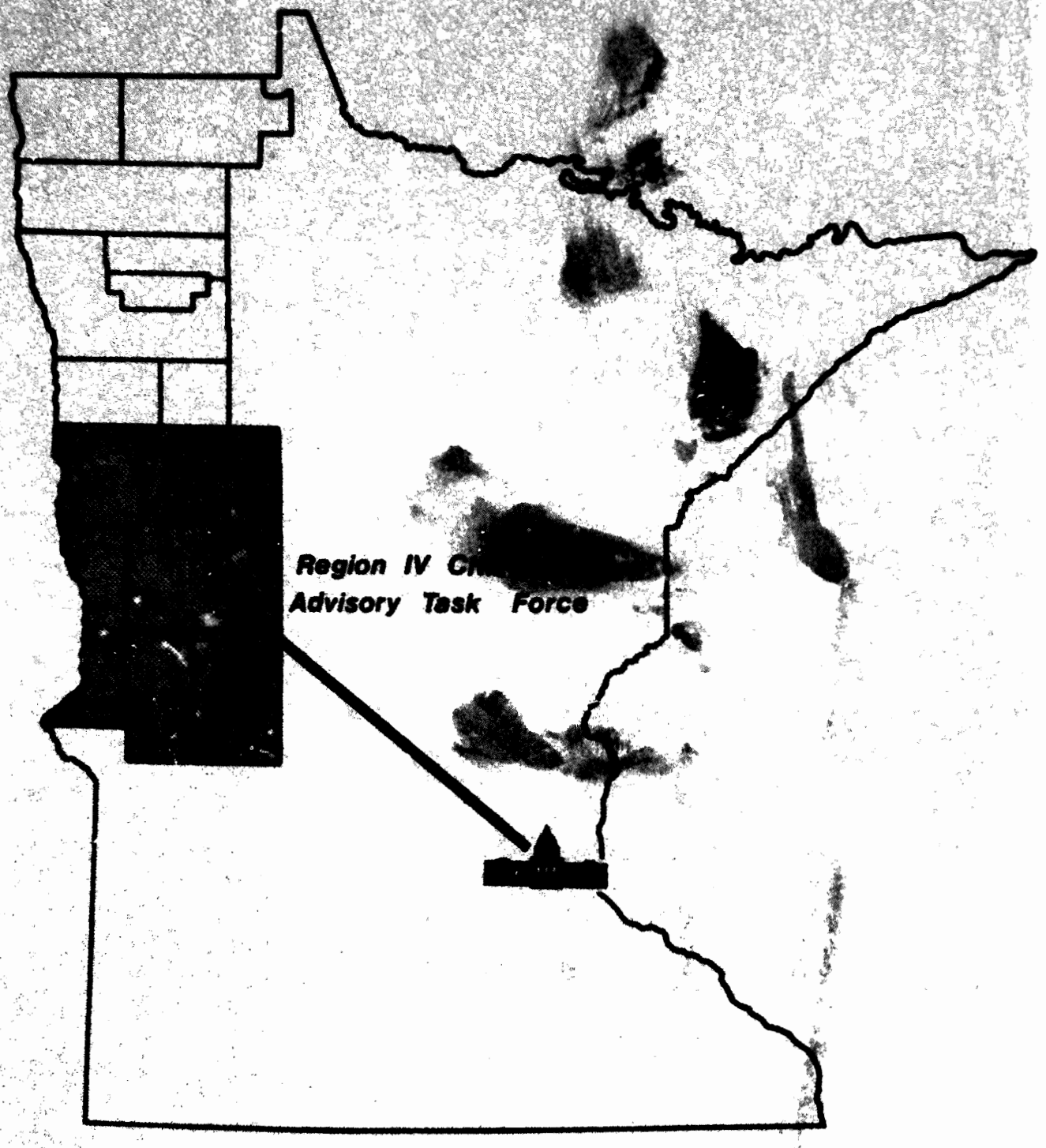
Fergus Falls State Hospital Study
Final Recommendation To The
Minnesota State Legislature



West Central Regional Development Commission

(2) FERGUS FALLS STATE HOSPITAL STUDY

FINAL RECOMMENDATIONS TO THE MINNESOTA LEGISLATURE

Region IV

State Hospital Task Force

(1) West Central Regional
Development Commission

Fergus Falls, Minnesota

(3) January, 1977

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ABSTRACT

The overall goal for mental health care in Region IV is to develop and implement a regional mental health delivery system which provides a full range of services to citizens of the area in service sites which are as close to the individual's home community as practical, within the constraints of quality of care and economic efficiency. The regional mental health delivery system would be planned, controlled, and operated locally so that the appropriate level of quality mental health services would be available to the area citizens in a responsive and responsibile manner.

Within the framework of this overall goal, the Region IV State Hospital Task Force, has documented the need to continue the Fergus Falls State Hospital and its services to the mentally ill, developmentally disabled and chemically dependent. The Hospital, however, must be developed and operated as an integral part of the mental health delivery system which exists within the Hospital's defined geographic catchment area - the 17 counties of Northwest and West Central Minnesota. As an element of the local mental health delivery system, the Fergus Falls State Hospital must be able to assume new roles and funtions and to develop service programs in direct response to the needs of the citizens it serves, as defined through a local mental health planning process.

In order to develop and implement the comprehensive, regionally based mental health delivery system and integrate the Fergus Falls State Hospital into this service system, the Region IV State Hospital Task Force recommends the following legislative actions.

1. State recognize the Region IV Area Mental Health Board as the local authority for development (over the next four years) of a model regional mental health delivery system in West Central Minnesota. Responsibilities of Area Board to include regional mental health planning, program development, decisions on program funding, and evaluation.

2. State delegate authority for administration of the Fergus Falls State Hospital to Region IV Area Board through a management services contract, in order to formally integrate Hospital services with the existing mental health delivery systems in the Hospital catchment area.

3. State allocate existing mental health service monies directly to Region IV Area Board for development and operation of the regional system. State delegate to Area Board control of the existing mental health service monies for Region IV and permit flexibility in the use of these funds within broad standards and guidelines established by the State.

4. Over the four years of the model period, State delegate control of any new monies appropriated for mental health services in West Central Minnesota to Region IV Area Board for incorporation into the model regional system.

