Approved: January 12, 1995
Date

MINUTES OF THE SENATE COMMITTEE ON WAYS AND MEANS.

The meeting was called to order by Chairperson Dave Kerr at 11:00 a.m. on January 9, 1996 in Room 123-S of the Capitol.

All members were present except:

Committee staff present: Alan Conroy, Legislative Research Department
Kathy Porter, Legislative Research Department
Eric Milstead, Legislative Research Department
Norman Furse, Revisor of Statutes
Michael Corrigan, Revisor of Statutes
Judy Bromich, Administrative Assistant
Ronda Miller, Committee Secretary

Conferees appearing before the committee:
Tim Colton, Kansas Legislative Research Department
Jane Rhys, Executive Director, Kansas Council on Developmental Disabilities

Others attending: See attached list

Chairman Kerr welcomed members to the 1996 Committee meetings and introduced Senator Burke as a new member of the Committee. He commended former state senator August Bogina for the professionalism of the previous Committee and introduced members of the current Ways and Means Committee staff. Fiscal analyst assignments for FY 96 (Attachment 1) and subcommittee assignments (Attachment 2) were distributed to members.

Senator Salisbury moved, Senator Lawrence seconded, that bill draft 5 RS 1544 be introduced as requested by Division of the Budget. The motion carried on a voice vote.

Senator Vancrum moved, Senator Brady seconded, that the Committee authorize the introduction of the Governor's appropriations bills as they become available. The motion carried on a voice vote.

The Chairman informed the Committee that the purpose of the meeting was to review the recommendations of the Governor's Commission on Hospital Closure with an emphasis on the financial implications and pointed out that the Governor provided $1 million in his budget recommendations for community planning. Tim Colton, Kansas Legislative Research Department, appeared before the Committee and reviewed the recommendations of the Hospital Closure Commission (Attachment 3). Following his overview of the report, members asked questions regarding the adequacy of current community childrens' programs, the timeframe for the Governor's budget amendments regarding closure issues, the financial impact of deinstitutionalization on public education, oversite of placement for quality assurance, the community role in becoming more active in MH and MR care systems, and whether incentives were in place to retain employees until the date of closure. Concern was expressed that no plan is in place for the pace of closure, that no recommendations for the funding of closure have been formulated, and that systems for quality assurance of client care by the date of closure are not in place. Members inquired about an opinion from the revisors' office regarding the constitutionality of the statutory charge in reference to the date of closure. The Chairman requested that the opinion be made available to members.

Members briefly discussed state expenditures for the developmentally disabled (Attachment 3-32), noting that recommended funding for FY 96 of $192.5 million does not include revisions made by the Governor. Staff commented that hospital expenditures remained relatively stable from FY 90 - FY 96, though MR hospital census decreased from 1,026 in FY 90 to 696 in FY 96. The Chairman pointed out that while a substantial amount of money has been spent to ready communities for client placement, there is still a great deal of transition that needs to take place. At the same time, total expenditures for hospitals have not been reduced significantly. "Dual" funding for community placement and hospitals is a position that is not financially sustainable.

Senator Rock requested additional information on the projected costs of closing large ICF/MRs, expressing doubt regarding the projected cost savings of community placement. It was noted that the total costs have not been captured because education costs are reflected in a different budget. The Chairman requested that FY 95 expenditures for education of MR and MH children be provided.

Jane Rhys, Executive Director of the Kansas Council on Developmental Disabilities, appeared before the Committee and reviewed additional recommendations for closure on behalf of the Kansas Developmental Disabilities Network and the Council on Developmental Disabilities (Attachment 4). In response to questions, Ms. Rhys stated that the Community Developmental Disabilities Organizations (CDDOs) will be the gatekeepers for the organization with the emphasis being on client choice. She told members that funding for CDDOs comes from county mill levies, SRS in the form of HCBS waivers, and from federal funds. She informed the Committee that InterHab (Attachment 4-12) is a statewide organization for all CDDOs. In response to a question, Ms. Rhys stated that training and oversite is provided through the quality assurance personnel of SRS and that procedures are in place in the event of noncompliance with state laws.

Dr. Wayne Sailor, University Affiliated Programs, University of Kansas, distributed copies of recent research and documentation in support of the basic assumptions listed on page two of the DD network planning Document for the closure process affecting Winfield State Hospital. This document can be obtained by addressing Wayne Sailor, Ph.D., Director, KU-UAP/Lawrence; 1052 Dole Center, University of Kansas; Lawrence, KS 66045; phone (913) 864-4950.

The Chairman adjourned the meeting at 12:35 P.M. The next meeting is scheduled for January 10, 1996.

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: JANUARY 9, 1996

NAME	REPRESENTING
Shannon Jones	SILCK
Gina McDonald	KACIL
Mary Ellen O'Brien Wright	Assis. Tech. for Kansans
Ellen Piekalkiewicz	Assoc. of CMHCs
[illegible]	United [illegible]
Rich Guthrie	Health Midwest
Tom Laing	InterHab
~~Jeat Lees~~	KAPS
Joan Kuka	KS Guardianship Program
Tori Mroz	KAPS
Sharon Huffman	KCDC
George Wall	KCDC
Michael Hutchins	SRS
Stuart Little	self
Don Green	Governor's Office
John Carlson	SRS
[illegible]	SRS
Robert E Mears	The Arc of Kansas
Tami Clymer	KAKE-TV, Wichita

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: JANUARY 9, 1996

NAME	REPRESENTING
DON POUND	SRS
LINDA McGILL	PMA
Sandra Byrne	KMHC
Grace Hobson	W. Eagle
Dean Averill	The Arc of Douglas Co.
Kathy Lobb	The ARC of Douglas Co
Maggie Griggs	Steve Hearing & Assoc.
Josie Lotter	Families Together, Inc.
Sherry Diel	Kansas Advocacy & Protective Services
Patty Gerdel	Families Together
Shelley Krestine	KCDD
Gretchen Carter	KCDD
Arlan Holmes	Division of Budget
Wayne Sailor	KU - UAP
Jennie L. Brennan	KS. Adv. + Protective Serv.
Lynne J. Jones	KS Health Care Assn.
Jane Adam	Keep for Networking
Dave Rhys	KS/DD Council
Tom Love	KS/DD Council

SENATE WAYS AND MEANS COMMITTEE GUEST LIST

DATE: JANUARY ~~10~~ 9, 1996

NAME	REPRESENTING
Dawn Reid	KSNA
Jane Lord	KHA
Amy Slater	Sen Salisbury
Heather Gray	Sen. Karr
Sue Krische	Sen. Pres. Office
Kory Myers	Cap-Journ
John Karp	City of Topeka

FISCAL ANALYST ASSIGNMENTS -- FY 1996

SWAM January 9, 1996 Attachment 1

Ian Conroy (4407)

252 Governor
422 Legislative Coordinating Council
425 Legislative Research Department
428 Legislature
446 Lieutenant Governor
540 Division of Post Audit
579 Revisor of Statutes

Julian Efird (3535)

276 Department of Transportation
365 Kansas Public Employees Retirement System
450 Kansas Lottery
553 Racing Commission
Budget Data Coordinator

Patricia Pierron (4429)

363 Kansas Neurological Institute
507 Parsons State Hospital
713 Winfield State Hospital
434 State Library
105 Board of Healing Arts
167 Dental Board
531 Board of Pharmacy
247 Comm. on Govt. Standards & Conduct
622 Secretary of State

Paul West (4409)

629 Dept. of SRS (except Division of MHRS)
140 Corporation for Change
Coordinator, Joint Committee on
State Building Construction

Laura Howard (4418)

367 Kansas State University
367 KSU-Veterinary Medical Center
367 KSU-Agricultural Extension
368 KSU-Salina
682 University of Kansas
683 University of Kansas Medical Center
715 Wichita State University

Pat Mah (4405)

264 Department of Health and Environment
331 Insurance Department
270 Health Care Stabilization Board of Govs.
206 EMS Board
543 Real Estate Appraisal Board
549 Real Estate Commission
016 Abstracters Board
562 Board of Tax Appeals

Kathy Porter (4419)

173 Department of Administration
176 Kansas Development Finance Authority
677 Judicial Branch
349 Judicial Council
328 Board of Indigents' Defense Services
670 State Treasurer
028 Accountancy Board
083 Attorney General -- KBI

Susan Wiegers (3183)

410 Larned State Hospital
494 Osawatomie State Hospital
555 Rainbow Mental Health Facility
664 Topeka State Hospital
694 Comm. on Veterans Affairs/Soldiers Home
454 Consumer Credit Commission
625 Securities Commissioner
094 Bank Commissioner
159 Department of Credit Unions
058 Commission on Human Rights
100 Board of Barbering
149 Board of Cosmetology

Don Cawby (3923)

