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Feasibility Study

and

Implementation Plan

Consolidation of State Mental Health Institutes

Submitted to Joint Standing Committee on Appropriations and Financial Affairs and Joint Standing Committee on Human Resources, Maine State Legislature

By Department of Mental Health and Mental Retardation
Sue W. Davenport, Commissioner

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INTRODUCTION

As the State of Maine expands opportunities for community hospitals, nursing homes and other providers to serve present and potential patients currently served by its two Mental Health Institutes, the consolidation of the remaining services in a single Institute has become an option to be considered. This report fulfills the requirement enacted by the Maine Legislature (PL 1993, Chapter 410, Part Z) ordering a feasibility study and implementation plan for such a consolidation.

During the 1992-93 legislative session, the Department of Mental Health and Mental Retardation responded to requests from the Joint Standing Committees on Appropriations and on Human Resources to consider the possibility of immediate or near future merger of the Institutes to one site. It was found that the combined census of the two Institutes is substantially higher than either facility could accommodate. The licensed bed capacity of the Institutes is: AMHI, 212; BMHI, 247. The combined census is approximated 420. The renovations necessary at either Institute to accommodate even a major fraction of the increased population would be extremely expensive. To expend substantial capital on renovation of wards the use of which would not be needed as the facility census continues to decrease would be unacceptable. If all patients were housed in existing or slightly expanded bed capacity overcrowding would interfere severely with care and treatment; also, it would jeopardize Joint Commission on Accreditation of Healthcare Organizations accreditation, Medicare certification and State Licensing - and the federal reimbursement which is contingent upon them. The Federal disproportionate share payments alone for services at these Institutes that would be lost is currently $25,000,000; other Medicaid and Medicare reimbursement totals $2,600,000. The even more stringent requirements of the AMHI Consent Decree (Bates v. Glover) would apply to the entire facility, requiring staffing levels significantly higher for the BMHI patients than are now in place. The traveling distance required for large numbers of persons seeking acute short term admission would increase significantly the difficulty in maintaining close contact with family and friends as well as increase the cost to county law enforcement for transport and reintegration to communities of origin. The factors of bed capacity, burden on community, external standards and cost make consolidation counterproductive until census and volume of admissions have been reduced significantly.

This study therefore addresses the feasibility and plan for consolidation once responsibility for acute psychiatric hospitalization is located in community hospitals and those patients requiring nursing home care are in community nursing facilities. Also, while these community alternatives are expanding, many patients who currently are unable to leave the Institutes will be provided with the intensive support necessary for return to their home areas, thereby further reducing the size of the resultant population, so that a facility of 175 beds will serve the needs of the entire State and could be achieved within a six year time frame pending resource allocation for community alternatives.

The implementation of this proposal will change mental health services to the citizens of Maine from an institutional based to a modern community based system. At the same time it will fulfill a major legal obligation. The AMHI Consent Decree (Bates V. Glover) entered into by the State in 1990 requires just such a conversion to community care and support. When fully implemented this will achieve that end.

FEASIBILITY ANALYSIS

The Legislative Order contained in the 1993 Budget requires that the Department of Mental Health and Mental Retardation examine the feasibility of consolidating the Bangor Mental Health Institute and the Augusta Mental Health Institute and submit an implementation plan to the Joint Standing committee on Human Resources and to the Joint Standing committee on Appropriations and Financial Affairs. This plan must recommend the location of the consolidated facility, specify the level of community-based development, including but not limited to private hospital development, needed in order to carry out the consolidation, include time lines for achieving the consolidation and address expected budget implications.

In carrying out this study, the Department was mindful of the intent of the Legislature to achieve cost savings while, at the same time, to maintain, and if possible, to improve the quality of patient care.

Also, the Department was mindful of the need to consult those who would be affected by such a consolidation. Work groups within the Department, drawing upon others as needed, defined the realistic limits of feasibility through the examination of identified issues. The Acting Commissioner extended an invitation to consumers, their families, providers of mental health services in the community and unions representing Institute employees to assist in developing a plan which would be responsive to their needs and preferences. A productive public meeting was held December 13, 1993 with 23 consumers and provider representatives attending. Valuable suggestions were received. Written comments and suggestions were helpful as well.

Values and Assumptions

All planning must occur with basic values in mind. Two important values underlie much of the work presented here.

Providers of care and treatment of severely mentally ill individuals must take into account the fragility -- psychological and frequently physical -- of these patients. Any plan which includes uprooting them from a setting in which they have become adjusted over months and years should be designed to minimize the shock of movement and certainly to avoid moving them more than once. A move from one Institute to another would be perceived by the long term patient as permanent and would have a serious demoralizing effect. It would make any subsequent attempt to place the patient in the community more difficult and more likely to fail. Subjecting the patient to unnecessary traumas would be unconscionable.

The value of providing treatment as close to home as possible has more than just an economic convenience dimension. When someone is admitted and begins a patient

career a long distance from home, and especially when the stay extends for two months or longer, reintegration into the home community becomes more difficult. This applies both to the patient and to the community he or she has left. The greater the separation from the natural support system the greater difficulty the patient has in maintaining contact and the greater is the tendency for the community to forget the patient and eliminate any place for him or her. This underlies the need to develop acute care in community hospitals and also to keep the largest possible number of those patients requiring extended Institute stays as close as possible to their home communities. The community must not be allowed to forget that their member who has been hospitalized for mental illness exists; the patient must never become estranged from family and community. In planning a future location for a consolidated Institute, adherence to this value requires that areas of population concentration in Maine be the overriding consideration.

The first step in determining feasibility is to clarify, consistent with values, the assumptions underlying any consolidation which would meet both the cost savings and good patient care requirements. These assumptions have to recognize the status of Maine's present mental health system, current community planning, the downsizing of facilities already under way, considerations of distance and accessibility, the limitations of existing physical facilities and the legal environment. It was apparent immediately, as noted in the introduction, that the numbers and acuity of the present Institute populations make consolidation prior to the development and utilization of adequate community alternatives unfeasible.

The first assumption is that, prior to consolidation, all patients requiring short stays will be served in community hospitals. This could be accomplished in three years, but only if necessary resource allocation occurs. Only those who require an extended period of treatment will be transferred to the State facility. To assure that each patient receives services as close to home as possible, with the least disruption and separation from family and other community support, the Department is cooperating with general hospitals in both the northern and the southern areas of Maine in promoting the development and expanded bed capacity for all those prospective patients, including those committed involuntarily, who now are served in the two Institutes during the acute phase of illness. Not only is this an important step in providing services to patients in the most appropriate location, but it is also cost effective in increasing third party reimbursement, including Medicaid. It also avoids the significant increase in cost that would be incurred by county law enforcement if large numbers of admissions had to be transported to a single location.

The second assumption is that nursing home bed capacity in the Institutes will be phased out over the next two and one half years. As in the case of acute care, this time line is dependent upon resource allocations. Those persons who are now in these beds and those others who are eligible for nursing home care will be placed in community nursing homes. Whenever possible, their choice of location will be respected.