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INTRODUCTION

The Fergus Falls State Hospital Study was initiated in August, 1975 in response to legislation calling for recommendations from the local community on the future role and functions of the Fergus Falls State Hospital. The Northwest (Region I) and West Central (Region IV) Regional Development Commissions each received $50,000 for conduct of the Study. State Hospital Task Forces were appointed by the respective Regional Development Commissions in accordance with membership requirements agreed upon by the Department of Public Welfare. The 15-member Task Force for Region IV consists of a county commissioner from each of the nine counties in Region IV, and representatives of the county social service departments, Lakeland Mental Health Center, Fergus Falls State Hospital, Department of Public Welfare and the West Central Commission.

From the outset, the Region IV Task Force recognized that it would be impractical to consider only the Fergus Falls State Hospital in its study design since the future roles and functions of the Hospital must be related to the many other agencies and organizations in Region IV that provide mental health care. The study, therefore, was based on the following principles:

1) that the Fergus Falls State Hospital is a regional mental health service provider;

2) that the Hospital, as an integral part of the regional mental health system, must be able to complement other service providers in the region and respond to the unique service needs of the area which it serves; and

3) that decisions to change the roles and functions of the Fergus Falls State Hospital will have a direct and immediate impact on the existing mental health services in Region IV.

For purposes of the Study and this report, the term "mentally handicapped" refers to individuals whose functions are limited because of mental illness, emotional disorder, mental retardation and other developmental disabilities and chemical dependency. The term "mental health system" refers to the full spectrum of services that can be associated with a mental health problem, ranging from prevention programs to residential care and aftercare programs.

The study design has attempted: (1) to analyze the problems in mental health service delivery; (2) to identify the needs for a full range of mental health services for the citizens of Region IV; (3) to define the future roles and functions of the Fergus Falls State Hospital within the broad framework of the Region's mental health delivery system; and (4) to clarify the Hospital's relationship to and to further integrate Hospital services with other mental health service providers in the Region.

Since representation on the Task Force was limited, the work program for the study was designed to include the involvement of a wide range of community organizations, agencies and individuals in each step of the process. Approximately 200 individuals representing a cross section of

elected officials, mental health providers, other health and social service providers, parents and relatives of mentally handicapped individuals and concerned citizens were involved in developing this report through a series of structured group sessions. These sessions were used to identify problem areas, define the Region's mental health goals and suggest alternative ways that the mental health system can be improved. The consistency in response among these various groups indicated a strong regional consensus on how mental health services in Region IV should be developed.

A detailed description of the study work program and the overall Regional goals for mental health services are contained in the Region IV Interim Report to the Minnesota Legislature, January, 1976. This final report contains a summary of the study findings and the recommendations to the Legislature for consideration and adoption.

OVERVIEW OF REGION IV

Region IV consists of nine counties in West Central Minnesota: Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse and Wilkin. The area is primarily rural with only the cities of Moorhead and Fergus Falls having over 10,000 population. The Region encompases 8,615 square miles with a total population of 191,621 in 1975.

It has been estimated that approximately 20 percent of the population could be mentally handicapped at some point of time in their life. For purposes of this study, the term "mentally handicapped" has been defined to include the following types of individuals: mentally ill or emotionally disturbed; developmentally disabled including individuals with mental retardation, cerebral palsy, epilepsy and other neurological handicaps; and chemically dependent including alcoholics and other drug abusers. Detailed estimates of the number of individuals who may be afflicted by the disability by county of residence have been calculated for the years 1975 and 1980. (See Table 1) Several cautions must be raised concerning the disability estimates. (1) Since the figures are based on national rates they therefore, reflect the maximum number of individuals who, because of their disability, could require services from the mental health system. They do not necessarily reflect the actual number of people who would seek care. (2) The total figures may be inflated because they are not mutually exclusive (i.e. individuals may have several disabilities and are counted in each disability category.) (3) National estimation formulas do not take into consideration the specific geographic and social characteristics of the local area, which may serve to inflate or reduce the figures as reported. (4) The estimates cannot reflect changes in the number of individuals who may seek or need services as a result of state and local statute requirements such as mandatory referral to treatment for persons convicted of driving while intoxicated offenses.

TABLE I

SUMMARY OF MENTAL HEALTH POPULATION ESTIMATES BY CONDITION AND COUNTY, 1975-1980

County	Total County Population		Mentally Ill and Emotionally Disturbed 1)		Developmentally Disabled 2)		Chemically Dependent 3)	
	1975	1980	1975	1980	1975	1980	1975	1980
Becker	25,196	25,635	2,520	2,564	1,361	1,385	1,310	1,333
Clay	49,044	51,787	4,904	5,179	2,648	2,797	3,139	3,314
Douglas	24,495	25,950	2,450	2,595	1,323	1,402	1,372	1,453
Grant	7,531	7,287	753	729	407	394	429	415
Otter Tail	47,176	46,961	4,718	4,696	2,548	2,536	2,642	2,630
Pope	11,179	11,168	1,118	1,117	604	603	626	625
Stevens	11,499	11,583	1,150	1,158	621	625	678	683
Traverse	6,121	5,923	612	592	330	320	324	314
Wilkin	9,380	9,289	938	929	507	502	516	511
Region IV	191,621	195,583	19,163	19,559	10,349	10,564	11,036	11,278
% of Change	+2.1%		+2.1%		+2.1%		+2.2%	

1) Based on 10 percent of the population
2) Based on the following estimation formulas: Mentally retarded - 3 percent of population
   Cerebral Palsied - 0.4 percent of population
   Epileptic - 2 percent of population
3) Estimated number of problem drinkers based on estimation formula of the National Institute of Alcoholism and Alcohol Abuse.

Within Region IV there are approximately 100 different agencies and organizations who provide some level of services to the mentally ill, developmentally disabled and chemically dependent. These mental health service providers range from informal voluntary citizens organizations to formal intensive treatment programs. There are, however, three organizational structures which provide almost all of the primary level care for the mentally handicapped. These are the Fergus Falls State Hospital, the Lakeland Mental Health Center, and the County Social Service Departments.

The Fergus Falls State Hospital was organized in 1887 as an inpatient treatment facility for the mentally ill. At its peak, the Hospital housed approximately 2,000 patients; however, during recent past years the annual census at the Hospital has been between 500 and 550. At present, the Hospital serves the mentally ill, mentally retarded and chemically dependent who reside in the Hospital's 17-county service area in Northwestern Minnesota. All nine counties of Region IV are included in the Hospital service area. Region IV residents account for 61 percent of the Hospital's average daily patient load and 77% of all hospital admissions. This utilization pattern may indicate that: 1) the proximity of the Hospital to Region IV generates greater utilization for admissions; 2) the greater development of community facilities in Region IV has resulted in a lower percentage of resident population of certain long term residents.