565 Department of Revenue
319 Youth Center at Topeka
325 Youth Center at Beloit
355 Youth Center at Atchison
412 Youth Center at Larned
258 Grain Inspection Department
391 Wheat Commission
234 Fire Marshal
204 Mortuary Arts Board
700 Board of Vet. Medical Examiners
118 Civil Air Patrol

Russell Mills (4420)

710 Department of Wildlife and Parks
055 Animal Health Department
561 Board of Regents
246 Fort Hays State University
379 Emporia State University
385 Pittsburg State University
034 Adjutant General
709 Kansas Water Office
634 State Conservation Commission

Carolyn Rampey (4404)

652 Department of Education
036 Council on Vocational Education
663 Board of Technical Professions
082 Attorney General
122 Citizens Utility Ratepayer Board
143 Kansas Corporation Commission
266 Hearing Aids Examiners

Timothy Colton (4181)

629 Mental Health and Developmental
Disabilities (a Division of SRS)
261 Kansas Guardianship Program
039 Department on Aging
046 Department of Agriculture
373 Kansas State Fair Board
359 Kansas Arts Commission
288 State Historical Society
280 Highway Patrol
488 Optometry Board

Eric Milstead (3184)

300 Department of Commerce and Housing
360 Kansas Inc.
371 Kansas Technology Enterprise Corp.
296 Department of Human Resources
565 Homestead Property Tax Refunds
482 Board of Nursing
102 Behavioral Science Regulatory Board
604 School for the Blind
610 School for the Deaf
Coordinator, Economic Development
Initiatives Fund

Leah Robinson (4447)

521 Department of Corrections
177 Ellsworth Correctional Facility
195 El Dorado Correctional Facility
313 Hutchinson Correctional Facility
400 Lansing Correctional Facility
408 Larned Correctional Facility
581 Norton Correctional Facility
660 Topeka Correctional Facility
712 Winfield Correctional Facility
626 Sentencing Commission
147 Ombudsman of Corrections
523 Parole Board

SENATE SUBCOMMITTEE ASSIGNMENTS

Senate Bills -- 1996

	Subcommittee	Analyst	Final Committee Action
Senate Bill No. _____			
Department of Administration -- KPERS			
Department of Administration	Vancrum	Porter	
Public Broadcasting	Salisbury		
	Karr		
Governmental Standards	Morris	Pierron	
Human Rights Comission	Brady	Wiegers	
Kansas Corporation Commission	Burke	Rampey	
Citizens Utility Ratepayer Board	Petty		
KPERS Budget	Kerr	Efird	
KPERS Issues	Morris		
	Rock		
Senate Bill No. _____			
Health and Environment			
Department of Health and Environment	Vancrum	Mah	
Corporation for Change	Rock	West	
Human Resources	Salisbury	Milstead	
	Brady		
Department on Aging	Burke	Colton	
	Karr		
Veterans Affairs/Soldiers' Home	Morris	Wiegers	
Homestead Property Tax	Petty	Milstead	
Wildlife and Parks	Moran	Mills	
	Brady		

SWAM
January 9, 1996
Attachment 2

	Subcommittee	Analyst	Final Committee Action
Senate Bill No. ____			
Higher Education			
KU	Burke Karr	Howard	
KUMC	Morris Kerr	Howard	
KSU KSU -- Salina KSU -- Vet. Med KSU -- Extension Pittsburg State University Emporia State University	Moran Rock	Howard Mills	
Wichita State University	Vancrum Petty	Mills	
Fort Hays State University Board of Regents	Lawrence Kerr	Mills	
Regents Systemwide	Kerr Burke Vancrum Karr Brady	Howard/Mills	
Senate Bill No. ____			
Commerce/Revenue			
Department of Revenue	Salisbury Morris Karr	Cawby	
Lottery Commission Racing Commission	Burke Petty	Efird	
Board of Tax Appeals	Lawrence Brady	Mah	

	Subcommittee	Analyst	Final Committee Action
Department of Commerce and Housing	Moran Rock Kerr	Milstead	
Kansas Inc. Kansas Technology Enterprise Corporation	Salisbury Vancrum	Milstead	
Senate Bill No. ____			
Capital Improvements	Kerr Vancrum Karr	Staff	
Senate Bill No. ____			
Fee Boards			
Abstracters' Board of Examiners	Kerr	Mah	
Board of Accountancy	Petty	Porter	
Board of Mortuary Arts		Cawby	
Board of Pharmacy		Pierron	
Board of Barbering		Wiegers	
Board of Cosmetology		Wiegers	
Board of Veterinary Medical Examiners		Cawby	
Kansas Dental Board		Pierron	
Board of Nursing		Milstead	
Board of Examiners in Optometry		Colton	
Real Estate Commission		Mah	
Consumer Credit Commissioner		Wiegers	
Bank Commissioner		Wiegers	
Department of Credit Unions		Wiegers	
Securities Commissioner		Wiegers	
Board of Technical Professions		Rampey	
Behavioral Sciences Regulatory Board		Milstead	
Board of Hearing Aid Examiners		Rampey	
Board of Healing Arts		Pierron	

	Subcommittee	Analyst	Final Committee Action
Senate Bill No. _____			
Legislative and Elected Officials			
Legislative Agencies	Moran	Conroy	
Governor	Rock		
Lt. Governor			
Attorney General	Lawrence	Rampey	
Secretary of State	Kerr	Pierron	
Insurance Commissioner	Petty	Mah	
State Treasurer		Porter	
Health Care Stabilization Fund Board of Governors		Mah	
Senate Bill No. _____			
Public Safety			
Youth Center at Topeka	Vancrum	Cawby	
Youth Center at Beloit	Lawrence		
Youth Center at Atchison	Morris		
Youth Center at Larned			
Ombudsman for Corrections	Vancrum	Robinson	
	Brady		
Parole Board	Lawrence	Robinson	
Adjutant General	Brady	Mills	
Fire Marshal	Kerr	Cawby	
Highway Patrol	Karr	Colton	
KBI	Moran	Porter	
	Petty		
EMS	Lawrence	Mah	
Civil Air Patrol	Moran	Cawby	
Sentencing Commission		Robinson	

SENATE SUBCOMMITTEE ASSIGNMENTS

House Bills -- 1996

	Subcommittee	Analyst	Final Committee Action
House Bill No. _____			
Transportation	Burke Morris Rock	Efird	
House Bill No. _____			
Other Education			
School for the Blind School for the Deaf	Salisbury Brady	Milstead	
Historical Society Kansas Arts Commission	Burke Moran Petty	Colton	
State Library Council on Voc-Ed	Vancrum Rock	Pierron Rampey	
House Bill No. _____			
Corrections			
Department of Corrections Topeka Correctional Facility	Vancrum Brady	Robinson	
Hutchinson Correctional Facility Norton Correctional Facility El Dorado Correctional Facility	Salisbury Moran Petty	Robinson	
Larned Correctional Mental Health Facility Winfield Correctional Facility	Morris Karr	Robinson	
Lansing Correctional Facility Ellsworth Correctional Faility	Lawrence Burke Rock	Robinson	

	Subcommittee	Analyst	Final Committee Action
House Bill No. _____			
Capital Improvements	Kerr Vancrum Karr	Staff	
House Bill No. _____			
Department of Education	Kerr Salisbury Burke Karr Rock	Rampey	
House Bill No. _____			
Judicial			
Judicial Council	Morris	Porter	
Board of Indigents' Defense Services	Burke		
Judicial Branch	Lawrence Rock	Porter	
House Bill No. _____			
Agriculture			
Department of Agriculture	Morris Petty	Colton	
Animal Health	Lawrence	Mills	
Grain Inspection	Burke	Cawby	
Wheat Commission		Cawby	
Kansas State Fair		Colton	
Conservation Commission	Vancrum	Mills	
Water Office	Rock		

	Subcommittee	Analyst	Final Committee Action
House Bill No. _____			
SRS			
Department of SRS	Kerr	West	
Kansas Guardianship Program	Salisbury	Colton	
	Vancrum		
	Rock		
	Petty		
Larned State Hospital	Burke	Wiegers	
Osawatomie State Hospital	Lawrence		
Rainbow Mental Health Facility	Brady		
Topeka State Hospital			
SRS Community Mental Health		Colton	
Parsons State Hospital	Morris	Pierron	
Winfield State Hospital	Moran		
Kansas Neurological Institute	Karr		
SRS Community MR/DD		Colton	

Overview of the Recommendations of the Governor's Commission on Hospital Closure and of Community Mental Health and Community Developmental Disabilities Services

Senate Committee on Ways and Means

9 January 1996

Timothy Colton, Senior Fiscal Analyst

Kansas Legislative Research Department

SWAM
January 9, 1996
Attachment 3

Order for Presentation

I. Statutory Charge for Governor's Commission

II. Commission Decisions on Hospitals to Close

III. Other Commission Decisions

IV. Community Mental Health Services--Overview

V. Community Mental Health Services--Funding

VI. Community Developmental Disabilities Services--Overview

VII.. Community Developmental Disabilities Services--Funding

VIII. Questions

Statutory Charge for Governor's Commission on Hospital Closure

Language was included in the 1995 Omnibus Appropriations Bill allowing expenditures to be made by an 11-member hospital closure commission, seven members of which were to be appointed by the Governor, and four members of which by the leadership if the Kansas House and Senate. The commission is required to submit to the Governor, on or before December 1, 1995, a report containing:

- a recommendation of one mental health hospital to be closed;
- a recommendation of one mental retardation hospital to be closed;
- recommended dates of closure;
- recommended policies to be followed in effecting the closure of the institutions; and
- recommended alternate uses for the institutions to be closed.