The Department of Mental Health and Mental Retardation has plans to develop sufficient nursing facility beds in the community through lease agreements and other arrangements to care for the NF residents currently in the two State Institutes and to assure capacity for the future needs of the community. Approximately 100 beds are being considered or are under development through a lease agreement. They provide three levels of service identified as Special, Special and Secure, and Dementia Units.

The third assumption is that the Augusta Mental Health Institute Consent Decree (Bates v. Glover) will continue to have jurisdiction over any successor facility. Its provisions must be applied to the structure, staffing and programs of any consolidated facility, and its community service requirements must be applied to all class members who leave the facility.

The fourth assumption is that, in addition to the short stay and nursing home eligible patients, there are a significant number who have been identified as able to live in the community with appropriate housing and clinical support and who could and should be discharged prior to consolidation. This is also consistent with Consent Decree requirements. Issue #8 addresses the plan for achieving this. Again, as above, the six year time line is dependent upon resource allocations and does not begin until necessary resources are in place.

The fifth assumption is that the State will continue to need to provide psychiatric hospital services for those patients who require extended periods of hospitalization. This includes those currently in the Institutes who, even with community development, have been assessed as unable clinically to live outside the Institute within the six year time line for such development and , also, those who will be admitted from community hospitals after a 30 day length of stay and who require longer term care before discharge. These patients who remain will require services of a quality no less than that now provided under Consent Decree and other standards.

Issue #1: Can patients be served in a single location which, at the same time, facilitates the involvement of family and friends?

Through continuing community development, as described in the assumptions above, the long term population (including forensic patients) can be reduced to 134. This is a feasible number to be served in a single location. Following are the distributions of this remaining population by home county (residence prior to admission):

COUNTY	AMHI	BMHI	TOTALS	%
Aroostook	0	9	9	6.7%
Hancock	0	6	6	4.5%
Washington	0	9	9	6.7%
Penobscot	0	28	28	20.9%
Piscataquis	0	2	2	1.5%
Somerset	2	1	3	2.2%
Waldo	1	0	1	.7%
Knox	3	1	4	3.0%
Lincoln	1	0	1	.7%
Kennebec	13	2	15	11.2%
Sagadahoc	1	0	1	.7%
Franklin	2	0	2	1.5%
Oxford	3	0	3	2.2%
Androscoggin	12	0	12	9.0%
Cumberland	25	0	25	18.7%
York	12	0	12	9.0%
None	1	0	1	.7%
Subtotals	76	58	134	

The attached state map of Maine Counties and DMHMR/DHS Service Regions depicts the above distributions, and County populations, to give a sense of north-south concentrations. Other factors to consider include:

The geographic center of the State is near Dover-Foxcroft.
The population center is in southern Kennebec County. Far more people are concentrated in the southern extreme than in the northern.

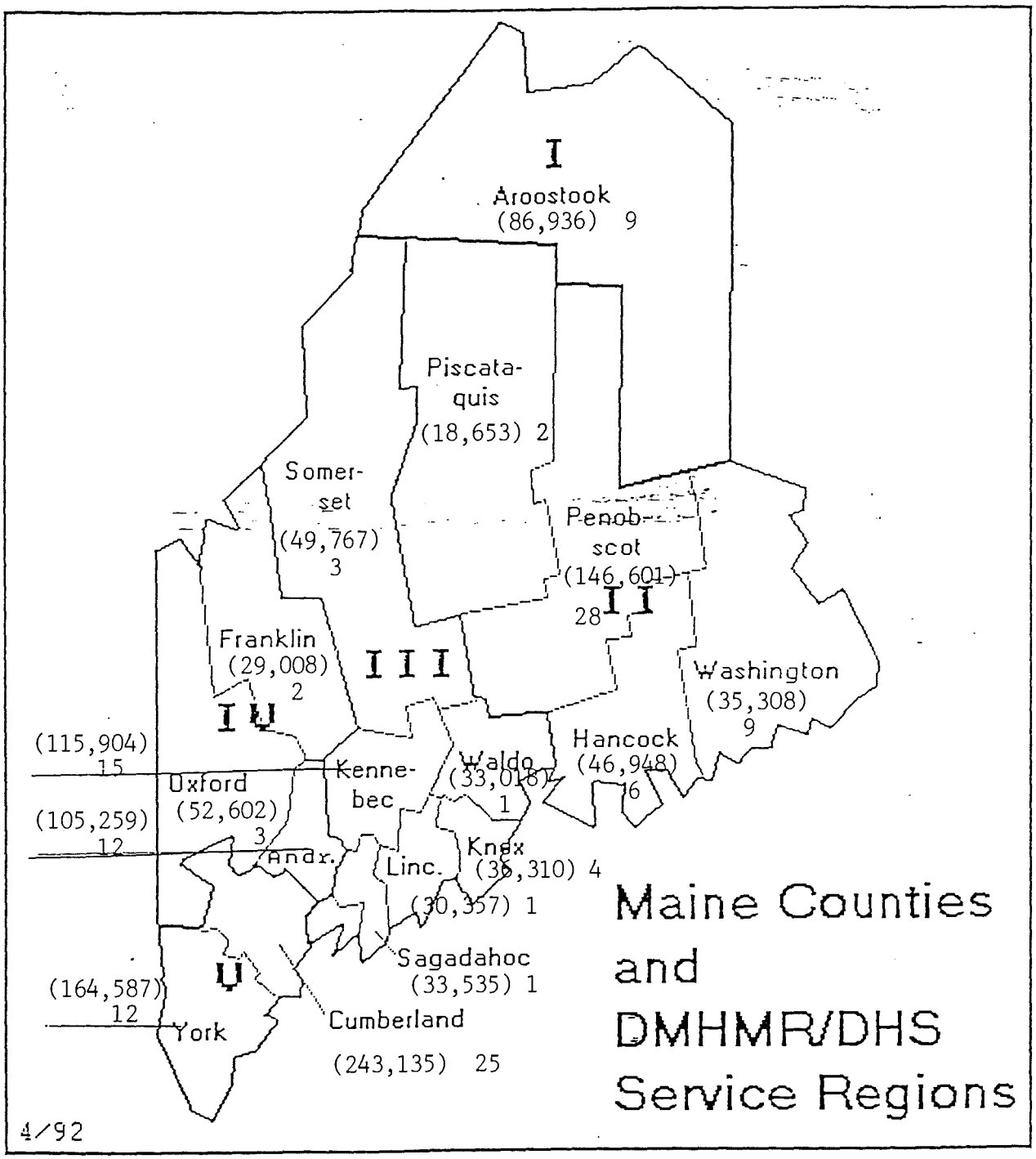
Interstate 95 provides the major transportation access throughout the State. Although no one will be admitted directly to the state facility prior to acute hospitalization in a community facility, we do anticipate some admissions from community acute units for individuals who require inpatient care beyond 30 days. We assume that ongoing community resource development will accommodate most of the long term needs of this group, and that slow turn over will occur in this longer term patient population for other reasons. As a single location will, inevitably be a longer distance from home for some patients, resources should be directed to assisting continued active involvement of families and significant others. If acute care were provided at the Institute this problem would be far more difficult to address because of the numbers of individuals traveling greater distances for care.

