilities and their families cannot be accomplished merely by reconfiguring or refinancing the current service system. Today there is a critical shortage of two vital components of a responsive system; service coordination and quality assurance and enhancement. Only the infusion of new fiscal resources will add these in full measure to the system.

There is a waiting list for services. Only the infusion of new fiscal resources will eliminate this list.

The estimated cost and interaction of fiscal resources has been projected through 1997. At that time, the system could be at full service. Then, as recommended by the Legislative Subcommittee on MHRS/MRDD, service reconfiguration (including the closure of one state hospital with concurrent redirection of funds to community services) and refinancing of services within the system could be the mechanisms to meet the new technologies as they fully evolve. The ongoing costs would increase by cost of living and by graduates from special education programs.

This plan will totally eliminate the waiting list for community services. It will also establish a comprehensive service coordination mechanism which will provide greater system efficiency and effectiveness on behalf of persons who are mentally retarded or developmentally disabled and their families.

* Please note that the costs illustrated are estimated and approximate, denoting the resources needed for a full service system for persons who are developmentally disabled. **They do not represent the SRS/MHRS FY 1993 budget request.**

Pro. No. 19

Estimated Costs of Providing Full Services for Persons
Who have Mental Retardation or Developmental Disabilities
in Kansas by 1997
As recommended by the 1991 MH&RS Legislative Subcommittee

Revised 01/03/92

SERVICE TYPE	FY 93 Persons Served	FY 93 SGF Cost (millions	FY 93 FED Cost (millions	FY 94 Persons Served	FY 94 SGF Cost (millions	FY 94 FED Cost (millions	FY 95 Persons Served	FY 95 SGF Cost (millions	FY 95 FED Cost (millions	FY 96 Persons Served	FY 96 SGF Cost (millions	FY 96 FED Cost (millions	FY 97 Persons Served	FY 97 SGF Cost (millions	FY 97 FED Cost (millions
Service Coordination	5064	$0.00	$3.04	6162	$0.50	$3.85	7118	$0.75	$4.62	8070	$1.00	$5.45	9000	$1.50	$6.32
Supported Employment/Supported Living Services															
* VR Matching Grants	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80	75	$0.40	$1.80
* MH&RS Continuation Grants	75	$1.00		150	$2.07		225	$3.23		300	$4.48		375	$5.84	
* State General Funds	218	$2.45		436	$5.09		654	$7.94		872	$11.00		1090	$14.34	
Medical Services															
* HCBS/MR Recipients	1218	$1.75	$2.63	1615	$2.33	$3.49	1900	$2.74	$4.10	2166	$3.12	$4.68	2470	$3.56	$5.34
* SGF Recipients	3816	$3.82		4176	$4.18		4544	$4.54		4837	$4.84		5130	$5.13	
Day and Residential Habilitation Services															
* Existing SGF Services(incl.SS	3478	$30.98		3478	$30.98		3478	$30.98		3478	$30.98		3478	$30.98	
* COLA for Existing Services		$1.24			$2.53			$3.87			$5.27			$6.82	
* Existing HCBS/MR Recipients	786	$7.58	$11.37	786	$8.35	$12.52	786	$9.12	$13.68	786	$9.48	$14.22	786	$9.86	$14.79
* New HCBS/MR Recipients	108	$1.04	$1.56	358	$3.80	$5.70	466	$5.41	$8.11	570	$6.88	$10.31	712	$8.93	$13.40
* Reduce Institutions using HCB															
State Institutions	190	$3.46	$5.19	273	$5.17	$7.76	356	$7.02	$10.53	439	$9.00	$13.50	510	$10.90	$16.35
Private Institutions	134	$1.63	$2.44	213	$2.69	$4.04	292	$3.84	$5.76	371	$5.07	$7.60	402	$5.73	$8.59
Family Support Services															
* Family Subsidy	400	$1.20		800	$2.40		1200	$3.60		1600	$4.80		2000	$6.00	
* Other Family Support Services	144	$0.43		288	$0.86		432	$1.29		576	$1.73		719	$2.16	
Agency Support Services															
* SRS Field Staff		$0.25	$0.25		$0.26	$0.26		$0.27	$0.27		$0.28	$0.28		$0.29	$0.29
* Local Consumer Councils		$0.41			$0.42			$0.44			$0.46			$0.47	
* CMRC Staff Training		$0.79			$1.15			$1.43			$1.71			$1.98	
* Bi-Annual Needs Assesment		$0.22			$0.24			$0.26			$0.28			$0.29	
* Rate Setting Study		$0.20													
Institutional Services															
* Three State Institutions	829	$27.36	$41.04	746	$26.80	$40.20	663	$26.16	$39.24	580	$25.41	$38.12	497	$21.34	$29.48
* Large Private ICFs/MR	516	$7.32	$10.98	437	$6.70	$10.04	358	$5.93	$8.89	279	$4.99	$7.48	200	$3.86	$5.79
* Small Private ICFs/MR	346	$7.37	$11.05	346	$7.95	$11.93	346	$8.59	$12.89	346	$9.27	$13.91	346	$10.02	$15.07
Total (Unduplicated)	7155	$100.90	$91.36	8098	$114.87	$101.59	8899	$127.80	$109.87	9696	$140.44	$117.36	10471	$150.41	$117.23
FY 92 SGF $82.85 mm Inflated		$86.16	$68.90		$89.61	$71.66		$93.21	$74.53		$96.93	$77.51		$101.08	$8.08
Additional State General Funds		$14.73	$22.46		$25.26	$29.93		$34.59	$35.34		$43.51	$39.85		$49.34	$109.15