The bill directs the commission to consider the following factors in making its decision: a) the savings created by the closure and the impact on funding for community MR and MH services; b) the impact of closure in hospital clients and their families, and the availability of alternative services for those clients; c) the economic impact of closure on the institutions' host communities; d) the feasibility of using the closed institutions to house other state services or programs; e) the impact of closure on hospital employees and the ability of those employees to find other employment and f) any other factor considered relevant by the commission. The language also stated, however, that nothing required the commission to recommend the closure of an MR or an MH institution if the commission determined that no closure should be recommended. The Governor has until the 8th of January, 1996, to submit the report to the legislature, and the recommendation is to be final unless rejected by the Legislature on or before the 45th day of the regular legislative session.

Commission submitted its report to the Governor on 30 November 1995

Mental Retardation Hospital to be Closed:

Winfield State Hospital and Training Center

Mental Health Hospital to be Closed:

Topeka State Hospital

Both Hospitals to be Closed by

31 December 1997

No Specific Recommendations

as to

Pace of Closure or

on

Funding of

Closure Process

Other Commission Recommendations

Guiding Principles of Closure Process

1. Client care, welfare and safety must be the primary considerations in all closure process decisions.

2. Specific initiatives and comprehensive procedures must be implemented ASAP to assist hospital employees to find other state jobs or other employment.

3. Governor and Legislature must make necessary financial commitment to ensure appropriate care of people with MI and DD is not compromised by closure of hospitals. Funding must be sufficient and flexible enough to allow for appropriate resources, whether in community or other hospital settings.

4. Coordinated state initiative should be undertaken to assist Winfield and Topeka in minimizing effect of closing on local economies and to identify areas of possible new economic development.

Other Advisory Recommendations in Response to Statutory Charge

✓ **Policies and Procedures to Facilitate Closures and Assist Displaced Clients and Employees**

✗ Development of Comprehensive Closure Operational Plan
1. Relating to Hospital Clients and Employees
2. Relating to Winfield and Topeka Communities
3. Relating to Other State Uses for Facilities

1(a). Client Family and Guardian Recommendations

✗ Clients, Families and Guardians Should Participate in Placement Decisions
✗ Least Disruption Possible for Clients
✗ Client/Family Choice Should be Honored
✗ Clients/Families Must Be Kept Informed of All Aspects of Closure Process
✗ Individual Placement Plan and Necessary Funding and Services Must Precede Placement
✗ Quality Assurance Programs Should Be Reviewed and Enhanced as Appropriate to Assure Quality Client Care

1(b). Employee-Related Recommendations

✗ SRS Should Form Team of Personnel Officials to Meet with Affected Employees and to Keep Employees Informed of Closure Process and Other Issues

2. Community-Related Issues

✗ Closure Relating to Economic Impact on Winfield and Topeka Should be Managed by Secretary of Commerce and Housing; Accomplished though Task Force Appointed by Governor; Task Force to Include Representatives of Communities

3. Other State Uses for Facilities

✗ Governor Should Appoint "Alternate Use of Facilities Feasibility Committee"
Consisting of:
Secretary of Administration
Secretary of Corrections
Chair of Kansas Youth Authority
Other Heads of Agencies as Determined by Governor.

✗ Committee to Consider:
Adaptability
Conversion Cost
Cost Effectiveness of Using Facilities for

Corrections
Juvenile Corrections
State Office Facilities
Any Other Possible Use Determined by Governor

✗ Committee Should Work With Economic Task Force

✗ If Facilities are not Suitable for State Uses, the Facilities Could be

Sold; or

Given to Communities For Their Use in Finding Replacement Industry, or Other Economic Development Uses, or Other Uses

Other Commission Recommendations

✗ SRS should provide options and a recommended course of action pertaining to the movement of hospital clients to community programmes or to other hospitals. Should have achievable options in addition to those that would have been in place without closure.

Plan should address financial and policy implications to hospital system and to community systems.

Plan should include client-centered cost analysis and projections.

Plan should consider possible changes in federal funding policies.

Plan should be flexible in terms of flow of dollars, e.g., a single line item for mental health and retardation community programs and hospitals.

✗ Savings resulting directly from closure should be retained and used for services to MI and DD populations.

✗ University of Kansas Affiliated Programmes at Parsons should provide its expertise to SRS and MH and DD providers at no cost.

✗ SRS needs to address medical/legal implications of deinstitutionalization

Identify acceptable risks of providing least restrictive living environments and seek to avoid unnecessary restrictions based on defensive positions taken by doctors concerned about liability or public safety.

✗ Communities need to become more active in MH and MR care systems

✗ SRS, CHMCs and CDDOs need to cooperate to build a guide to the procedures and rules involved in establishing community programs and services.

SRS should work with CHMC and CDDO in Cowley and Shawnee Counties to develop affiliates and new service providers.

- ✗ SRS needs to do follow up with MH clients and to determine relationship between MH deinstitutionalization (including MH Reform) and the transinstitutionalization of persons with MI into penal system.

- ✗ Community providers' role in initiating, developing and implementing community placement plans should be expanded.

  Follow-up and oversight of placements need to be enhanced.

  Persons in ICFs/MR and NFs/MH need to receive least restrictive level of care and be integrated into continuum of care.

- ✗ State and community officials should develop strategy to deal with crisis management and drug treatment. Community hospitals, nursing facilities and private psychiatric hospitals could be part of that strategy.

- ✗ SRS should consider combined MH/MR facilities on the same campus.

- ✗ SRS, Health and Environment, the Board of Education and their community counterparts need to develop an interagency plan to address all aspects of delivery of MH services to children and adolescents.

- ✗ Service delivery system needs to be reviewed: there exist so many service delivery systems and providers that it is difficult to get a grasp of the full scope of services and funding that currently exist, the extent to which they are used, and the extent to which they are adequate.

- ✗ The state should develop an MH/MR Strategic Plan which could include closure of additional hospitals.

- ✗ Children should be given priority in deinstitutionalization from MR hospitals. Goal should be reintegration in family (to extent possible).

- ✗ SRS needs to determine extent to which persons with DD are in MH hospitals, and, if feasible, develop community placement plans for them.

- ✗ SRS should continue to explore options that would allow KU Med Center, Wyandotte or Johnson County CDDOs, Osawatomie SH or other groups to assume responsibility for Rainbow's programs and facilities.

- ✗ SRS needs to continue and expand review of benefits of privatizing and outsourcing operations and programs.

The balance of the Commission's report is devoted to a review of the Commission's methodology and operations.

State Mental Health Hospitals
FY 1996
Operating Expenditures
Average Daily Census