It is estimated that the number of patients requiring extended care admission to an institute beyond the 30 days in a general hospital facility would be approximately 250-300 per year.

Issue #2: Does the location provide the availability of resources and services, including access to public and private agencies, to continue to reintegrate the Institute's longer stay patients into the community?

Reintegration of longer stay patients is affected by a number of factors. Probably the most significant is the availability of services and supports in the "destination" community where an individual wants to live. Long term community resource development should prioritize the needs of these individuals. Another concern is the services and supports available within the institution to prepare, facilitate and support an individual's transition to community living. This is an issue of institutional program design and staffing, and availability of other resources. For example, institutional services must be driven by rehabilitation objectives that develop skills and supports that are useful and transferable to community living needs. Implementation of Individualized Support Plans is one way to address this. Also, continuing system effort to further the common foundation between institutional and community ways of providing services must be reflected in Departmental policies and practice.

In addition, it is important that resources be available, in the locality where the Institute is sited, that the longer term patients can access in order to help acclimate them to life outside the institution.



Population in parenthesis
Number of Long Stay Patients

Transportation, in order to access community resources, is a long standing issue for any consumer of mental health services. Most of the larger population centers have some limited public transportation. Institution resources would need to supplement existing public transportation in order to reduce or eliminate this barrier.

Issue #3: Do patients have access to general hospital and medical services?

Population centers in Maine generally have available these services, including clinic services and private specialists. Specifically, they are available at both Augusta and Bangor.

Issue #4: Is there a setting and acceptable location with adequate number of beds, which meets physical and therapeutic standards for housing and for providing rehabilitation services to the population who will remain in the Institute? If so, where?

The physical plants of both the Augusta and Bangor Mental Health Institutes have the capacity to treat 175 patients. Each is, at present, licensed for more than this number. However, both are aging and inefficient physical plants which will require major future investment. Augusta is much closer to the center of population.

Issue #5: What are the renovation costs of meeting #4 above?

At present, none at Augusta. At Bangor forensic unit security renovations would be required. Essential for savings in staffing at Bangor would be renovation of Ward K-4 at an estimated current cost of $840,000.

Issue #6: How should a successor Institute be staffed?

An analysis of staffing requirements based on experience at AMHI and BMHI, on the special characteristics of a severely impaired extended care patient population, and on the specific mandate of the Bates vs. Glover Consent Decree has resulted in the following: Clinical Staff - 282; Administrative and support staff - 199 at the AMHI site or 187 at the BMHI site. The difference of 12 support staff at the two sites reflects AMHI's larger physical plant and its responsibilities in maintenance and housekeeping. AMHI is responsible for maintaining grounds for several other state buildings and provide housekeeping services to office buildings housing the Division of Mental Health and regional offices of the Division of Mental Retardation and the Bureau of Children with Special Needs.

Issue #7: Where would a professional labor pool be most available? Are there market analyses which address this?

The Maine Department of Labor prepares an Occupational Employment Analysis Report which provides current workforce information on a county by county basis. This

report, along with information that is available from professional health care licensing boards and other organizations provide adequate data on which to make assumptions relative to the availability of health care professionals on a geographical or major population center basis.

Should consolidation result in an increase in professional staffing levels at either existing facility (or at a new facility) a major professional recruitment issue will undoubtedly occur. Current labor markets are not adequate in the Augusta or Bangor areas to accommodate substantial staffing increases.

Issue #8: What are the resources necessary to extend Consent Decree coverage statewide?

Estimates regarding the type and extent of community support services, housing and crises services necessary to successfully discharge long-term stay patients from BMHI and AMHI so that a 175 adult psychiatric bed facility have been developed and followed.

HOUSING

How many patients at AMHI and BMHI are identified as needing housing, housing assistance, or supports in order to be safely discharged prior to consolidation?

After excluding 1) the forensic population whose discharge is court dictated, 2) those who are assessed as unlikely to be able to benefit from community placement within the next several years, regardless of the level of intensive support, 3) those who require a specialized nursing facility, the total population identified as of October 31, 1993 as needing community housing and supports is 111 patients.

While these 111 patients (91 from BMHI and 20 from AMHI) are considered to be able to move into community settings, many of the communities of choice lack sufficient services and/or opportunities to support and help maintain community living, especially in the more northern and rural areas of the state.

As noted above, the resource development necessary for community living for AMHI and BMHI patients does not include persons who are assessed to require a specialized nursing facility (NF) unit. It is anticipated that the separate NF community development plan will be implemented prior to consolidation and, therefore, is not included here.

What are the costs and types of residential development required, by region, prior to consolidation?

Generalized categories of residence are identified below for development purposes and assume appropriate supportive services will be available in order to support the community living arrangements recommended.

It is estimated that of these 111 community living arrangements, approximately 60-70 can be developed within the first two years. This takes into account 1) the reality of community development saturation in both the southern AMHI catchment area (Regions III-V) and the greater Bangor area, 2) the small provider infrastructure available to initiate or support considerable new development, and 3) the difficulties and limited experience with models for serving persons in low mass areas.

These first community living arrangements emphasize the development of therapeutic and supervised community alternatives in the more northern counties and greater Bangor area in recognition of the comparatively fewer such options developed in those areas in the past.

If all these 111 patients could be placed prior to consolidation, the remaining consolidated psychiatric population (excluding short stay and nursing home level inpatients at both institutes as well those for whom discharge plans are already in progress) as of the end of October, 1993, of both institutes would be 134 patients hospitalized 90 days or more at BMHI (58) and AMHI (76).

What is the breakdown by region for those considered able to live in the community with appropriate supports prior to consolidation?

Region I (Aroostook) - 8%

Region II (Hancock, Penobscot, Piscataquis, Washington) - 65%

Region III (Kennebec, Knox, Lincoln, Somerset, Waldo) - 16%

Region IV (Androscoggin, Franklin, Oxford) - 5%

Region V (Cumberland, York) - 6%

COMMUNITY LIVING ALTERNATIVES: DEVELOPMENT AND COSTS

Northern and Eastern Maine (Regions 1 and 2)

Year 1 and 2
Start up costs: $422,000 *Yearly Expense: $108,756*
Year 3 and 4
Start up costs: $218,000 *Yearly Expense: $ 94,080*
Year 5 and 6
Start up costs: $465,000 *Yearly Expense: $ 57,324*

Southern Maine (Regions 3,4, and 5)

Year 1 and 2
Start up costs: $118,000 *Yearly Expense: $ 46,968*
Year 3 and 4
Start up costs: $ 29,000 *Yearly Expense: $ 12,408*
Year 5 and 6
Start up costs: $205,000 *Yearly Expense: $ 34,652*

**For future yearly costs add 5% to yearly costs.*
Back up data and costs for each service is available.

What funding mechanisms are necessary to help individuals maintain housing?