NOTES:
1. This sheet estimates costs for a full service system for persons who are developmentally disabled.
2. This sheet does not reflect SRS appropriation requests due to limited state resources.
3. This sheet does not reflect SGF costs for service coordination because existing SGF will be used as certified Medicaid match.
4. Most funds on this spread sheet, including the $82.55mm appropriated for fy 92, were inflated 4% per year.
5. This sheet does not include any additional support from local counties.
6. In FY 97 Kansas will consolidate from three state mental retardation hospitals to two.

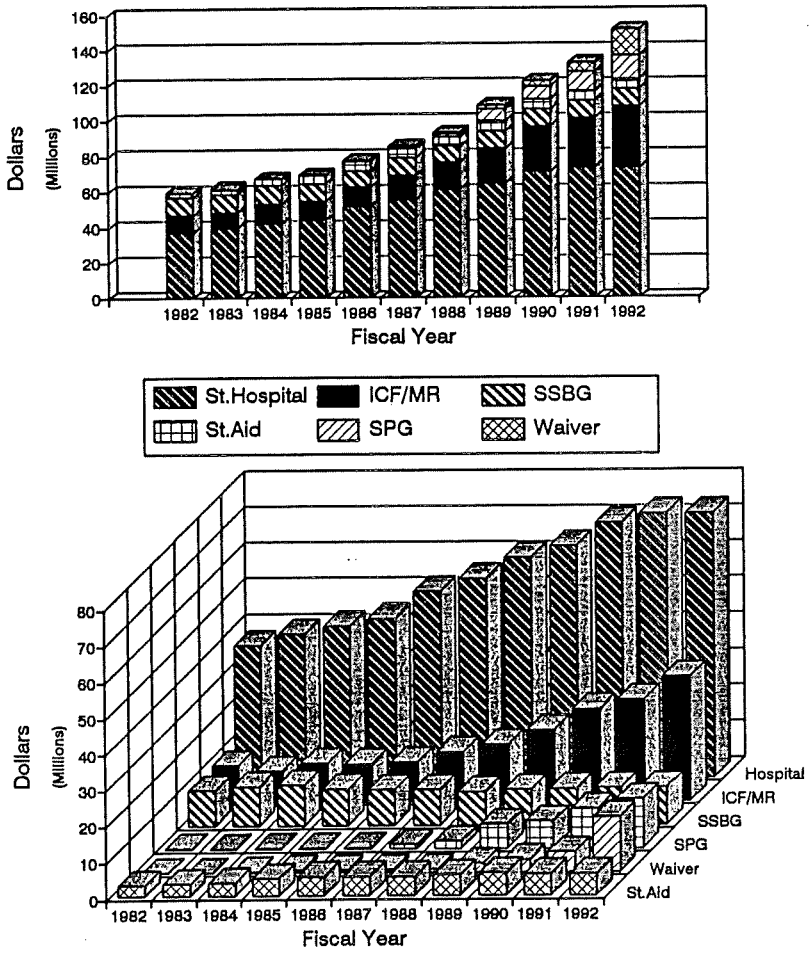
14-16

WHERE WE ARE

For several decades, services for persons with mental retardation and other developmental disabilities have been moving out of state operated institutions and into local communities. This was not a policy in response to institutional failure. In fact, Kansas institutions have provided and continue to provide excellent service. The movement was rooted in science (experience has shown community based care to be a better value) and in moral obligation (to allow full inclusion in community life). It is in recognition that home, family, friends, education, job, and community support networks need not be sacrificed for access to service.