DRAFT

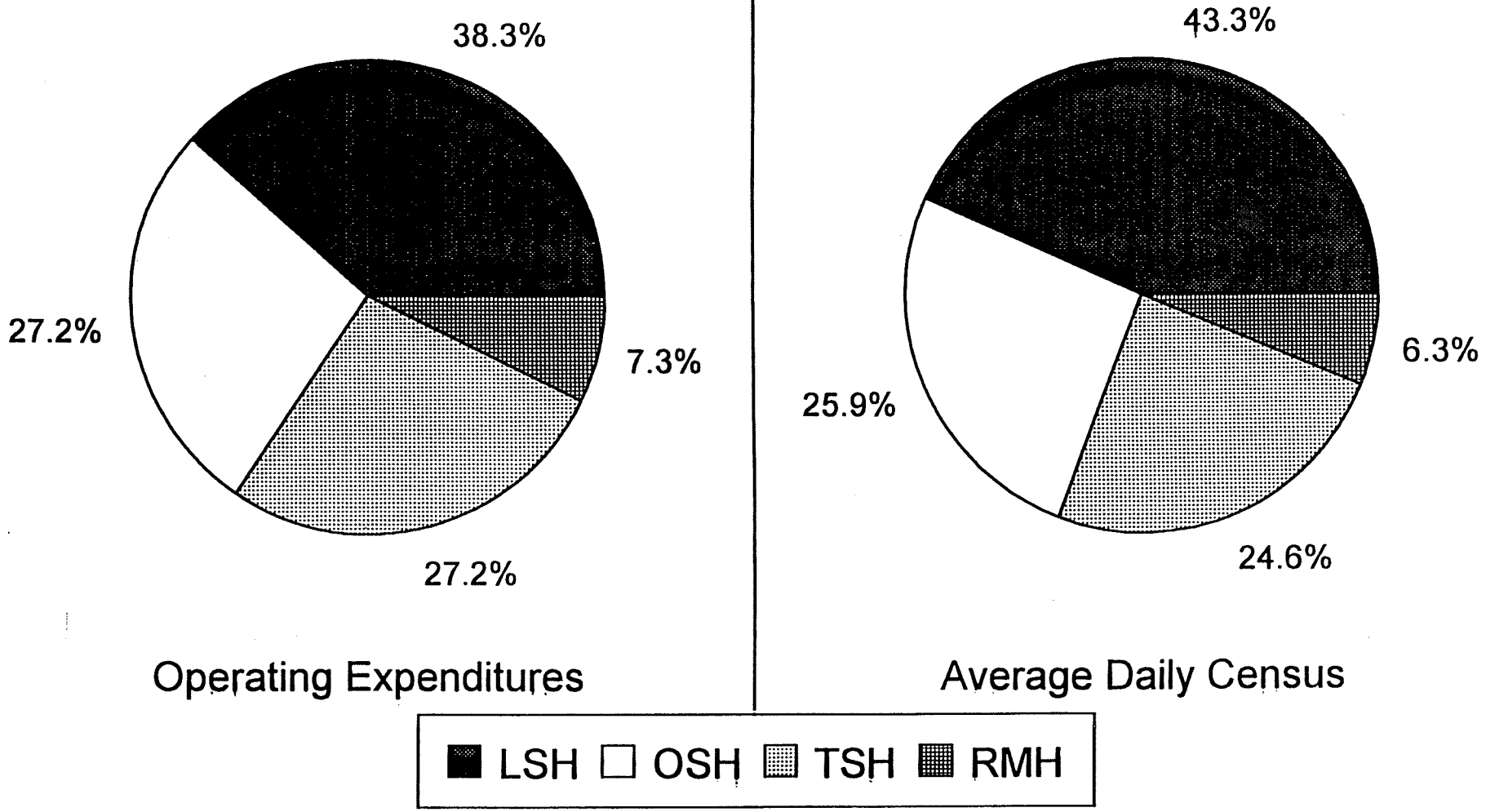
DRAFT

▪ Larned State Hospital	$30.7 Million	343 ADC
▪ Osawatomie State Hospital	$21.7 Million	205 ADC
▪ Topeka State Hospital	$21.8 Million	195 ADC
▪ Rainbow Mental Health	$ 5.8 Million	50 ADC
▪ TOTAL	$80.0 Million	793 ADC

3-12

DRAFT

State Mental Hospitals
FY 1996
Percentage of
Operating Expenditures and Average Daily Census



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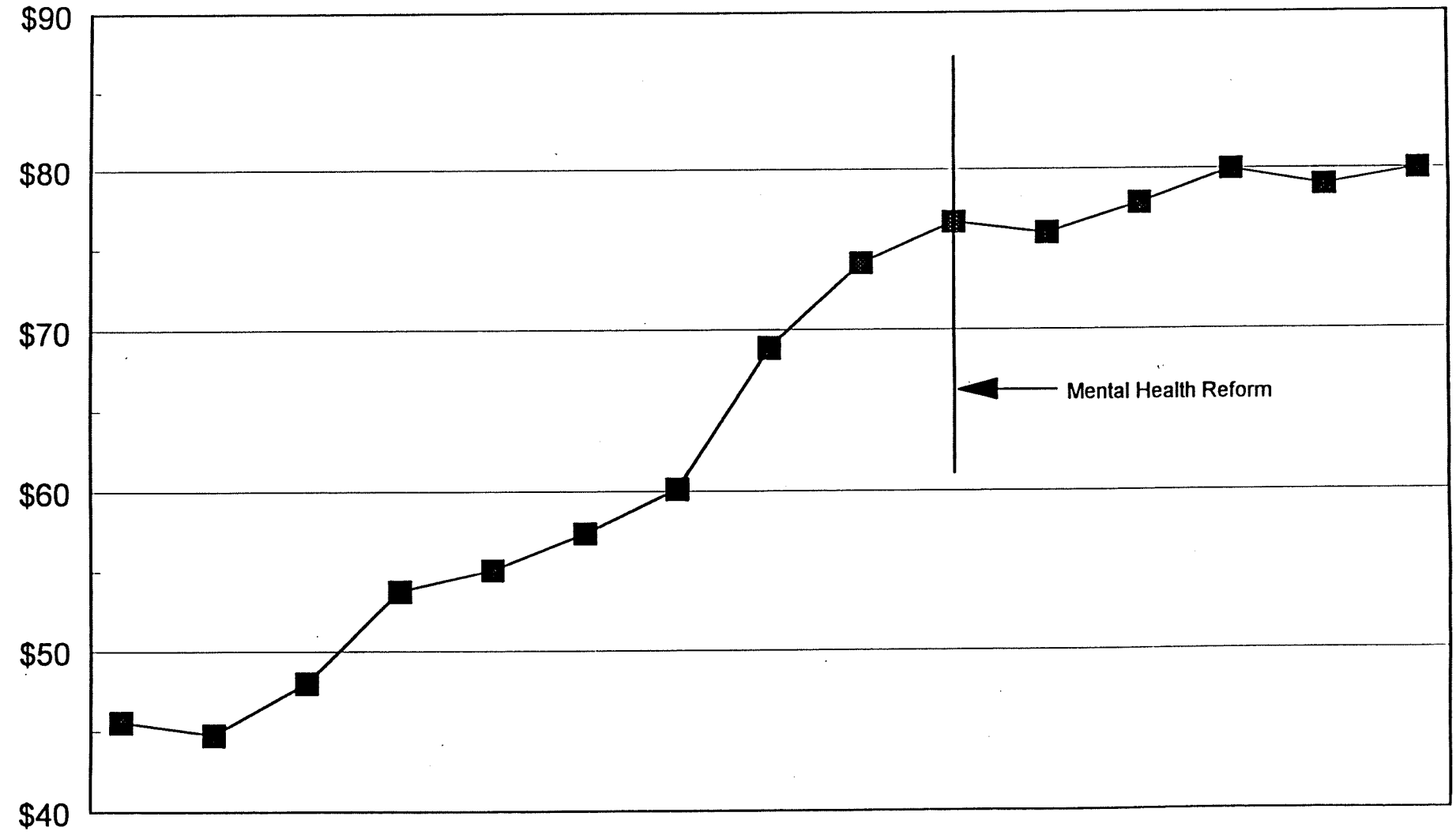
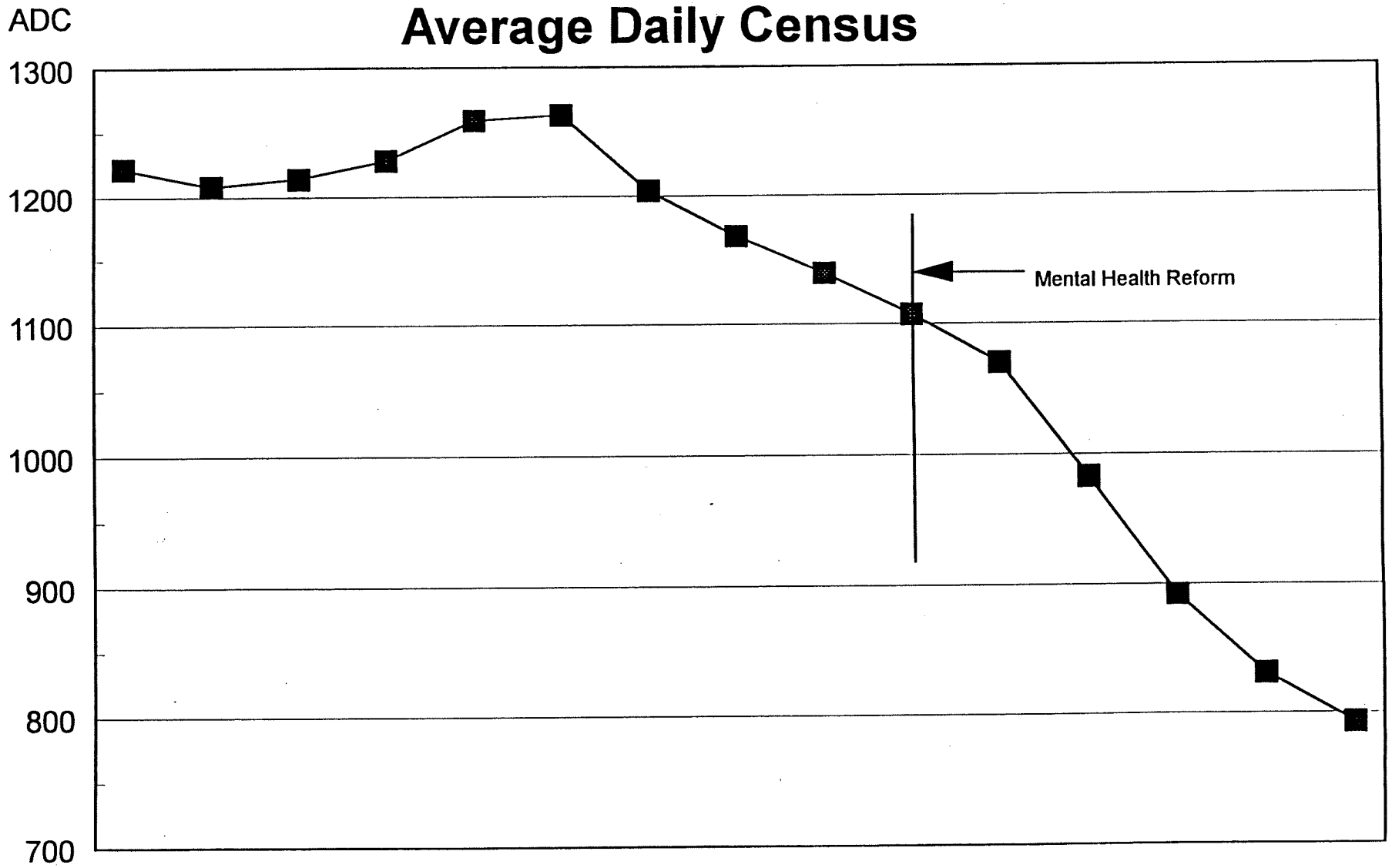
State Mental Health Hospitals
FY 1982 -- FY 1996
Annual Operating Expenditures