The Lakeland Mental Health Center is a private, non-profit corporation providing a full range of outpatient consultation and education mental health services persuant to the Minnesota Community Mental Health Centers Act. The Center's service area consists of the 9 counties in Region IV. The bulk of the Center's services are provided in the main facility in Fergus Falls. However, offices are maintained in Moorhead, Breckenridge, Alexandria, Detroit Lakes, White Earth, and Morris. During FY 1974-75, the Center served approximately 3,600 individuals for a total of over 12,000 visits.

The County Social Service Departments have basic responsibility to establish and oversee implementation of a continuing social and rehabilitation plan for each person with a statutorily defined mental handicap. The County Social Service Departments can provide, arrange for or fund the full array of services for the mentally ill, developmentally disabled and chemically dependent. Services generally provided directly by each county department include counseling, social rehabilitation, follow-up, protective service, information and referral, public information and consultation to other agencies. As the need arises, transportation may also be provided directly.

PROBLEMS AND ISSUES IN MENTAL HEALTH SERVICE DELIVERY

During its study of mental health services over the past year, the Region IV State Hospital Task Force has identified a long list of problems and needs. Many of these reflect specific problems faced by individual provider agencies (eg. group homes forced to expend large amounts of money for remodeling to conform to revisions in licensing regulations). Other problem areas refer to the more basic issues underlying the problems in mental health service delivery in Minnesota. It is the position of the Region IV Task Force that attention to the individual, operational problems constitutes a "band aid" approach to improving mental health care in our Region and the State as a whole. It is more realistic (and so much more difficult) to address the problem at its cause and make necessary changes in the basic system of mental health care. For this reason, the Task Force's final report concentrates on the basic, underlying problems within the mental health system as a whole.

Coordination of Services into a System of Mental Health Care

The State of Minnesota, through legislation and departmental rules and regulations, has provided for the development and funding of a variety of mental health programs and services. These services range across the broad spectrum of mental health care including such things as inpatient care through the State Hospital system, outpatient care through community mental health centers and county social service agencies, residential care such as group homes and halfway houses, and other community-based services such as detoxification programs, and day activity centers. There currently exists in Minnesota, statute or regulatory authority for providing nearly all needed services for the mentally ill, developmentally disabled and chemically dependent. Yet, despite this potential, there still does not exist in Minnesota a formally integrated system of mental health care. There are several examples, both in Region IV and across the state, of efforts to relate each of the mental health service components to each other. These efforts must be continued, and more importantly, must be expanded and formalized so that mental health services can, in fact, be integrated into a unified system of mental health care. Such formal integration of services is hampered by the lack of clearly defined responsibility, relationships and authority for the Legislature, the State departments, and community mental health service providers.

In the absence of an integrated mental health system, programs and services are often developed, funded, controlled and, to a large degree, operated as separate and distinct programs isolated from each other. Each service component is defined in separate legislation which outlines the basic principles behind the service. When viewed alone, the legislation appears to be appropriate and defensible. However, when viewed collectively, obvious gaps and duplications in services and other potential problem areas become visible. Often the various mental health programs are in competition with each other to capture the limited dollars that are available. There are no incentives for these service programs to work together to improve mental health care in the community, in the region or in the state.

At the state level, a variety of agencies have been assigned some level of responsibility in the area of mental health. (eg. the Department of

Public Welfare, Department of Health, Department of Corrections, State Fire Marshall, etc.). It will be difficult, if not impossible, to formally integrate mental health service delivery until mechanisms for interagency and intra-agency coordination are established at the state level. Efforts to improve operation of the State bureaucracy must address the general responsibilities and authority of each agency and its relationship to other state agencies as well as to regional and local service providers. In addition, state reorganization efforts should clearly define and perhaps redefine state agency roles and functions to include only those activities which are appropriate at the state level. Specifically, the state agencies should be concerned with such things as development of integrated funding, technical assistance, standard-setting and routine fiscal monitoring. The responsibility for need identification and service delivery should be left to local government.

Local Involvement in Mental Health Decision-Making

Counties and local communities have little opportunity to participate in the decision-making process and to exercise control over the development of mental health programs in response to community needs. For example, over the past years the state has provided the impetus for the development of community-based services. However, the funding guidelines for such services have been accompanied with definitive instructions on the types of programs which should be established. These State guidelines for community programs are based on generalized needs which may or may not be appropriate to a specific geographic area within the state. It is difficult for State agencies to be cognizant of the unique needs of an area and to take into consideration these often conflicting local needs when developing statewide guidelines. When decision-making and funding authority is vested at the state level, local communities often are forced to establish programs which fit statewide guidelines rather than develop services which are more appropriate to the local needs. A local mental health delivery system is closest to the citizens it serves, can keep aware of the changing needs in the local area and, therefore, can be responsive to the unique needs of its citizens.

The Community Mental Health Center Act outlines a strategy and defines an organizational structure to help resolve this problem of differing local needs for mental health services. The legislation creates Area Mental Health Boards and vests in these Boards the responsibility for planning for comprehensive services for the mentally ill, mentally retarded and chemically dependent. The law further requires the Area Board to see to the development of needed mental health services. However, while it is the responsible agent, the Area Board does not have the authority to actually initiate and fund needed new services. These fiscal decisions are retained at the State level. Area Boards, therefore, are unable to fully exercise their powers under the law.

The State can and should assure the availability of a minimum range of services at the local level. These services, however, should be provided in accordance with local community needs identified through the local mental health planning process. The structure for assuring responsible and responsive local mental health services already exists in the Area Mental Health Boards. However, the State must recognize the Area Board's responsibility to plan, develop, implement, administer and evaluate mental health services at the local level and delegate to the Area Board

the authority to actually carry out its responsibilities to the fullest extent. This would require that mental health service monies be allocated to the Area Board, as the local mental health authority, with the provision that the Area Board has flexibility to utilize the funds within broad state guidelines to establish and support programs identified as priority services in the area mental health plan.

It is often argued that under such delegation of authority, the State would not have the means to assure that the monies are spent appropriately. Questions of whether or not local authorities can be held accountable are inappropriate since the State currently has a variety of mechanisms to demand accountability for funds returned to the local area. These include such things as the state audit system, licensing and certification requirements for mental health facilities and staff. Accountability can be maintained through these existing regulatory functions of the State.