Although much progress has been made in Kansas community integrated service capacity building, more work remains. In spite of increased spending over the last decade, Kansas' national ranking among all states dropped from 5th (in 1977) to 38th (in 1988) in the per capita amount spent on community MR/DD services.[1]

Kansas MR/DD Expenses
by Major Category 1982-1992



[1] Braddock, David, et.al.; The State of the States in Developmental Disabilities (Baltimore, Brookes, 1990).

14-167

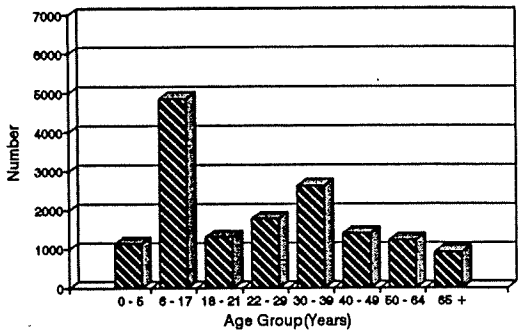
PEOPLE
(As of July, 1991)

* Studies estimate there are about 15,200 Kansans with mental retardation & other developmental disabilities
(HSRI,MRI,1990)

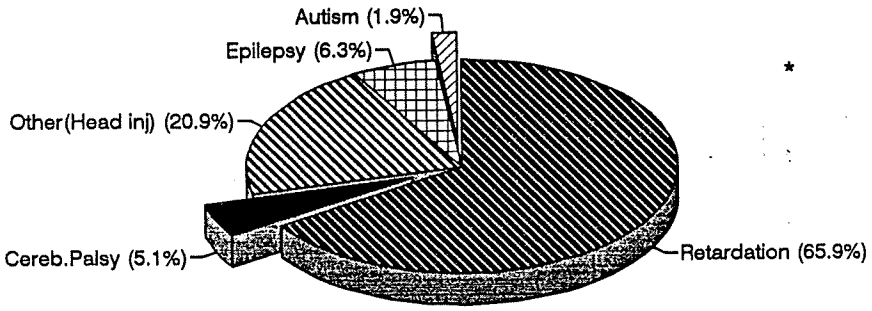
* Most have additional conditions of disability and 30% have psychiatric diagnoses

* About 7,300 are children under the age of 21

Kansans with MR/DD
by Age Group



Types of Developmental Disability

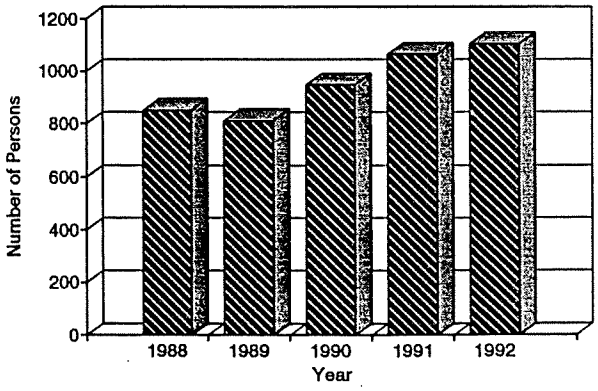


* Although mental retardation is most prevalent, other developmental disabilities (cerebral palsy, autism, epilepsy, and head injuries) are included