Fiscal Year	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	19
All Funds	45,543,272	44,743,995	47,969,939	53,722,070	55,049,198	57,346,904	60,113,718	68,878,447	74,086,812	76,650,139	75,963,082	77,812,536	79,947,104	78,958,341	79,96

DRAFT

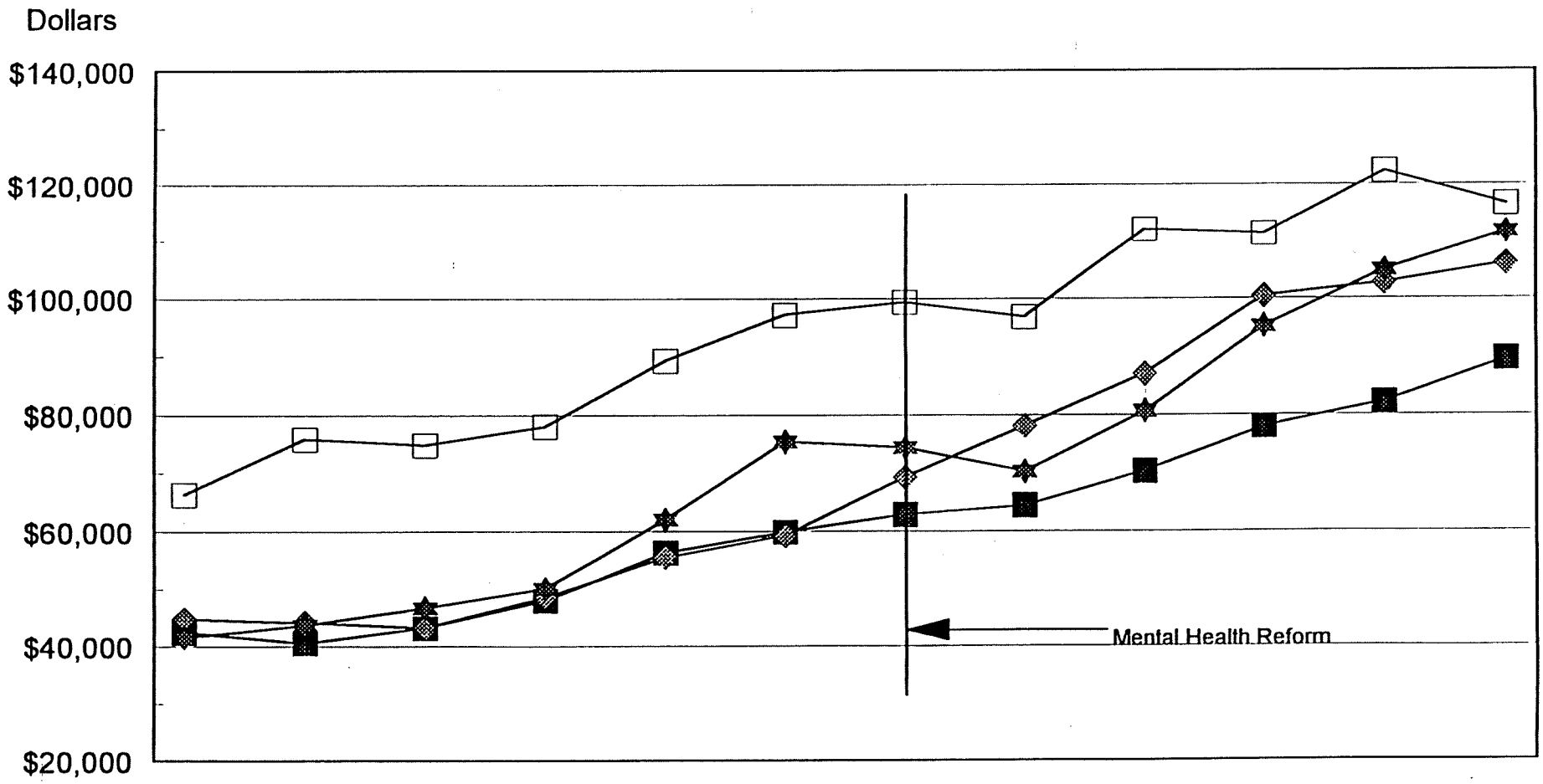
State Mental Health Hospitals
FY 1982 -- FY 1996
Average Daily Census



Fiscal Year	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
ADC	1,222	1,208	1,214	1,228	1,259	1,263	1,204	1,168	1,139	1,107	1,070	983	892	831	7[illegible]

DRAFT

State Mental Health Hospitals
FY 1985 -- FY 1996
Annual Operating Expenditures per Average Daily Census



Fiscal Year	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
LSH ■	42,453	40,486	43,169	47,946	56,268	59,860	62,831	64,379	70,273	77,891	82,092	89,509
OSH ◆	44,822	44,169	43,180	48,479	55,436	59,258	69,230	78,095	86,990	100,379	102,572	105,967
TSH ★	41,544	43,727	46,738	50,089	61,981	75,351	74,299	70,200	80,581	95,115	104,824	111,
RMH □	66,339	75,836	74,799	78,008	89,283	97,119	99,327	96,809	112,004	111,267	122,392	116,450

Provisions of Mental Health Reform

- The Secretary of SRS is to adopt rules and regulations which provide that, within the limits of appropriations, no person shall be inappropriately denied necessary mental health services from any mental health center or state psychiatric hospital.

- Through coordinated utilization of the existing network of mental health centers and state psychiatric hospitals, Kansas residents in need of mental health services are to receive the least restrictive treatment and most appropriate community-based care.

- As more persons are treated in community programs rather than in state hospitals, funds from the state shall follow persons who are mentally ill from state facilities into community programs.