Financing of Mental Health Care

Mental health services are financed through a variety of public and private sources. The bulk of the monies available for services for the mentally ill, mentally retarded and chemically dependent are public dollars. Federal and state funds are usually appropriated on a categorical basis with strict controls over how the monies can be used. This categorical approach to funding often denies local areas the opportunity to develop services which are truly needed. Funding patterns under the present system too often determine the kind of care an individual receives (i.e. the State Hospital is the cheapest resource for local units of government so it is used whether or not it is the most appropriate place). Changes are needed in the way funds are appropriated and administered so that a full range of needed services can be developed.

Traditionally, the responsibility for care and treatment of the mentally handicapped has been vested in the public sector with the Federal, State and local governments each having some defined responsibility. Therefore, responsibility for financing mental health services must be shared among these three levels of government. In particular, a workable and trusting partnership needs to be established between the state and local governmental units. The level of funding responsibility for each governmental unit must be clarified, based on given constraints. Since mental illness, mental retardation and chemical dependency are statewide problems for which the entire state has responsibility, it seems appropriate that the State should have major funding responsibility. Counties should be required to participate in funding mental health care through reimbursements for patient care under existing county welfare operations. Additional county funding from general county revenues is limited because of imposed levy limitations. Although county welfare budgets are not affected by levy limitations, counties are still hampered in their efforts to generate the large amounts of money necessary to provide mental health services.

Because mental health care is expensive, it will be necessary to continue to expand funding sources in the private sector. Health insurance companies operating in Minnesota must be encouraged to broaden their benefit packages for mental health services and citizens must be encouraged to participate in such benefit programs.

ROLES AND FUNCTIONS OF THE STATE HOSPITAL WITHIN THE CONTEXT OF A REGIONAL MENTAL HEALTH SYSTEM

The findings of the Region IV State Hospital Task Force point out the need to insure that quality, comprehensive and responsive mental health services are available to the residents of West Central Minnesota. It is the right of our citizens to expect a full range of services for the mentally ill, mentally retarded and chemically dependent to be provided through a coordinated system of public, private and voluntary agencies. These services should be available as close to the individual's home community as practical, within the constraints of quality of care and efficiency and economy of program operation.

The development of needed mental health services must assure that mentally handicapped individuals receive the appropriate level of care at the appropriate time in the appropriate setting. The ability to define needs and develop services which are specific to a given population in a defined area of the state such as Region IV is enhanced when there exists a local structure which has the responsibility and authority to control the development and funding of mental health services. Local control results in more responsive mental health care since the local level is the most accessible level for the citizens.

In a predominantly rural area like Region IV where sparse populations are distributed over a large geographic area, and where 80% of our towns have less than 1,000 population, a regional mental health authority appears to be the most effective level of control. Mental health problems, in this setting, transcend county boundaries. The necessary resources to solve our mental health problems must often be provided through regional facilities since the small size of the counties and the limited professional staff and financial resources at the county level would preclude the development of quality and economical mental health services. The regional administrative framework, therefore, provides sufficient size to insure effective administration, while at the same time it remains small enough to be aware of the constantly changing needs and problems in the service area and to respond to these needs in a timely and responsible manner. Through local administration, the mental health service delivery system would be able to respond to the service needs of our area as they arise and, if the local mental health authority had decision-making powers, it would be in the position to make internal adjustments in the mental health system budget to accomodate these needed changes.

The mechanism for implementing a locally-controlled mental health service delivery system already exists in Minnesota through the Community Mental Health Center Act. Under this legislative authority, the Area Board is required "to provide comprehensive service for the three disability groups of mentally ill, mentally retarded and chemically dependent by directly administering such services or in other ways insuring their delivery." The scope of services to be provided by the Area Board include as a minimum the following services:

(1) Collaborative and cooperative services with public health and other groups to purposes of prevention of mental illness, mental retardation, alcoholism and other psychiatric disabilities;
(2) Informational and educational services to the general public and lay professional groups;

(3) Consultative services to schools, courts, health and welfare agencies, both public and private;
(4) Outpatient diagnostic and treatment services;
(5) Rehabilitative services for patients suffering from mental or emotional disorders, mental retardation, alcoholism and other psychiatric conditions, particularly those who have received prior treatment in an inpatient facility;
(6) Detoxification and alcoholism evaluation and service facilities.

Under the law then, the Area Board must see that a full range of services are available in Region IV, but is not required to actually provide the services.

In fulfilling its legislative mandate, the Area Mental Health Board is responsible for the following functions:

(1) Implement, operate or assist in the establishment of programs in mental health, mental retardation and inebriety and other psychiatric disorders;
(2) Assure delivery of appropriate services for these disability groups;
(3) Plan and coordinate all programs and services, in both the public and private sector, in the areas of mental health, mental retardation, inebriety or addiction problems and other psychiatric disorders;
(4) Review and evaluate community mental health programs and provide such reports and recommendations to the Commissioner of Public Welfare and the general public;
(5) Seek out and promote multi-source funding for programs and services for the disability groups;
(6) Promote the development of 3rd party payment systems;
(7) Develop specific working agreements with social service agencies, both public and private, and educational and judicial agencies;
(8) Review and approve all plans and budgets for community mental health, mental retardation, inebriety and other psychiatric disorder programs;
(9) Encourage and assist innovative private treatment programs.

The Area Mental Health Board, then, is the central focus for comprehensive planning and identification of mental health needs, for development and/or delivery of a full range of mental health services, for resolution of problem areas in mental health, and for overall evaluation of the mental health system. It should be the single, identified authority in the Region and as such would serve as a resource for county commissioners, and other public and private mental health and related service providers. The Area Board does not usurp the powers, authorities and responsibilities of the County Welfare Boards or private mental health providers, but provides the mechanism whereby services can be integrated into a system of mental health care and be more effectively coordinated.

Within this context of a regional-based, and regionally controlled mental health service system, the Region IV Task Force assessed the current status of the Fergus Falls State Hospital and evaluated the Hospital's potential future roles and functions. Although the State refers to the Fergus Falls State Hospital as a Regional facility, the State definition of "regional facility" differs from that of the Task Force.

As indicated in the introduction, the Fergus Falls State Hospital Study was based on three basic premises:

- that the Fergus Falls State Hospital is a regional mental health service provider;
- that the Hospital, as an integral part of the regional mental health delivery system, must complement other existing mental health service providers and respond to the particular service needs of the area; and
- that decisions to alter programs at the Hospital will have a direct and immediate impact on the other mental health resources in the area.