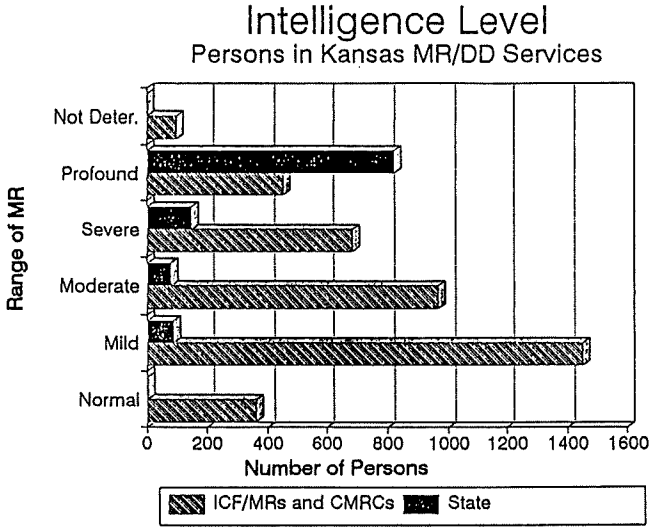
* Over 1,100 persons (children & adults) are waiting for community based services

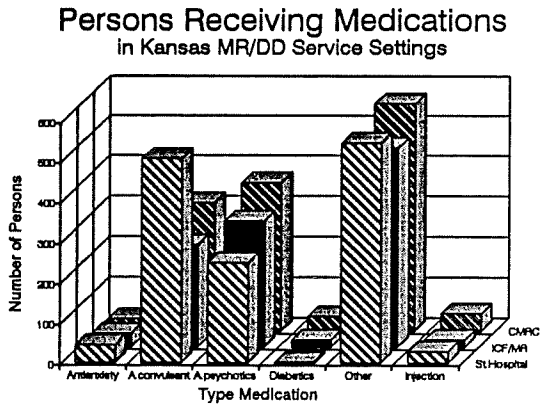
* Some Kansans with MR/DD do not seek services because of difficulties dealing with the system, or the services don't match what is needed, or generic services are sufficient

Waiting List for Services at CMRCs
in Kansas 1988-1992



14-168





* There are more persons with severe or profound mental retardation in the community than there are in state institutions

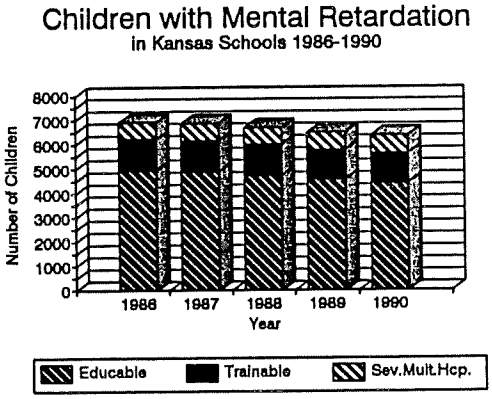
* About 3,800 persons require medications

SCHOOL

* About 6,400 are children in special education programs in Kansas schools. Their numbers have declined in the last five years.

* Most are in segregated classrooms and even schools

* Headstart, day care, and infant stimulation provide some service to less than 300 children



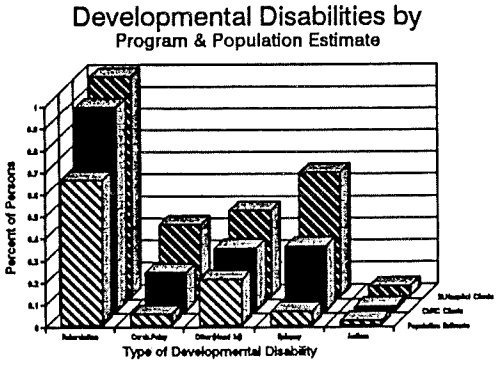
* Typically, there is little formal support for children and their families outside of special education or institutions.

WHAT PEOPLE CALL HOME

* Just under 1,000 persons (including over 200 children) are served by 3 state MR hospitals

* About 1000 persons are served in private ICF/MR residential settings

* About 1,700 reside in a variety of community residential settings



* Just over 4,000 persons are served by 27 Community Mental Retardation Centers serving 98 (of 105) counties

* Over 1500 persons served by CMRCs live at home with relatives, 300 live alone, and 200 are in individual integrated living arrangements

* About 30 children live in foster care

* Many adults live in congregate settings segregated from the community

* There may be a substantial portion of adults at home, who are unknown to the larger community in which they live and who receive no specialized or generic services

* Many who would like to live in integrated settings, remain in group homes or segregated apartment buildings