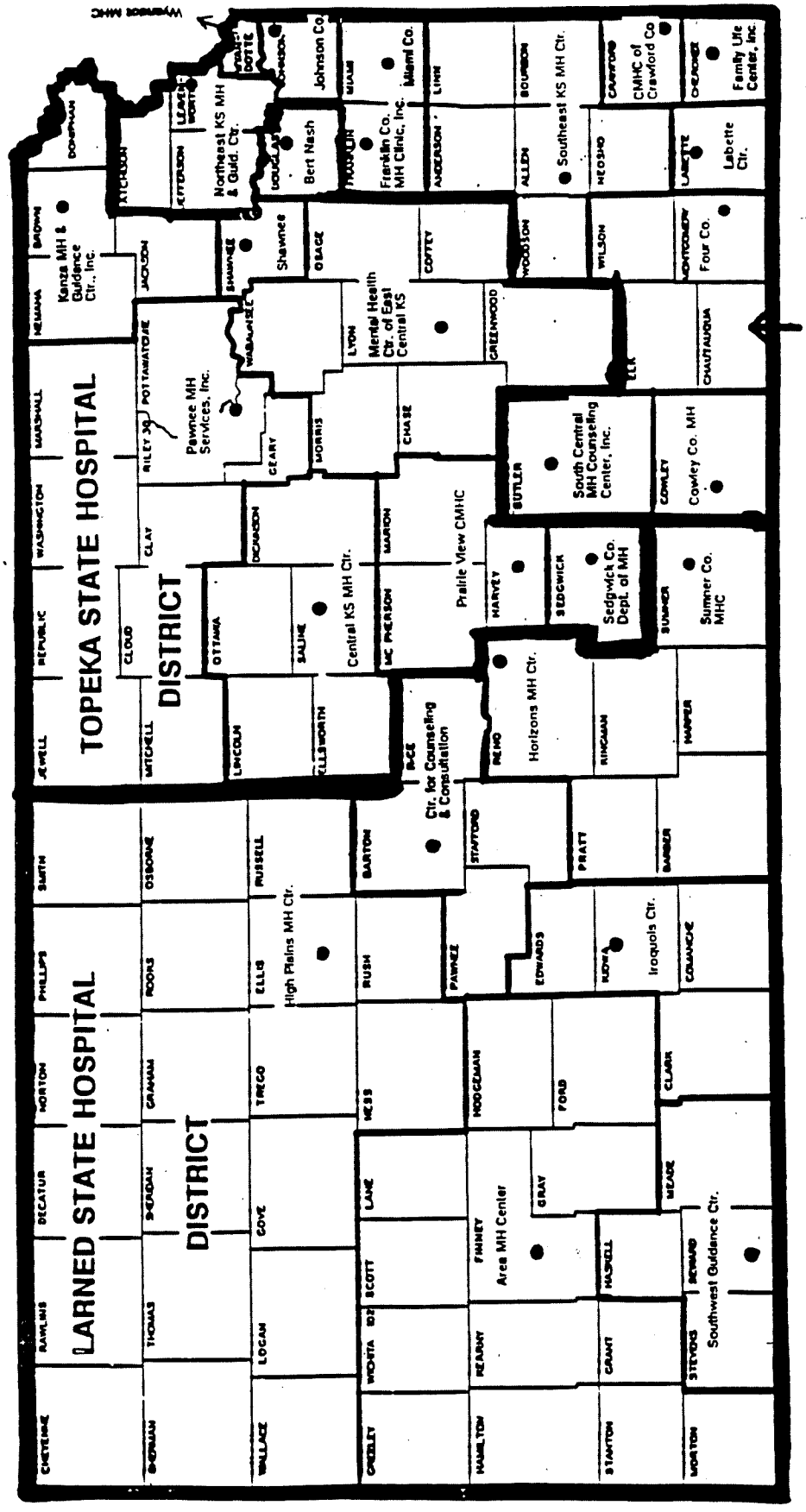
- The Secretary of SRS is to provide oversight in many areas, including, among others, establishing standards for providing community-based mental health services, assuring the development of specialized programs, monitoring the establishment and development of community-based mental health services, and adopting rules and regulations to ensure the protection of persons receiving mental health services.

- The Secretary is to review and approve the annual coordinated services plan for each mental health center and is to withhold state funds from any mental health center which is not being administered in accordance with the provisions of the annual coordinated services plan and budget.

The Act includes many provisions for participation by consumers of mental health services, family members, and consumer advocates in planning and service delivery.

Attachment I

STATE HOSPITAL CATCHMENT AREAS AND COMMUNITY MENTAL HEALTH CENTERS



State Mental Health Hospital Bed Reductions Specified in the Mental Health Reform Act, 1990 Sub. for H.B. 2586 (K.S.A. 1992 Supp. 39-1610)

Fiscal Year	Osawatomie State Hospital	Topeka State Hospital	Larned State Hospital
1991	20-30 adult beds (22 adult beds closed Apr. 2, 1990)	--	--
1992	20-30 adolescent beds (20 adolescent beds closed Nov. 12, 1991)	--	--
1993	20-30 adult beds (20 adult beds closed Aug. 4, 1992)	20-30 adolescent beds (20 adolescent beds closed Feb. 12, 1993)	--
1994	--	20-30 adult beds (36 adult beds closed Jan. 28, 1994)	20-30 adult beds (30 adult beds closed Nov. 30, 1993)
1995	--	20-30 adult beds (31 adult beds Jan. 31, 1995)	20-30 adult beds (30 adult beds Feb. 1, 1995)
1996	--	--	20-30 adult beds

The closures of one 34-bed ward within the Special Security Program at Larned State Hospital and one 30-bed ward at Osawatomie State Hospital, effective September 18, 1994, were not bed reductions specified in the Mental Health Reform Act. Both recommended closures were in response to lower than anticipated average daily census figures.

MENTAL HEALTH REFORM -- COMMUNITY FUNDING

		OSAWATOMIE CATCHMENT AREA	TOPEKA CATCHMENT AREA	LARNED CATCHMENT AREA	STATEWIDE TOTAL
FY 1991	Screening	437,850	0	0	437,850
	Community Support	630,000	0	0	630,000
	Total	1,067,850	0	0	1,067,850
FY 1992	Screening	919,485	0	0	919,485
	Community Support	2,646,000	0	0	2,646,000
	Total	3,565,485	0	0	3,565,485
FY 1993	Screening	965,460	965,460	0	1,930,920
	Community Support	4,167,450	1,389,149	0	5,556,599
	Total	5,132,910	2,354,609	0	7,487,519
FY 1994	Screening	1,013,733	1,013,732	1,013,732	3,041,197
	Community Support	4,375,822	2,917,215	1,458,608	8,751,645
	Total	5,389,555	3,930,947	2,472,340	11,792,842
FY 1995	Screening	1,064,420	1,064,420	1,064,420	3,193,260
	Community Support	4,594,613	4,594,613	3,063,076	12,252,302
	Total	5,659,033	5,659,033	4,127,496	15,445,562
FY 1996	Screening	1,117,641	1,117,641	1,117,641	3,352,923
	Community Support	4,824,345	4,824,345	4,824,345	14,473,035
	Total	5,941,986	5,941,986	5,941,986	17,825,958
FY 1997	Screening	1,173,523	1,173,523	1,173,523	3,520,569
	Community Support	5,065,562	5,065,562	5,065,562	15,196,686
	Total	6,239,085	6,239,085	6,239,085	18,717,255

Persons Served by Mental Health Reform

Fiscal Year	Persons Receiving Case Management Services	Persons Screened by CMHC Prior to State Hospital Admission
FY 1990	2,400	400
FY 1991	3,400	780
FY 1992	4,912	810
FY 1993	6,300	1,912
FY 1994	6,200	7,402
FY 1995 Est.	6,600	7,500
FY 1996 Gov.	7,225	7,500

Services Offered by CMHCs

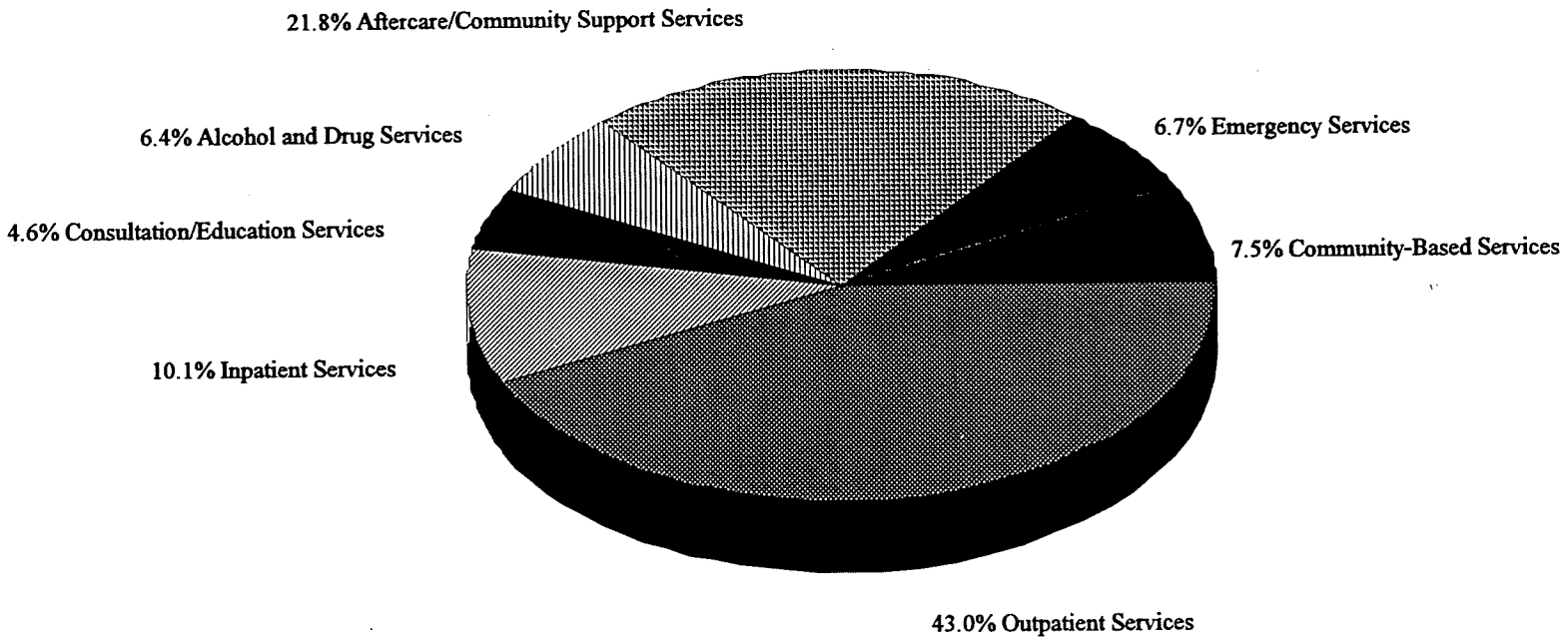
a. Basic Services

- Outpatient Services for Adults
- Outpatient Services for Children
- 24-Hour Emergency Services
- Screening Services
- Partial Hospitalization
- Case Management Services for Adults and Children
- Community Support Services
- Medical Services
- Alcohol and Drug Abuse Services
- Consultation and Education Services