The development proposed here reflects regional real estate differences and is based on the assumption of diverse funding availability such as the CROP fund (mental health bond referendum) administered by the Maine State Housing Authority (MSHA), federal sources (HUD 811, McKinney, etc.), and low-cost MSHA financing. As these special low-cost financing programs are less available and more conventional funding must be used, the greater cost to the State general fund is dramatically evident -- as can be seen in the third biennium of this development.

The housing proposed takes into account existing housing resources, reflects regional real estate differences, and encourages the development of non-profit housing corporations, as well as an expansion of clustered and integrated, scattered living units.

COMMUNITY SUPPORT SERVICES

Proposed program development for those individuals now at the two mental health institutes who have been there over 30 days incorporates intensive and comprehensive supportive services for maintaining stable community living.

What are the services?

While relatively few of all consumers of mental health services require highly specialized, structured residential service/treatment programs, a significant percentage of those at the two State psychiatric institutions may call on the State's responsibility for assuring the availability of these intensive services for those adults with serious mental illness and serious functional impairments who are the most vulnerable. In such residential therapeutic facilities, on-site staff and services (budgeting, daily living skills, medication management, etc.) are assured and, within the parameters of the treatment program, change as the needs of the individual resident change. At the same time, additional supportive services (such as case management, vocational, educational, social, etc.) may be provided through other community agencies in the larger community.

Some of the institutes' population, however, can -- with appropriate and varying services -- maintain stable community living in a range of community living options. In most of these other instances, mental health services are not part of an integrated on-site treatment program and are not tied to the specific physical site. Emphasis is placed on outreach and home-based services directed to the individual wherever that individual chooses to live, separating access to housing from access to services, but recognizing the need for both.

In any living arrangement, however, through the individualized support planning process, the specific services to be provided are chosen by the individual consumer in conjunction with family, friends, and service providers, as wished by the consumer.

Such community supportive services in the community include the following:

1. Integrating
   - Outreach, Case Management/Community Support.
   - Individualized Support Planning (ISP).
   - Transportation.

2. Rehabilitative
   - Vocational (pre-vocational, supported employment, business ownership, etc.).
   - Educational.
   - Independent living skills.
     - Activities of daily living: budgeting, cleaning, cooking, use of transportation.
     - Community integration skills: accessing and utilizing community resources: shopping, transportation, church, social/fraternal

organizations, other personal growth and social and leisure skill building.
- Flexible in-home supports.
- Social support activities.
- Social and leisure activities.
- Personal growth activities (adult ed, etc.).
- Companion/peer partners.

3. Treatment
   - Illness management.
   - Crisis intervention and stabilization.
   - Medication management.
   - Psychiatric assessment.
   - Psychotherapy and counseling (mental health and/or concurrent disorders such as substance abuse).
   - Home health & other health care.
   - Specialized Training: psychogeriatric, deafness, minority cultures, etc.

4. Basic Supports
   - Housing assistance, Rental subsidies, Related housing costs.
   - SSI/SSDI/AFDC eligibility.
   - Medicaid, Medicare.
   - Food Stamps.
   - MH Rights.

Among the service areas vital to the maintenance and improvement of mental health and community living are housing support services, those specifically related to locating, securing, and maintaining suitable housing. These include the following supportive services:

- Provision of affordable housing availability information;
- Funding for security deposits, first-month rents, and household equipment and furnishings;
- Moving arrangements;
- Budgeting training;
- Representative payee;
- Assistance with rental applications;
- Information on landlord/tenant laws and regulations, etc.;
- Household maintenance training - cleaning, cooking, laundry, etc.

Other services may also be delivered by agencies in the health, entitlement, education, labor, and other service systems. All services must endeavor to enable the integration

and maintenance of the person in the natural life of the community, including church, social/fraternal organizations, volunteerism, etc.. Also important to the success of this ongoing process is the involvement of the individual's natural support systems such as family, friends, neighbors, and mutual support groups.

What is the programming and personnel necessary to deliver those services?

The range of services necessary include 24 hour staff supervised community living arrangements, independent living services, vocational services, physical/psychiatric/medication management services, substance abuse services, psychotherapy services, nursing services, and community support/case management. Total costs per person per year (1994 rates) are as follows: 24 hour therapeutic residence $44,042; 24 hour supervised residence $32,828; 24 hour Independent staffed community living $125,128; In home assisted community living $12,259 - $15,859; Semi-independent community living $11,348. Back up data and costs for each service is available.

In addition to these individualized costs should be added such essential services as crisis intervention, social/recreational activities (except for those activities provided to those living in the programming within the structured residences), peer support, acute community inpatient care, and special needs -- which are seen as being developed on a broader population basis. Additional costs may also be incurred in rural areas, where the types and numbers of services available generally decrease with the population/demand.

The importance of a comprehensive community support/case management system to this process of integrating patients at AMHI and BMHI who have had long stays into communities throughout Maine cannot be over-emphasized. It will take adequate numbers of community support/case management workers to assist returning individuals and to coordinate and assure appropriate community and in-home services. This must further be buttressed by statewide psychiatric crisis services and local community acute psychiatric inpatient capacity.

How much new funding will it cost to serve those identified above?

	Years 1 & 2	Years 3 & 4	Years 5 & 6
24-Hr. Therapeutic:	$1,849,764/year (42 x $44,042/year)		$ 792,504/year (18 x $44,042/year)
24-Hr. Supervised	$ 328,280/year (10 x $32,828/year)	$ 262,624/year (8 x $32,828/year)	$ 131,312/year (4 x $32,828)

24-Hr/Staff Individual	$ 250,256/year (2 x $125,128/year)	$ 375,384/year (3 x $125,128/year)	
In-Home Supports	$98,072-$ 126,872/year (8 x $12,259-15,859/year)	$98,072-$ 126,872/year (8 x $12,259-$15,859/year)	$ 36,777-47,577/year (3 x $12,259-15,859/yr)
TOTAL SERVICES:	$2,526,372-2,555,172/yr. 62 persons	$736,080-764,880/yr 19 persons	$960,593-971,393/yr 25 persons
TOTAL HOUSINGS	$ 695,724	$ 353,488+155,724	$ 765,976+262,212
	$3,222,096-3,250,896	$1,089,568-1,118,368	$1,726,569-1,737,369

6-YEAR
TOTAL: $10,011,869-$10,166,669 (106 people) SERVICES

TOTAL: $2,651,060 HOUSING

TOTAL COMMUNITY RESIDENTIAL: **$12,662,929 - $12,817,729** (assumes development in second half of each biennium and carries forward operating costs into each succeeding biennium)

What funding mechanisms must be in place in order to maintain flexible delivery of services?

Obligations to meet the preferences and choices of consent decree class members requires development of alternative service/housing models for persons who wish to live in outlying areas which currently have limited service resources available at those locations. Alternative funding strategies, such as redeployment of institution staff and existing Medicaid streams, to deliver flexible support services to these individuals must be incorporated into funding mechanisms and service delivery development. Flexible "wrap-around" funds, Medicaid options which include in-home services, and individually oriented outcome funding are integral to a service delivery system which has the capacity to respond to individual needs.