WORK

* Some people get jobs on their own

* Most who work (about 2750 persons) do so in segregated day centers and sheltered workshop settings

* Many who would like to work in the community, remain in segregated sheltered workshops

* About 270 are in integrated employment

* There is a great need for supported employment programs which provide individuals with integrated work options

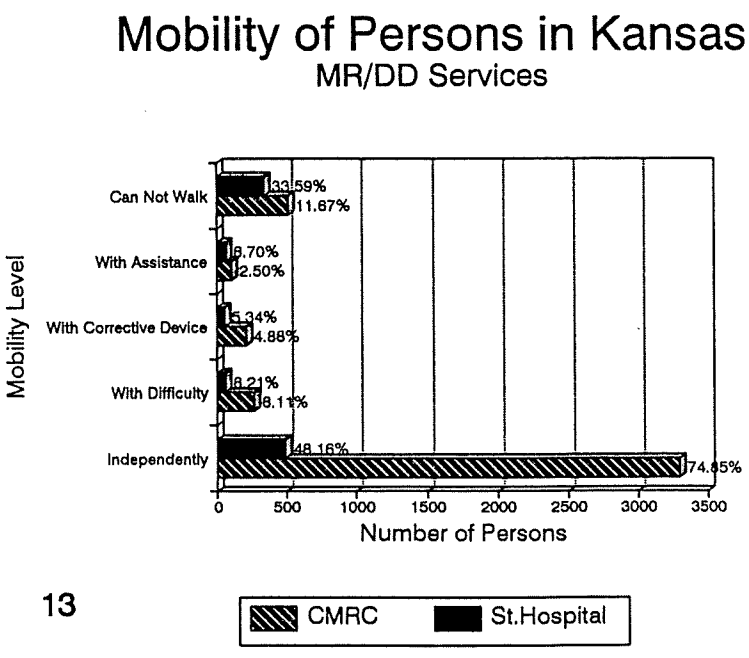
RECREATION

* Recreation is often segregated and structured in groups

* Individual recreation is not encouraged or supported

TRANSPORTATION & MOBILITY

* Although most persons walk independently, transportation, when available at all, is tied to agencies and is segregated.



ACHIEVEMENTS

Under the plan developed by the MR/DD Advisory Committee, a number of objectives for 1991 were achieved.

* Community MR/DD services were expanded by at least 150 previously unserved individuals. This helped reduce waiting lists.

* The MR/DD portion of the HCBS waiver was transferred to MH&RS. HCFA approval was received for increased HCBS rates. Approval was also received for a much larger waiver to serve individuals with MR/DD beginning in FY 1992.

* HCBS slots were allocated to SRS Area Offices to be used by existing community MR/DD programs. Some of these funded, either directly or indirectly, the placement of individuals out of State MR/DD Hospitals.

* The new HCBS waiver included services for children. This expanded service availability to a new segment of the MR population. Implementation of the objectives for the existing waiver continued.

* Administration of the ICF/MR program was transferred to MH&RS. Limitations to increasing the number of additional ICF/MR beds were established. Recommendations from providers in the development of a new reimbursement methodology were solicited. Service costs based on the level of severity of disability of persons were adopted.

* A family support program plan was developed which dedicated some existing funds to family support services. Additional funds were requested in the new HCBS application. Some expansion in state general funding was set aside by the legislature for a pilot family support program. This will also encourage community MR/DD providers to use available special purpose grant funds for family support programs. Modest gains in the development of family support services should result.

* The Kansas Rehabilitation Information System (KRIS) was updated and is now accurate and operational. Implementation of the Developmental Disability Profile (DDP) for all clients is in progress. Linkage exists between KRIS and the DDP systems. Automation of an ICF/MR and facilities certification data system is also in the process of development.

* Census reduction is shown in the ten year chart on state hospital census in an earlier portion of this report.

* A key element in providing advice and guidance in developing service plan and budget objectives is solicitation of thoughtful advice from all parties with a stake in the outcomes. More parents, advocates and University Affiliate Program representatives have been added. This will build in more consumer feedback and services expertise to planning processes.