Under our interpretation, then, the Fergus Falls State Hospital should focus on the communities within its catchment area and their needs, rather than focus on the Department of Public Welfare and the needs of the state as a whole.

Under current legislative and Department of Public Welfare policy, however, the term "regional hospital" essentially refers to a geographic area of the state from which the Hospital accepts patients. Staff authorizations and funds for support of the State Hospital are based on and limited to a pre-defined set of services required by the inpatient population at the facility. It is difficult for the Hospital to establish specialized inpatient programs which are unique to the needs of the citizens in its catchment area Likewise, Hospital services cannot be used to supplement needed services for non-hospitalized individuals who reside in the Hospital's catchment area.

The findings of our Study and the recommendations which follow are based on the goal to develop a local system of mental health care which provides a full range of service as close to the individual's home community as is practical. Inpatient care, whether provided through the State Hospital system or through private facilities, is an essential part of the continuum of mental health care. State Hospitals, therefore, should be integrated into the total system of community mental health services rather than be operated as separate and isolated treatment programs. Lack of integration between the inpatient and outpatient components of the mental health system has tended to enforce the public misconception of state hospitals as final "dumping grounds" for the mentally handicapped, rather than as essential service components of the system at a regional level.

Service integration can lead to the development of innovative mental health programs and services since the professional expertise that currently exists in the inpatient and outpatient sectors can be pooled. Under the present patterns of funding and administration of inpatient and outpatient services as separate entities, it is difficult for the individual service components to implement new and creative programs. Opportunities for consultation, staff development and training within the total mental health system can be expanded to insure an adequate supply of appropriately trained mental health personnel for the development of additional community-based programs. Service integration can lead to more efficient and effective use of available staff, provide opportunities for staff-sharing in the development of new services, and provide the means to eliminate costly duplication of effort. These improvements in the functioning of the mental health system should result in better patient care for the mentally ill, mentally retarded and chemically dependent.

The ability of the State Hospital to respond to the particular service needs of its 17 county catchment area will require a change in existing state funding and programming policies. Flexibility in Hospital administration is essential so that new roles and functions can be implemented, based on mental health needs identified through a local planning process. The ever-changing role of the Hospital, however, should be coupled with the growth and development of community-based mental health programs and/or facilities. It is anticipated that a defined transition period would occur during which the communities would continue to establish local programs and/or facilities, and the State Hospital would alter its programs to correspond with such community development activities.

As needs change, the Hospital would develop new roles and functions. Precisely what these new roles and functions are would depend upon such factors as: (1) the unique mental health problems in the 17 county Hospital catchment area; (2) the area's interest and ability to develop community-based alternatives; and (3) the proximity of the Hospital to the area citizens. The location of the Hospital in Fergus Falls will no doubt result in increased usage by the residents of Region IV and perhaps create a greater demand for the Hospital to provide mental health services to residents and provider agencies in the nine counties of West Central Minnesota. Care must be taken, therefore, to insure that the Hospital quarantee continuation of a quality inpatient program which meets the requirements of state law such as the Minnesota Hospitalization and Commitment Act prior to developing new roles and functions in its catchment area.

Program flexibility within the service components of a regional mental health system must be accompanied by flexibility in funding. Mechanisms must be developed to break down the barriers to flexibility imposed by existing categorical funding patterns. Mental health budgeting must allow for funds to be channeled into program areas which are defined as priority needs in the local planning process. As programs are developed and as the roles of the State Hospital and other service providers change, there must be a corresponding shift in mental health budgeting to allow for funds to be transferred between the service components (for example, from the Hospital budget to community programs or from community programs to the Hospital, depending on each one's newly-defined roles).

DETAILED RECOMMENDATIONS

In order to respond to the problems outlined in previous sections and to develop a comprehensive, regionally-based mental health delivery system, the Region IV State Hospital Task Force makes the following recommendations. These recommendations take into consideration the facts that: (1) the Hospital catchment area consists of 17 counties in northwest and west central Minnesota; (2) Regions I and IV are committed to similar overall mental health goals as described in the coordination report; (3) Regions I and IV differ in the strategies each identifies as necessary in order to achieve the common goals; and (4) Region I does not wish to participate in regional management of the Fergus Falls State Hospital. For these reasons, the recommendations are written to conform to the existing service structure in Region IV, but could easily be expanded to include the entire 17 county catchment area.

1) Over the next four (4) years, develop a model comprehensive mental health delivery system in Region IV in which authority for mental health planning, program development and funding, service delivery and evaluation is vested in the Region IV Area Mental Health Board.

2) In the model system, develop a clearly defined partnership between the State and the Region IV Area Mental Health Board in order to formally integrate inpatient and residential services provided through the State Hospital with outpatient and community-based services in Region IV. Such service integration to be accomplished by the State delegating to the Region IV Area Mental Health Board responsibility for operation and management of the inpatient care services for the mentally ill, mentally retarded and chemically dependent at the Fergus Falls State Hospital through a management services contract. During the 4 years of the model period, the State shall maintain ownership of and financial responsibility for the Hospital, but shall not be directly involved in operation and management decisions on a daily basis.

3) State shall enter into an agreement with the Region IV Area Mental Health Board to assist in the development of the model regional mental health system through: (1) provision of funding for development and operation of the system for a period of four (4) years; (2) provision of consultation and technical assistance to Region IV Area Board as necessary. Funding of the regional model requires that the State delegate control of mental health services monies and decisions on program funding to the Region IV Area Mental Health Board and permit flexibility in the use of these funds within broad standards and guidelines established by the State.