b. Specialized Services

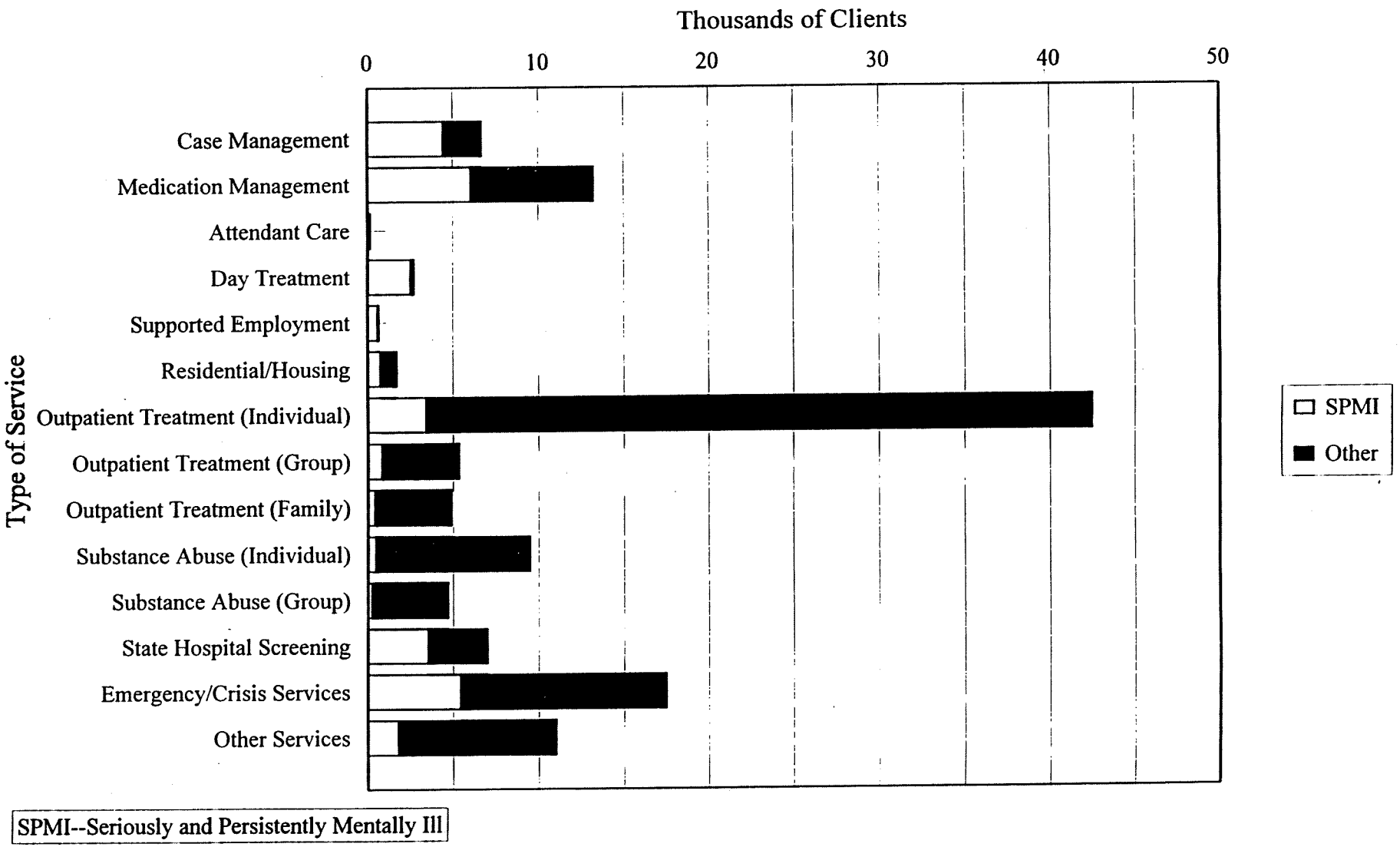
- In-Patient Hospitalization
- Drop-In Services for People with Severe and Persistent Mental Illness
- Vocational Services for People with Severe and Persistent Mental Illness
- Services for Victims and Perpetrators of Sex Crimes
- Projects for Homeless People
- Residential Programs for Adults
- Alcohol and Drug Detoxification Services
- Intermediate Residential Care for Alcohol and Drug Treatment
- Half-Way Houses for Alcohol and Drug Abusers
- Parenting and Parent Education Programs
- Pre-School Day Treatment Programs
- Children's Day Hospital Services
- Child Abuse Treatment Programs
- Divorce and Mediation Workshops

CMHC Expenditures--Calendar Year 1994



Attachment II

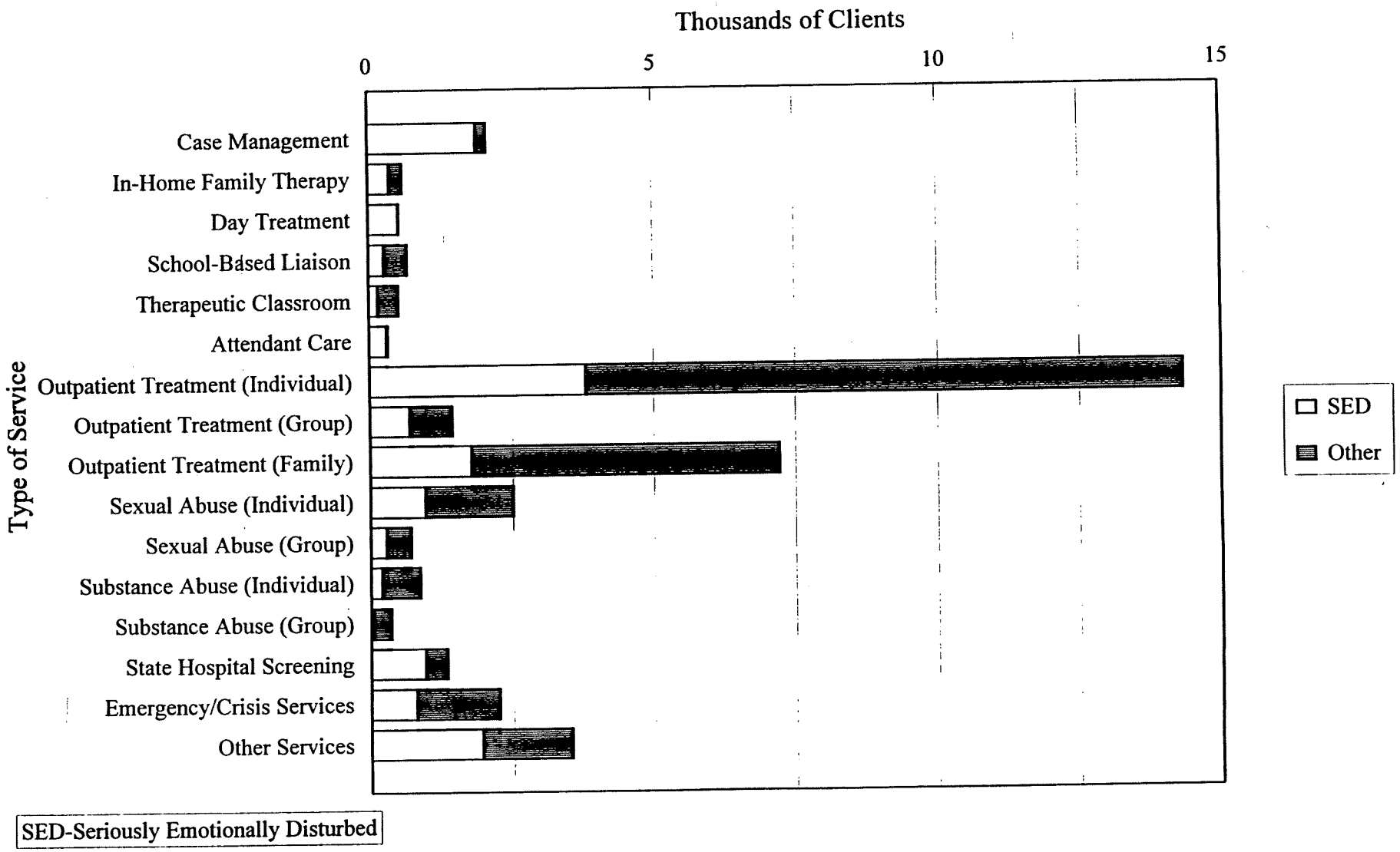
Community Mental Health Services for Adults -- Calendar Year 1993