How many more community support workers must be hired in order to be sure all discharged patients could receive a community support worker?

Assuming a community support worker to client ratio of 1:17, the system would have to minimally increase its CSW capacity by 7 in order to fill the need required by the 111 persons identified above. These seven new CSW's do not, however, make up for the current shortfall existing in the greater Bangor area. Nor would seven workers actually be able to cover all individuals who would live in the outlying areas.

At least 13 new CSW's are anticipated to be needed if all 111 patients are to be supported in the communities of their choice.

Recommendations

* It is recommended that the 111 persons have housing options and support services development made available as soon as possible, but within at least two stages of development. Due to the reality of community development saturation in both the southern catchment area and the greater Bangor area; the small provider infrastructure available to initiate or support considerable new development; as well as the limited experience with models for serving persons in low mass areas.

* Enhancement of Community Support services throughout the state is critical to the management of resources and to helping individuals with serious mental illness maintain community living. The community support worker is the link between the individual and services. Without this service, and vital crisis services, the State hospital will continue to be a necessary community option for those other than long-term stay patients.

* Obligations to meet the preferences and choices of consent decree class members requires development of alternative service/housing models for persons who wish to live in outlying areas which currently have limited service resources available at those locations. Alternative funding strategies, such as redeployment of institution staff and existing Medicaid streams, to deliver flexible support services to these individuals must be incorporated into funding mechanisms and service delivery development.

Issue #9: What is the future location of the forensic unit? Does it remain within the Department of Mental Health and Mental Retardation? Should the acute care of inmates be done by the Department of Corrections?

In studying the need for services to "forensic" patients, clarification of the categories covered under the designation "forensic" is necessary:

1. Persons acquitted of crimes by virtue of having been found Not Criminally Responsible by Reason of Mental Disease or Defect (sometimes referred to as "NGRI's").

2. Persons found Incompetent to Stand Trial.
3. Persons admitted for Stage 3 of Title 15 pre-trial evaluations.
4. Inmates from the state correctional system and the county jails who are in need of acute inpatient psychiatric treatment. (This is the only category which would be considered "acute".)
5. Inmates form the state correctional system who are chronically mentally ill, who are nearing the ends of their sentences, and who are in need of being transitioned back to the community.

Note: The rare female forensic patients are treated on regular hospital units, not on the Augusta Mental Health Institute Forensic Unit.

Also, some consolidation has already occurred in that all patients in categories 2 and 3 above from the Bangor Mental Health Institute service area have already been admitted to AMHI for the past several years. It is planned that all new category 1 patients will enter AMHI as soon as AMHI has the bed capacity to receive them.
For a consolidation to be possible there would have to be an expansion of the forensic unit beyond the present AMHI 33 bed capacity. The option of moving the responsibility for category 4 inmates to community acute care facilities does not appear feasible both for security and for cost reasons -- third party reimbursements such as Medicaid is not available for these hospitalizations. Community hospitals have been extremely reluctant to admit inmate-patients of either gender to psychiatric units, due to: presence of guards in the milieu, assault risk, security risk and lack of staff expertise. County sheriffs have not wanted to do this either, largely due to the expense of guard coverage. The county holding custody would have to pay the costs of inpatient treatment. The alternatives of Department of Corrections or County jails developing inpatient psychiatric capability or contracting out of state are not clinically or financially feasible either.

The frequency of use by correctional facilities for category 4 inmates over a 12 month period at the AMHI unit was:

State Facilities	
Maine State Prison	3
Maine Correctional Center	3
County Jails	
York	15
Cumberland	10
Androscoggin	3
Franklin	1
Oxford	1
Kennebec	1
Somerset	4
Waldo	2
Knox	1
Lincoln	0
Total	44

The average length of stay of inmates, including those found Incompetent to Stand Trial, on AMHI's forensic unit in 6 month time blocks for the last four years is as follows:

Time Block	N	Average LOS in days
Jan - Jun 1990	43	24.5
Jul - Dec 1990	26	67.8
Jan - Jun 1991	10	78.5
Jul - Dec 1991	15	124.8
Jan - Jun 1992	22	36.3
Jul - Dec 1992	18	62.1
Jan - Jun 1993	32	24.1
Jul - Nov 1993	25	54.0

Average LOS for the 6 month time blocks: 59.0 days.
The occasional female inmates admitted to regular AMHI admission units are not included in the above tables.
BMHI has very few category 4 inmate admissions. It does have 5 category 1 patients residing in the facility.
It would not be feasible economically for a forensic unit to be free-standing from the rest of a state hospital. When the consolidation happens, the forensic unit should be included. A facility located near the state's population center would be the preferred location. Major considerations would be (a) distance of inmates from family/support systems, and (b) transportation distance for county sheriff's departments. This is most critical for the category 4 acute inmate patients. Creation of an inpatient psychiatric treatment capability within the Department of Corrections would be neither cost effective nor clinically desirable.

ISSUE #10: What are the ongoing savings in operating one Institute?

Any analysis of long term savings is complicated by the unknown future of Medicaid disproportionate share. At present 62% of the Institute budgets, excluding nursing homes, is reimbursed by the federal Medicaid program.

During the early transition period, while community general hospital, housing and other programs are developing, there would be no savings. The community programs must exist before patients can be accepted into them. The savings from staff reductions during the transition period would be needed to provide community support and Medicaid seed for the patients now served elsewhere. Upon consolidation there would be savings in administrative costs. The most significant savings of well over $1,000,000 per year would be realized in not having to maintain the physical plant of one Institute. However, as the Bureau of General Services report points out, there is a cost of maintaining vacant space the amount is unknown.

ISSUE #11: What cost savings would occur if existing physical plants were made available for other state purposes?

The Bureau of General Services has done an analysis with various options, including the cost of a new facility, these are found in the attached report.

IMPLEMENTATION PLAN

Size and Location

The analysis of issues has resulted in a projection of need for a 175 bed facility. This would include space for the 134 identified long term patients remaining after more appropriate alternatives have been developed for short term acute care and nursing home care and when adequate community support makes possible the community placement of 111 of the longer term care patients now residing in the Institutes. This provides space also for a small addition to the forensic capacity, some patients requiring inpatient treatment beyond 30 days and any increase in incidence resulting from an increase in the population of the State. Discharges will continue to occur from this combined population making it possible for the facility to operate near but not over its 175 bed capacity.

Clinical staffing ratios of a 175 bed facility would not be significantly different from that required under Consent Decree and other standards for the Augusta Mental Health Institute at present. This is an important consideration in that recruitment in Augusta (or any other Maine labor market) for specialized professionals is already difficult and a significant increase in demand in one city would be very difficult to meet.

In order to minimize one of the most significant negative effects of any consolidation -- that of increased distances that patients and others would have to travel -- the location should be as near as possible to the center of the State's population. Augusta meets this requirement as the center of population is only a short distance to the south and west. At the geographic extremes, York County has twice the population of Aroostook.