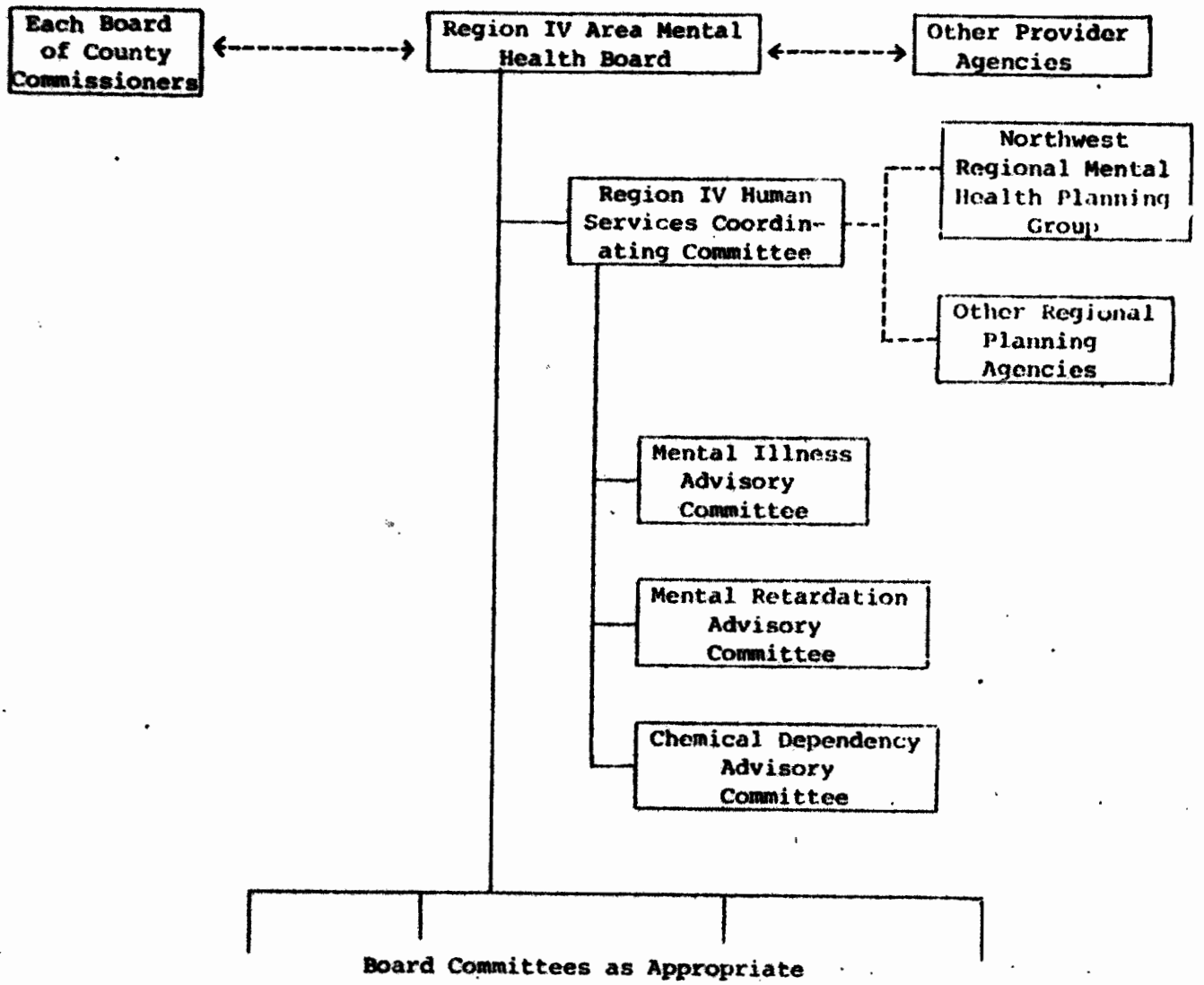
4) Over the four (4) years of the model period, the State shall delegate control of any new monies appropriated for mental health services to the Region IV Area Mental Health Board for incorporation into the model regional mental health system.

5) In implementing the model system, the Region IV Area Mental Health Board shall keep necessary data and records to allow the Legislature to evaluate the cost and benefits derived from providing a full range of integrated mental health services at a regional level.

Documentation will include such data as: improvements in patient care; efficiencies of centralized planning administration and funding of mental health services at the regional level; measurements of cost affectiveness resulting from integration of services.

A detailed description of these recommendations, their impact on the existing system, and a description of the proposed mental health system and its functions is presented below. Figure 1 contains the organization chart for the Region IV Mental Health System.

Figure 1
REGION IV MENTAL HEALTH ORGANIZATIONAL MODEL



Mental Health Planning

One of the prerequisites to successful regional control of mental health services is the development of an effective mental health planning program. Planning can and must be conducted at various levels. For purposes of the model, we have defined three distinct types of mental health planning: (1) community (regional) planning; (2) program planning; and (3) individual (patient) planning. A description of these levels of planning and their interrelationships are discussed below.

Community (Regional) Planning

The focus of community mental health planning is on the needs and problems of the mental health system as a whole within defined geographic boundaries. Community planning activities include: (1) identification of mental health problems and needs for the region and each county; (2) exploration of alternative ways to meet identified needs and to solve problems in the mental health system; (3) identification and analysis of existing and potential funding sources for mental health services; (4) establishment of priorities for mental health program funding based on identified local needs; (5) development of a data and information system to support planning activities; and (6) on-going evaluation and monitoring of the mental health system.

The Region IV Human Services Coordinating Committee shall serve as the community mental health planning body for West Central Minnesota and shall conduct the planning activities described above. The Coordinating Committee reports to and receives direction from the Region IV Area Mental Health Board. The Coordinating Committee is a recommending body which develops plans and submits them to the Area Mental Health Board. The establishment of priorities and decision-making on funding and program development remain the responsibility of the Area Mental Health Board.

The membership of the Coordinating Committee will consist of the major public and private agencies involved in mental health and related social services. The composition shall include the following:

Each County Social Service Department
Lakeland Mental Health Center
Regional Association of Retarded Citizens
Day Activity Center Directors Association
Fergus Falls State Hospital
West Central Regional Development Commission
Minnesota Department of Public Welfare
Minnesota Department of Health
Minnesota Department of Corrections
Minnesota Department of Education
Minnesota Department of Employment Services
Minnesota Division of Vocational Rehabilitation
One Representative of Community Residential Facilities
One Representative of the County Veterans Service Officers
One Representative of County Public Health Nurses
One Representative of Local Mental Health Associations
One Representative of Chemical Dependency Halfway Houses
One Representative of Sheltered Workshops
One Representative of Legal/Judicial System

The Coordinating Committee will seek citizen input in the planning process through three Advisory Committees in the areas of mental illness, mental retardation and developmental disabilities, and chemical dependency. The existing Advisory Committees of the Lakeland Mental Health Center and the Fergus Falls State Hospital will be combined to form the new Advisory Committees. In addition, the planning activities of the Coordinating Committee will be coordinated with other planning programs functioning in Region IV including those of the Regional Development Commission, each County Social Service Department and Min-Dak Health Systems Agency.