* HB 2530, amending the nurse practice act in the 1991 session, must be reconsidered in 1992. Impediments to community inclusion for MR/DD persons often involve the routine administration of oral medications (anticonvulsants) or feeding in well stabilized gastronomy tubes. For instance, under some current interpretations of the law, they cannot attend a Kansas City Royals baseball game because there is no "licensed" care provider available to administer a routine medication or feeding. Dialogue between SRS and Board of Nursing regarding possible necessary revisions to the act resulted in the proposed legislative changes.

LEGISLATIVE SUBCOMMITTEE ON MHRS

Many of the concepts proposed in this document were endorsed by the Legislative Task Force on Social and Rehabilitation Services (Report on Kansas Legislative Interim Studies to the 1992 Legislature, Task Force on SRS, Filed with Legislative Coordinating Council, January, 1992, Proposal 19) as proposed by the Subcommittee on Mental Health and Retardation Services. Highlights are summarized as follows:

GENERAL CONCLUSIONS

* The mission statement and principles of service provision (p. 4) were endorsed.

* New ideas such as futures planning, nuclear families, reallocation of resources, and a people first value system (p. 5) were also formally recommended to the Legislature.

* The spreadsheet on page nine was expanded from an original three year plan to a five year plan to include the closure of one state hospital.

LEGISLATION

* An enlarged statutory description of developmental disabilities, increasing the target population from mental retardation to mental retardation and developmental disabilities was endorsed.

* A bill allowing delegation of noninvasive nursing practices (most particularly needed to allow support in home settings, medication and tube feeding) was recommended.

COMMUNITY MR/DD PROGRAMS

* A five year plan to strengthen the infrastructure of community services, eliminate waiting lists, reduce census at state hospitals, eliminating all large bed ICF's/MR by the year 2000 was proposed. The funds needed to accomplish this are reflected in the spreadsheet on page nine.

* Community Mental Retardation Centers were designated to provide service coordination (targeted case management) for adults who are mentally retarded or developmentally disabled. Also, the MHRS presentation on certified match utilization of Medicaid was approved.

HOSPITAL CONSOLIDATION

* Closure of one state mental retardation hospital by 1995 was recommended, factors for making the determination were identified, and community programs are to give special consideration in hiring displaced state hospital workers.

VOCATIONAL REHABILITATION AND SPECIAL EDUCATION

* Transition counselors are to work closely with families, students, education, and community providers for long range transition planning.

* Special education (noted to be significantly underfunded) is to be closely monitored and returned to at least the ninety percent funding level.

AUTISM

* Establishment and funding of a Kansas Resource Center on Autism was recommended.

DIRECTIONS STATE AGENCIES

* SRS is to study combining appropriations for state mental retardation hospitals and community programs.

* SRS/MHRS is to establish standards for community development centers, core services, quality assurance and enhancement.

* MHRS is to work at establishing funding relationships with county governments.

* The Kansas Department of Transportation is to review methodology for operating costs of transportation and federal reimbursement allowances, and to determine if current transportation policy is consistent with the Americans with Disabilities Act.

* SRS Vocational Rehabilitation is to coordinate closely with special education.

INDEPENDENT COMMISSION ON CONSOLIDATION OF MR/DD HOSPITALS

The consolidation, or closure, of a state-operated hospital should be decided on criteria related to the best interest of clients and their families. When the decision is made in a highly political environment such as the legislative process, special interest groups exert their influence to protect their interests. The result is the people whose interest is most fundamental to the decision are not adequately included in the process due to lack of organization and political strength.

In order to make this critical decision on merits and study, an Independent Commission on Consolidation of MR/DD Hospitals should be created and given authority to hire outside expertise. The Commission should include representation of families and legislators. It would be made up of the following:

Consumers and/or Families --three (3) representatives
Professional experts -- two (2) representatives
Private citizen -- one (1) representative

The Commission will be appointed by the Governor.

One family member or consumer shall represent the interests of the individuals receiving services in state hospitals. One member should represent the interest of the individuals receiving services in community programs and one individual should represent the interests of individuals on waiting lists for services.

The professionals shall be recognized experts in the field of Developmental Disabilities with experience in DD policy making and/or in management of services to people with developmental disabilities. Kansas has experts with national reputations in the field of DD at the University of Kansas and at the Kansas University Affiliated Facility at

ATTACHMENT 15

Parsons.

The Commission will be given a budget sufficient to hire outside expertise to study all issues related to closing a hospital.

The Commission will make its decision public no later than October 1, 1993.