The geographic center of Maine, in the general area of Dover-Foxcroft and Dexter, is not near most of the population who would utilize the Institute and is not accessible to the I-95 corridor. Moreover, the center of population has been moving south for many years and is likely to continue to do so.

An analysis of the county of origin of the long term patients who would be remaining in the consolidated Institute reinforces the desirability of locating near the center of population, although the distribution does not exactly follow county population patterns. Over time, development of community support services in Penobscot County and other areas of eastern and northern Maine, which would be required under Consent Decree mandates, should decrease further the proportion of long term patients from these areas, as the same access to needed services would be provided to citizens of Maine in whatever region of the State they resided.

As noted in the discussion of forensic issues, Augusta is a much more convenient location than is Bangor for serving the needs of county jails. Acutely mentally ill inmates are the one short stay population for whom the Institute will remain a primary resource and transporting them long distances for short stays would be a significant burden on the counties.

New Facility

It is in the long term interest of the State of Maine to construct a new 175 bed facility rather than to continue into the next century to use any of the existing outmoded, inefficient and expensive to maintain facilities. A facility on the existing Augusta Mental Health Institute campus could continue to utilize such recently constructed buildings as the Sleeper Gymnasium, an important adjunct for the treatment and rehabilitation of extended care psychiatric patients. A new facility, funded perhaps through certificates of participation would, over time, pay for itself through reduced costs in staffing, heat and maintenance.

Buildings now housing Institute patients would become available for other state use. However, costs of renovation for office use would be substantial because of adaptation requirements, presence of asbestos, other environmental considerations and the need to meet the standards of the Americans with Disabilities Act.

Utilization of Existing AMHI Facility

If a new facility is not available, the existing Augusta Mental Health Institute can accommodate the consolidated population. Continuing repair and renovation have brought it into conformity to licensing, accreditation and Consent Decree standards. It has highly secure facilities for criminal Court referrals and transfers from correctional facilities -- the only such hospital facilities in the State.

Community based development necessary:

In order to assure that patients who could and should be out of the Institutes and in or near their home communities are provided the necessary services, the Division of Mental Health has developed a six year plan summarized in the issues review above. Implementation begins when the necessary funds have been allocated. The time frame for this, as well as the community development of acute care and nursing home alternatives assume that the necessary funding takes place. This, taken in conjunction with the Consent Decree and other concurrent programs and plans, defines the community support required. Planning includes the Maine Mental Health Services Plan, the long range plans for geriatric services, the Maine Medicaid Program plans, and the planning with general hospitals and other providers in both southern and northern Maine for community based, comprehensive services to the acutely ill psychiatric patient population.

As patients leave the Institute and continue to be integrated into community programs, present Institute staff with expertise in the treatment of patients with continuing psychiatric disabilities should be utilized in providing support and case management services. They would be in the best position to assure continuity in the critical transition period. For at least the first few years of community living, the long stay institutionalized population would benefit from the utilization of experienced Institute staff in community support roles. Provision should be made for state employee lines to fulfill this function.

Also, there should be included expanded training opportunities for employees taking the new positions created and transition assistance for those pursuing career change. This plan is consistent with the transition to community based provision of care already underway for the last several years and will not result in additional loss of positions available to career employees.

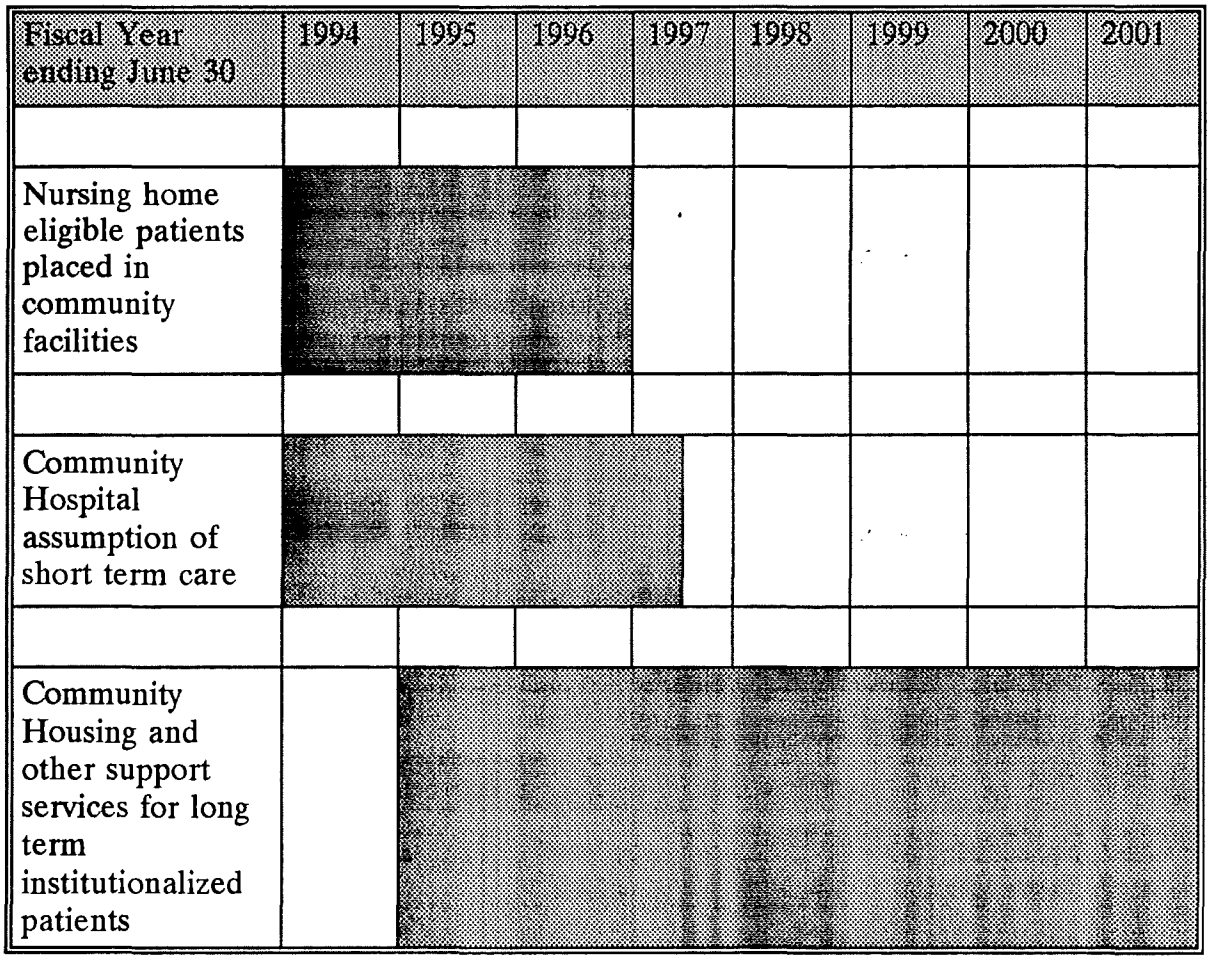
In Addition, the Department supports labor contract negotiations leading to an agreement that the present labor force would have the first right of refusal for any created jobs. It would also define the rights of the existing labor force in the staffing of the consolidated Institute. A negotiated agreement should be included in any implementing legislation.