To insure that the management and operation of the Fergus Falls State Hospital is responsive to the needs of the citizens of northwest Minnesota, a formal relationship will be established between the Mental Health Planning group in Region I and the Region IV Human Services Coordinating Committee. A uniform planning process and plan format will be established to insure planning consistency throughout the Fergus Falls State Hospital catchment area. Both Regions I and IV will define needs and establish priorities for mental health services at the local, regional and catchment area levels. The Region IV Area Mental Health Board, as the manager of the Fergus Falls State Hospital, guarantees to meet the needs for specialized services at the Hospital as defined by the regional plans. In addition, each regional plan will certify the projected number and type of patients expected to receive services at the Fergus Falls State Hospital in succeeding year, and will define the appropriate roles and functions of the Fergus Falls State Hospital in order to meet identified regional needs. The Region IV Area Mental Health Board will develop (in cooperation with the Department of Public Welfare) the following year's budget for the Fergus Falls State Hospital based on the projected use identified in the regional plans. The funds associated with reductions or expansions in use of the Hospital by either Region I or Region IV shall be diverted to or from the Hospital or community services budget as appropriate.

Program Planning

Essentially program planning includes those internal agency activities necessary to develop or continue a specific service program. Program planning in mental health is the responsibility of each mental health provider agency. It includes such things as identification of the component elements of the service program, determination of staff requirements, development of the program budget, identification of appropriate location, hours of operation, etc. for the service, and monitoring the program to assure quality of care and program effectiveness.

In on-going programs, mental health provider agencies conduct program planning as part of their routine administrative practices. As new needed services are identified through the community mental health planning process, the Region IV Area Mental Health Board will identify appropriate community agencies to develop needed new programs and assist these agencies in program development planning and implementation, if necessary.

Individual Planning

Individual (patient) planning in mental health is the development of the specific treatment plan for the client of any mental health program.

The development of such a plan is the responsibility of the mental health professional(s) providing the service in cooperation with the patient. Individual patient plans can be viewed as a road map for a client's course through treatment or service delivery with clearly defined outcome measures for success.

Mental Health Service Delivery

The organizational model outlined in Figure 1 provides local elected officials the opportunity to become more directly involved in mental health decision-making. It builds upon the strength of existing organizational structures and redefines roles and responsibilities to allow for more local flexibility in the development and funding of mental health programs.

The proposed organizational model for the regional mental health service delivery system assigns authority and responsibility for mental health care to the Region IV Area Mental Health Board. The scope of responsibility and the duties of the Area Board will continue to be those outlined in the Community Mental Health Services Act (see Chapter 4). The one essential difference, under the model, is that the Area Board will also have recognized and delegated authority, including funding authority, to carry out its responsibilities. In addition, the Area Board will have administrative control and responsibility for management and operation of both the inpatient programs at the Fergus Falls State Hospital and the outpatient programs at Lakeland Mental Health Center. The Area Board currently has administrative responsibility for the Lakeland Mental Health Center and will continue to operate the Center under the proposed reorganization model. However, we are recommending that the State, through the Department of Public Welfare, retain ownership and financial responsibility for the Fergus Falls State Hospital, but transfer responsibility and authority for administration and management of the facility, its services and staff to the Region IV Area Board through a management services contract. The details of this contract are outlined in the following section.Care will be taken to insure that the management services contract includes provision for maintaining clear accountability for administration of the Hospital budget to the Department of Public Welfare and the Legislature.

Other private mental health services such as day activity centers, the halfway houses for alcoholics, etc. would be coordinated with and related to the Area Board through working agreements and through membership on the Area Board's planning body - the Region IV Human Services Coordinating Committee.

Composition of the Region IV Area Mental Health Board

The Area Board has been incorporated as a private non-profit corporation under Minnesota and federal Internal Revenue Service Statutes. As required by recent amendments to the Community Mental Health Centers Act, the Area Board will consist of at least 18 members. The Boards of County Commissioners in each of the nine counties of Region IV shall appoint, at a minimum, one county commissioner and one lay representative to the Area Mental Health Board. Care will be taken to insure that the 18 member Area Board shall be representative of local health departments, medical societies, county welfare boards, hospital boards, lay associations concerned with mental health, labor, agriculture, business, civic and professional groups and the general public, as is now required by the Community Mental Health Centers Act. The Executive Director and the Directors of the inpatient and outpatient programs shall be

ex-officio members of the Area Board without voting privileges.

Appointments to the Area Board shall be for a term of three years. One-third of the terms of the membership shall expire each year. However, at all times, the Area Board will consist of a county commissioner from each county.

The Region IV Area Mental Health Board will establish committees as is necessary for the Area Board to carry out its responsibilities in planning, service delivery, and evaluation. In selecting membership for the committees, the Area Board will insure that each committee includes county commissioners and at least one representative from each county.

The Area Board will employ an Executive Director, Planning Coordinator and such other staff as it deems necessary for the proposed mental health system to function effectively. The existing staff of the Fergus Falls State Hospital and Lakeland Mental Health Center will be maintained intact under the new system and their rights and benefits will be recognized and guaranteed by the Area Board for the 4 years of the model period. The Area Board, as the authority for operation and management of inpatient and outpatient care, will direct staff as necessary to insure that services are provided as identified in the regional mental health plans.

Mental Health System Evaluation

In order to monitor the overall effectiveness of the regional mental health system, to collect baseline information against which the system can be compared and recommendations for improvement can be made, and to measure the success of the individual service components in meeting mental health needs in the Region, the Area Board will design and implement a comprehensive evaluation process. On-going self-evaluation of the Area Board, the Fergus Falls State Hospital and Lakeland Mental Health Center will be established as an integral part of the system administration and management. In cooperation with staff specialists within the Department of Public Welfare, common data collection forms and evaluation methodologies will be developed.

In addition, the Legislature may call for an independent evaluation of the Region IV model system during the 4 years of the model period. Such an evaluation could be provided by the Legislative Audit Commission or by an outside consultant and should include evaluation of both the regional system and the Department of Public Welfare, whose roles and functions would change under the proposed model.

Dissolution of Model System

The Region IV Task Force recognizes that unforeseen circumstances may arise during the course of the 4 year model period which can significantly affect the effective functioning of the regional mental health system (eg., major shift in federal funding for mental health services). Therefore, the agreement between the Region IV Area Mental Health Board and the State for operation of the regional mental health system shall include provision for termination of the agreement by either party at the close of each fiscal year during the model period, provided that 60 days notice of termination including statement of just cause for termination is given. Upon termination of the agreement, the mental health providers in Region IV (specifically

IMPLEMENTATION STRATEGIES AND RELATED BUDGET

Implementation of the recommendations and subsequent development of the Region IV comprehensive mental health systems shall occur through a three-phase transition process. The detailed activities of the appropriate state and local agencies and the corresponding budget requests are outlined below.