As a single facility will be a longer distance from home for some patients, resources should be directed to provide assistance to families and significant others in minimizing travel costs associated with visiting patients at the Institute. One option is to make available a house on the Institute grounds, privately managed, for visiting families.

Timelines

The time by which consolidation would be feasible is dependent upon the community development described in this paper. This development, in turn, requires appropriate funding allocations. If these programs come to fruition on schedule the population of the two Institutes will be reduced to the 175 census by July 1, 2001. Although the acute care and nursing facility components should be implemented within three years, the housing and community support component will take six years from the availability of funding - at least July 1, 1995. It should be noted that the Bureau of General Services estimates that new construction or major renovation would require five to ten years also.

TIMELINES FOR COMPLETION OF THREE MAJOR COMPONENTS
OF CENSUS REDUCTIONS AND TRANSFER OF RESPONSIBILITY



Budget Implications

Institute Costs:

A very rough estimate of the cost to build a new facility with square footage per patient comparable to that at New Hampshire Hospital has been set at $40,000,000. This could be reduced somewhat in that AMHI has already on the grounds the modern (opened 1990) Sleeper Gymnasium with 11,400 square feet of space which could reduce the size of the new construction accordingly.

There are significant ongoing savings in both staffing and maintenance - especially in heat and repairs which could allow the facility to eventually pay for itself. These are estimated at $2,000,000 per year.

The staffing of the existing AMHI facility of 481 staff at an average (1994) cost of $37,500 per employee would be almost $18,000,000. Annual operating costs other than staff are estimated at $3,800,000. Currently through disproportionate share payments or the successor to such payments through National Health Care Reform, the net cost to the general fund for this facility is $8,284,000.

The added responsibilities assumed by the Augusta Mental Health Institute in provision of housekeeping services and maintenance to an office building housing Department of Mental Health and Mental Retardation staff, and groundskeeping responsibilities for a large campus with several other State office buildings, together with more square footage in patient areas to maintain, require 12 more staff than would the Bangor Mental Health Institute location and $500,000 more in All Other. $361,000 in State funds would generate Medicaid funds to make up the $950,000 differential. Augusta's central location makes it clearly the preferred choice from the point of view of patient care.

Community Costs

The cost to transfer and maintain in the community the patient population identified above is as follows:

1. The support of 50-55 added acute care beds in community hospitals can be financed through the elimination of approximately 80 Institute beds and of the present diversion program. This is a current State general fund expenditure of approximately $6,000,000. It will be phased in over two to three years with individual general hospitals expanding units followed by the closure of Institute acute care beds at intervals throughout the period. For example, in order to close a 25 bed Institute Unit (only the closure of a unit would release the necessary funds), 17 new beds would have to be added in the community. The Medicaid seed would have to be provided by the State for the community beds before those in the Institute could close.

2. Other community services: An annual budget allocation of $3,700,000 will be necessary to fund crisis services and other community support which would make possible the limiting of the most expensive alternative of all -- inpatient care -- to 50-55 additional beds, a reduction of one third from the present demand.

3. Community nursing homes with psychiatric capability will replace Institute nursing home beds over the next two to three years also. The savings from Institute unit closings will be needed to fund Medicaid seed for community beds with a break even fiscal effect.

4. Community residential and support programs would be funded over a six year period. This is presented above in Issue #8. The total capital and operational budget for this program is approximately $12,800,000 for the six year period. Almost $1,500,000 of this funding is start-up costs. There is a potential for utilizing diverse funding sources in addition to the State general fund. The allocation of federal funds for housing is competitive. The Department would use all available channels to leverage 10-20 % of capital cost in federal funds through the housing authority or HUD.

It should be emphasized again that these programs are required under the Bates vs. Glover Consent Decree whether or not consolidation takes place.

Summary

In summary, the implementation of Institute consolidation can be achieved in a minimum of seven years, providing the steps above, including funding, are implemented. It will result in some economies of scale, particularly in the discontinuance of maintenance of one aging Institute physical plant. There will be long term savings in the requirement for fewer state employees and reduced reliance on state operated inpatient facilities. In future fewer of the severely mentally ill will become so dependent on an institution as to require the very expensive supports now necessary to maintain the 111 persons now identified for supervised housing in the community.

The removal of the extended care psychiatric patients from their home areas to a distant single facility is the most serious negative aspect of this proposal.

As we enter the 21st century a 175 bed facility, especially one of modern construction, can be a model resource for the care and treatment for those Maine citizens who are most in need of active extended mental health in-patient care.

DEPARTMENT OF ADMINISTRATIVE & FINANCIAL SERVICES
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M E M O R A N D U M

TO: Richard Besson, Director of Hospital Services, AMHI
John Conrad, Director of Hospital Services, BMHI

FROM: James H. Keil, Director, Bureau of General Services

DATE: December 30, 1993

SUBJ: Consolidation of the Mental Health Program (AMHI & BMHI)

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This is a response to your November 19, 1993 request for information relating to consideration of consolidation of the Mental Health Program. Please keep in mind that this response is based on a short walk-through at both campuses and information garnered from staff members. We recognize, at this point, it is difficult to have more concrete information to work with.

As I understand it, portions of the mental health program will be contracted out to private vendors and that longer term care will be consolidated at either Bangor Mental Health Institute or at Augusta Mental Health Institute, either in existing buildings or in a new building. In either case, proposals should include the premise that vacant space would be renovated at the receiving institution for the consolidated mental health program and the vacated institution would be renovated for general office space.

Also, you have asked our perspective on the idea that a new facility for the mental health program might be constructed elsewhere and all the vacated space at AMHI and BMHI would be renovated into general office space.

You have indicated that your goal for the total population in the proposed consolidated mental health program to be 175 clients. It is my understanding that each institution has approximately 400,000 gross square feet of available space. This could be converted to

office space (if both institutions were vacated). You have asked our perspective on what would be involved in such a consolidation.

Both BMHI and AMHI are near population centers, and both support sizeable state government operations. Best use scenarios would see all buildings occupied by programs to assure funds and support for proper maintenance. If these buildings stand vacant they will still be a significant maintenance cost to the State. Any vacated space at either institution should be converted to general office space and occupied through the vacating of leased space, where practicable.

Vacated space at AMHI could provide opportunities for renovating for as much as 90% of the leased space in the Augusta area. Nearly all Bangor leases could move into vacated space at BMHI under some scenarios. Presently the State leases approximately 425,000 Sq. Ft. in the Augusta area and approximately 125,000 Sq. Ft. in the Bangor area. We anticipate, as Attachment "A" indicates, that renovation costs could be funded by avoidance of some lease costs if this concept became part of a long-range plan.