In developing the budget estimates, the Region IV Task Force anticipates that the inpatient service (hospital) and the outpatient service (mental health center) as described in the proposed new system will continue to be eligible for, and receive financial support from the sources which currently fund the Fergus Falls State Hospital and Lakeland Mental Health Center. These current sources of funding are as follows:

Inpatient		Outpatient	
State General Revenue	25%	State Grant-in-Aid	40%
3rd Party Reimbursement	75%	County Revenues	22%
		3rd Party Reimbursement	38%

Third Party Reimbursement includes: private pay; private health insurance; counties ($10/mo. under general assistance); counties (hold orders); federal Medicare; and medical assistance.

The current funding arrangements provide for the costs of mental health care to be provided through federal, state and local public revenues and through the private sector (insurance, patient billing, etc.)

Phase I. Development of Program Details and Negotiations with State for Implementation and Operation of the Regional System - January 1, 1977 - June 30, 1978.

RESPONSIBLE AGENCY	ACTIVITY	COMPLETION DATES
Organizational Activities		
1. Legislature	Pass enabling legislation to implement Region IV recommendations.	April, 1977
2. Area Board	Develop detailed position description for Area Board staff; recruit and employ staff.	July, 1977
3. Area Board	Identify and develop procedures to insure Area Board composition, legal structure and accounting system are in accord with state requirements to assure accountability for State funds to be administered locally.	January, 1978

RESPONSIBLE AGENCY	ACTIVITY	COMPLETION DATE
Organizational Activities		
4. Area Board & Northwest Region	Develop formal working relationships and agreements to insure coordinated planning, and guaranteed services for Northwest residents.	January, 1978
5. Area Board & DPW	Identify elements of agreement between State and Area Board for implementation of Management Services Contract. (Such elements to include: responsibilities of DPW in system implementation; maintenance of Hospital grounds in conformance with codes; total hospital operating budget for FY 1978-79 based on estimated usage as contained in Regional plans; provisions for collection and reimbursement of Area Board for services provided at FFSH; etc.	January, 1978
6. Area Board & Northwest Region	Establish service needs, and projected usage of FFSH by Regions I & IV residents. Develop detailed inpatient programs and budget necessary to meet Regions I and IV identified needs.	March, 1978
7. Area Board & DPW	Negotiate final agreement with State for implementation of model system including management services contract for FFSH and receipt of funds for community-based services.	April, 1978
8. Area Board, Region I and DPW	Establish agreements for transfer of supplemental funds generated by changes in utilization of the FFSH by Region I and/or Region IV, to the appropriate mental health authority in each Region.	May, 1978
Planning & Evaluation Activities		
1. Human Services Coordination Committee & Region I Planning Group	With assistance from planning staff, develop work program for mental health planning including planning process, plan format, and content and time frames for completion.	September, 1977
2. Human Services Coordinating Committee	Prepare Region IV comprehensive mental health plan including priorities for program development & funding in FY 1978-79.	March, 1978

RESPONSIBLE AGENCY	ACTIVITY	COMPLETION DATE
Planning & Evaluation Activities (continued)		
3. Area Board	In cooperation with DPW and Legislature identify evaluation needs.	November, 1977
4. Area Board	Design and implement evaluation process and methodology.	January, 1978

BUDGET - PHASE 1

Salaries & Wages (Executive Director, Planning Coordinator & Clerical)	$57,000
Fringe Benefits	11,400
Consultants for System Development (legal service, data processing, etc.)	10,000
Area Board Meetings & Supplies	10,000
TOTAL	$88,400.

NOTE: During FY 1977-78, the budgets for the Fergus Falls State Hospital and the Lakeland Mental Health Center will be funded, dispersed and controlled as they are at present.

Phase 2. Initial Implementation of Regional Model - July 1, 1978 - June 30, 1979

RESPONSIBLE AGENCY	ACTIVITY	COMPLETION DATE
1. Area Board	Administer FFSH & Lakeland Mental Health Center in accordance with Regions I and IV plans and requirements of written agreement with DPW.	On-going
2. Human Services Coordinating Com. & Region I	Prepare biennial mental health services plan for each Region.	December, 1978
3. Area Board & Region I	Establish service needs & projected usage of FFSH by Region I residents. Develop detailed inpatient programs and budget necessary to meet Region I and Region IV identified needs. Coordinate with DPW for submission of Budget request to Legislature including provision for transfer of supplemental funds generated by changes in utilization of FFSH to or from FFSH budget to appropriate mental health authority in each Region.	December, 1978
4. Area Board	Conduct on-going evaluation of regional system.	On-going

RESPONSIBLE AGENCY	ACTIVITY	COMPLETION DATE
5. Area Board	Complete formal evaluation report on first year's operation; develop detailed recommendations for improving the system (if necessary).	April, 1979

ESTIMATED BUDGET - PHASE 2

(Based on 1978-79 request from Fergus Falls State Hospital and 10% inflation factor for Lakeland Mental Health Center and Central Area Board Administration.)

Central Administration

Salaries & Wages & Fringe (same staff level)	$75,240	
Area Board Expenses	10,000	
Subtotal		$ 85,240

Community-Based Services $ 903,896

Inpatient Services

(Current estimate based on 515 patients. It is anticipated that usage will change based on the changing mental health needs identified in the regional plans. This may result in shift in funds from hospital budget to the appropriate local mental health authority(ies) in Regions I and IV and vise versa. The total inpatient services budget then, may be significantly different from the figure reported here.) $9,849,392

GRAND TOTAL $10,838,528

NOTE: It is anticipated that the total projected financial liability for the State during FY 1978-79 would not be significantly higher than that which the State would normally spend for mental health services.

Phase 3. Further Refinement & Evaluation of Regional Model - July 1, 1979 - June 30, 1981.

RESPONSIBLE AGENCY	ACTIVITY	COMPLETION DATE
1-5	Same as for Phase 2	Same as for Phase 2
6. Area Board	In cooperation with Region I and DPW, develop recommendation to 1981 legislature regarding formal continuation, modification or discontinuation of Region IV Model Mental Health System.	January, 1981

EXPECTED BUDGET - To be determined during the latter part of FY 1978-79 based on regional plans.