Our perspective on such a move has taken into account a cursory review of capital funding, moving costs, time frames, economic impacts of vacating leased space, environmental concerns, funding of maintenance and maintenance staff levels, and conceptual considerations of building a new mental health building(s). We will need the opportunity to review recommendations when more specifics are available.

CAPITAL FUNDING

No capital funding is presently available. A mechanism such as a direct bond issue, certificates of participation, or some form of finance authority would be needed to furnish funding for capital construction design and study, DEP triggered issues, site and utility upgrades and contingency costs.

The following construction estimates (of construction costs only) project highest cost scenarios, taking into account full compliance with all codes, federal laws pertaining to asbestos and asbestos removal, the Americans with Disabilities Act, various environmental and hazardous waste removal regulations and many as-yet unquantified cost categories, which would necessarily be defined in a more detailed analysis.

ASSUMPTIONS

Using three northern New England hospital projects within the past 3 years for comparison, we have assumed an average space required per patient of 1,780 S.F. if BMHI is used, and 2,365 S.F. if AMHI is used. This includes beds, dietary facilities, administration, rehab services, medical records, medical ancillary spaces, library, staff education, conference rooms and professional offices.

Option #1: Consolidate Mental Health program (175 beds) into renovated space at AMHI. Renovate approximately 125,000 S.F. at BMHI, and 71,927 S.F. at AMHI into office space. This would leave approximately 275,000 S.F. vacant and unrenovated at BMHI.

* Construction costs (interior only) are estimated to be approximately $61,000,000 (610,802 S.F. X $100 per Square Foot)

Option #2: Vacate the mental health programs at both AMHI and BMHI, renovate each campus to office space, and move the consolidated mental health program (175 beds) to a new building.

* Construction costs (interior only) are estimated to be approximately $88,000,000 (886,302 S.F. X $100 per square foot)

New building at $40,000,000 (175 beds X 1780 S.F. X $100 per S.F.)

Option #3: Consolidate the mental health program (175 beds) to either BMHI or AMHI and renovate only enough space to run the program.

* Construction costs (interior only) are estimated to be approximately $41,000,000 (413,875 S.F. X $100 per square foot) AMHI/BMHI

Note 1: Unoccupied buildings tend to deteriorate rapidly, and still require some heating and maintenance, which, in this climate, can be considerable.

Note 2: Either campus could conceivably absorb a consolidated program of 175 beds at little immediate renovation cost, if present levels of patient services are continued, (with the possible exception of additional security requirements for forensic patients). This would, at best, be a temporary option due to building deteriorations mentioned above. In the short run, upgrades to new codes would only be required when renovations were begun, which might offer some potential for a phased approach.

Option #4: Consolidate the mental health program into BMHI (175 beds) and renovate the remaining 80,000 S.F. of vacant space at BMHI into office space, then renovate the approximately 400,000 Sq. Ft. at AMHI to office space. The renovated vacant space at both locations could be used to absorb 60% of the leased space in Bangor and 90% of the leased space in Augusta.

Total cost estimate = $80,000,000.

* Add costs for parking (minimum $500/car), site, utilities, A/E fees, road, DEP upgrades, and 10% contingency.

* (above) These estimates do not include any consideration for exterior parking, site, utility, road upgrades or related design costs.

MOVING COSTS

One-time direct costs of moving the mental health program to AMHI or BMHI or to a new building, and the cost of moving state employees from leased space into renovated AMHI and/or BMHI space would range from $200,000 to $3,000,000 depending on the option selected.

OPERATING COSTS (STATE-OWNED) COMPARED TO LEASED SPACE (See Attachment "A")

Preliminary analysis indicates that vacated space renovated to office use at BMHI and AMHI could be operated within a range of $9.00 to $11.00 per square foot per year (including capital cost). This compares with $9.00 to $12.00 currently paid in the Augusta area and $10.00 to $13.00 currently paid in the Bangor area for leased space.

TIME FRAMES

It would take five to ten years to accomplish any of the above options, considering the time to finance, design, construct, and move. However, time will vary, depending upon the option selected.

ECONOMIC IMPACT OF VACATING LEASED SPACE

Approximately $4,000,000 per year would be removed from the private leasing business in the Augusta area and $1,300,000 per year from the Bangor area if all leased space was vacated and replaced by renovated space. This would result in a considerable impact on the economies of these areas. Another necessary consideration is scheduling that would allow reasonable time for adjustment by private sector lessors. This may involve consideration of timing relative to the statewide economy.

ENVIRONMENTAL IMPACT

This preliminary study does not address the possibility of having to do on-site, perimeter and off- site improvements to accommodate increased traffic which may be required under the site

location statutes of DEP as a result of change of use. Concentrating office space on one side of the river in Augusta may require off-site improvement in the transportation system. BMHI is located near arterial highways and should pose less of a problem in this regard.

The large areas required for parking might cause some resistance to permit approvals for environmental considerations. These alternatives will require as many as 1,300 new parking spaces on either campus, or about ten acres of land. A parking garage should be considered in Augusta, or very careful screening required to reduce the visual impact from the State House.

CONCEPT OF BUILDING A NEW MENTAL HEALTH BUILDING AT BMHI OR AMHI

A new building(s) could be constructed at either BMHI or AMHI.

Construction of any buildings on the BMHI grounds will most likely be challenged by the West Side neighborhood group. While they have no statutory authority they are very active politically.

Construction of a new mental health building at AMHI would probably cause encroachment on the Piggery Road area and would most likely meet resistance from public interest groups.

MAINTENANCE FUNDING AND STAFFING

Consideration of such funding and staffing is critical to the successful implementation of a consolidation program.

CONCLUSION

The estimates of cost in this report are preliminary and should not be used for budgeting of project costs. Further study by a consulting Architect/Engineer should be done to bring the projects(s) to concept stage with accurate preliminary total project budgets. This step is necessary before project funding is requested. Funds in the amount of 1.5% of the anticipated construction amount should be made available for the concept study. Once the scope of a program is defined we can advise you on the structuring of A/E concept fees.

RECOMMENDATION OF THE BUREAU OF GENERAL SERVICES

Option #4 makes the most complete use of both campuses, but it requires more funding relative to other options. Option #3 may allow consideration of developing a phased approach. Phase one might be the immediate consideration of (175 beds) on one campus or the other, dependent upon immediate needs and recommendations of Department of Mental Health.

Phase two should include seeking an appropriation to fund a complete study by a consulting professional and a long-range plan for maintaining uninhabited buildings while undertaking gradual renovations as funding becomes available.

JHK:prs

pc: H. Sawin Millett
Dale Doughty

ATTACHMENT "A"

(Computation of costs of owning and operating office space at AMHI and BMHI)

Capital cost to renovate
($100/Sq. Ft. depreciated over 40 years) = $2.50

Debt service at 6%, 10 year bond amortized over 40 years = $0.90

Repairs = $2.00

Maintenance (heat lights, snow plowing, janitorial etc.) = $3.70

Total cost per Sq. Ft. per year = $9.10

ASSUMPTION:

For the purpose of preliminary analysis, we will use $9.00 to $11.00/Sq. Ft./Yr.