SPMI--Seriously and Persistently Mentally Ill

Attachment III

Community Mental Health Services for Children -- Calendar Year 1993



SED-Seriously Emotionally Disturbed

NURSING FACILITIES FOR MENTAL HEALTH IN KANSAS

Name and Location	Number of Beds
Applewood Care Center Chanute/Neosho County	50
Brighton Place North Topeka/Shawnee County	34
Brighton Place West Topeka/Shawnee County	50
Cedar Grove Health Care Center DeSoto/Johnson County	50
Countryside Health Center Topeka/Shawnee County	60
Edwardsville Manor Edwardsville/Wyandotte County	100
Florence Health Care Center Florence/Marion County	60
Friendship Manor Rehabilitation Center of Haviland Haviland/Kiowa County	50
Gatewood Care Center Russell/Russell County	46
Heritage Village of Eskridge Eskridge/Wabaunsee County	60
Indian Trails Mental Health Living Center Topeka/Shawnee County	82
Medicalodge of Paola Paola/Miami County	96
Valley Health Care Center Valley Falls/Jefferson County	80
Valley Vista Care Center Junction City/Geary County	52
Westview Nursing Center Peabody/Marion County	52
Total Bed Capacity	922

Attachment IV

Overview of State Funding for Community Mental Health Services
FY 1991 -- FY 1996

Mental Health Services	Actual FY 1991	Actual FY 1992	Actual FY 1993	Actual FY 1994	Approved FY 1995	Rec. FY 1996
Mental Health Admin.	$ 401,699	$ 406,551	$ 492,869	$ 549,285	$ 1,369,377	$ 1,387,259
State Aid	10,032,643	10,032,644	10,256,398	9,948,518	10,032,644	10,032,644
Mental Health Reform	000	3,565,485	7,472,660	12,201,332	15,455,010	17,825,952
Mental Health Grants	5,284,911	5,427,733	5,706,671	5,901,610	9,106,381	11,608,476
Federal Special Projects	286,510	518,763	368,993	3,174,200	1,287,013	1,287,340
Court-Ordered Evaluations	62,204	40,200	31,680	50,110	41,691	43,150
Total--All Funds	$ 17,484,967	$ 19,991,376	$ 24,329,271	$ 31,825,055	$ 37,292,116	$ 42,184,821
Medical Assistance						
NF-MH Program -- State General Fund	$ 5,352,052	$ 7,046,079	$ 4,419,411	$ 6,880,373	$ 6,117,783	$ 5,901,094
Total -- All Funds	$ 22,837,019	$ 27,037,455	$ 28,748,682	$ 38,705,428	$ 43,409,899	$ 48,085,915
Total -- State General Fund	$ 19,964,247	$ 22,069,086	$ 25,798,354	$ 33,091,239	$ 37,852,732	$ 40,816,756

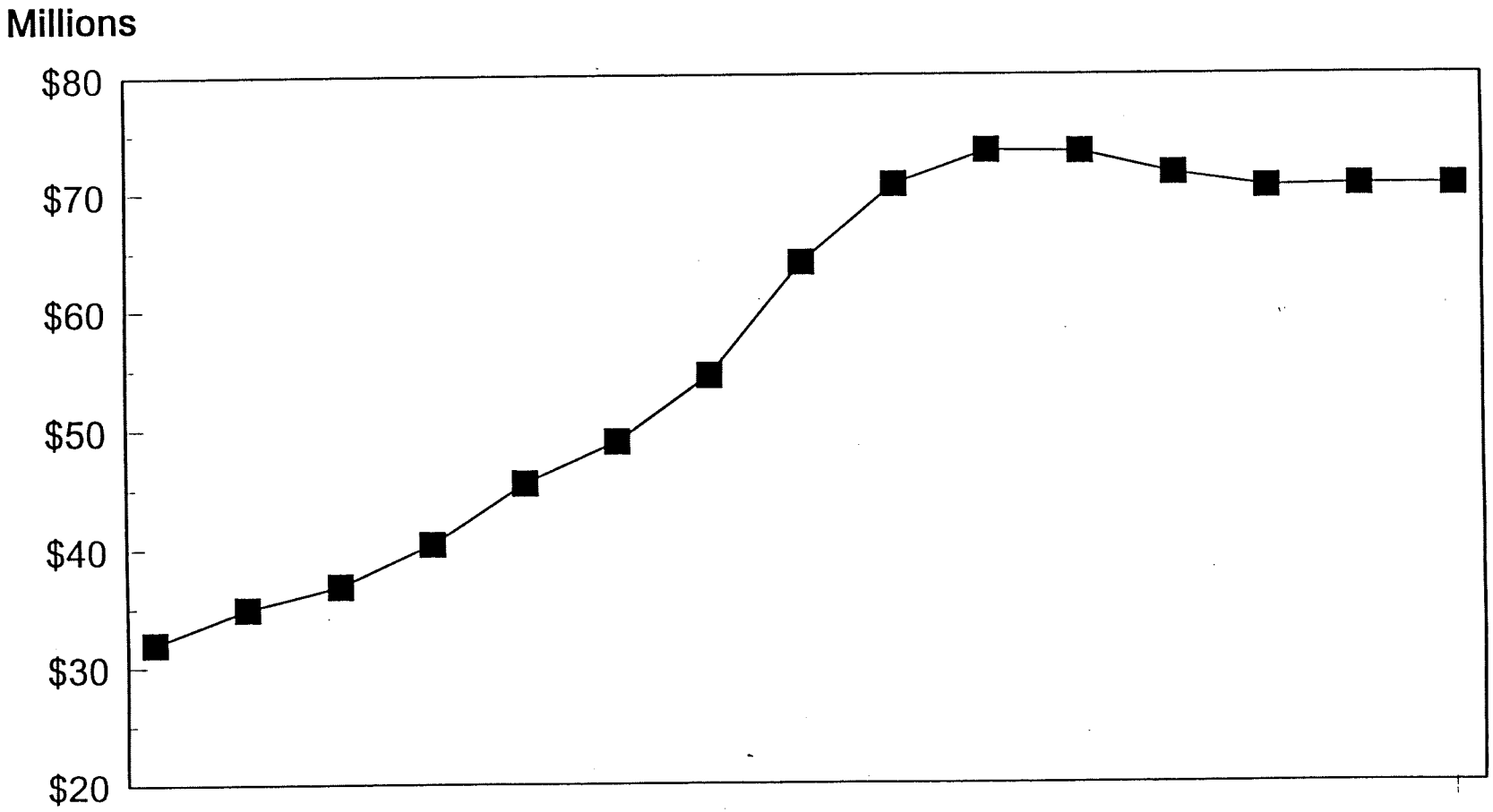
- Mental Health Administration refers to that part of the Division of Mental Health and Retardation Services that is responsible for administering mental health programs and funding.
- State Aid refers to the basic state grant to community mental health centers. The grant is distributed to centers on the basis of a per-capita formula.
- Mental Health Reform refers to funding provided to enact the Mental Health Reform Act, which was passed by the Legislature in 1990.
- Mental Health Grants refers to state and federal moneys that appropriated as grants in order to carry out specific programs or projects.
- Federal Special Projects refers to a number of smaller federal grants designed to enhance the community mental health delivery system, *e.g.*, the Mental Health Statistical Improvement Project, and other training and research (*i.e.*, nonservice delivery) grants.
- Court-Ordered Evaluations refers to contractual fees for psychiatric evaluations ordered by courts in order to establish competency to stand trial (billed to MHRS at $240 per evaluation).
- NF-MH stands for Mental Health Nursing Facilities.

The large increase in Mental Health Administration from FY 1994 to FY 1995 is because of the enactment of the Sexually-Violent Predator Program. Funding for that program's implementation is contained in the Mental Health Administration line item.

State Mental Retardation Hospitals
FY 1996
Operating Expenditures
Average Daily Census

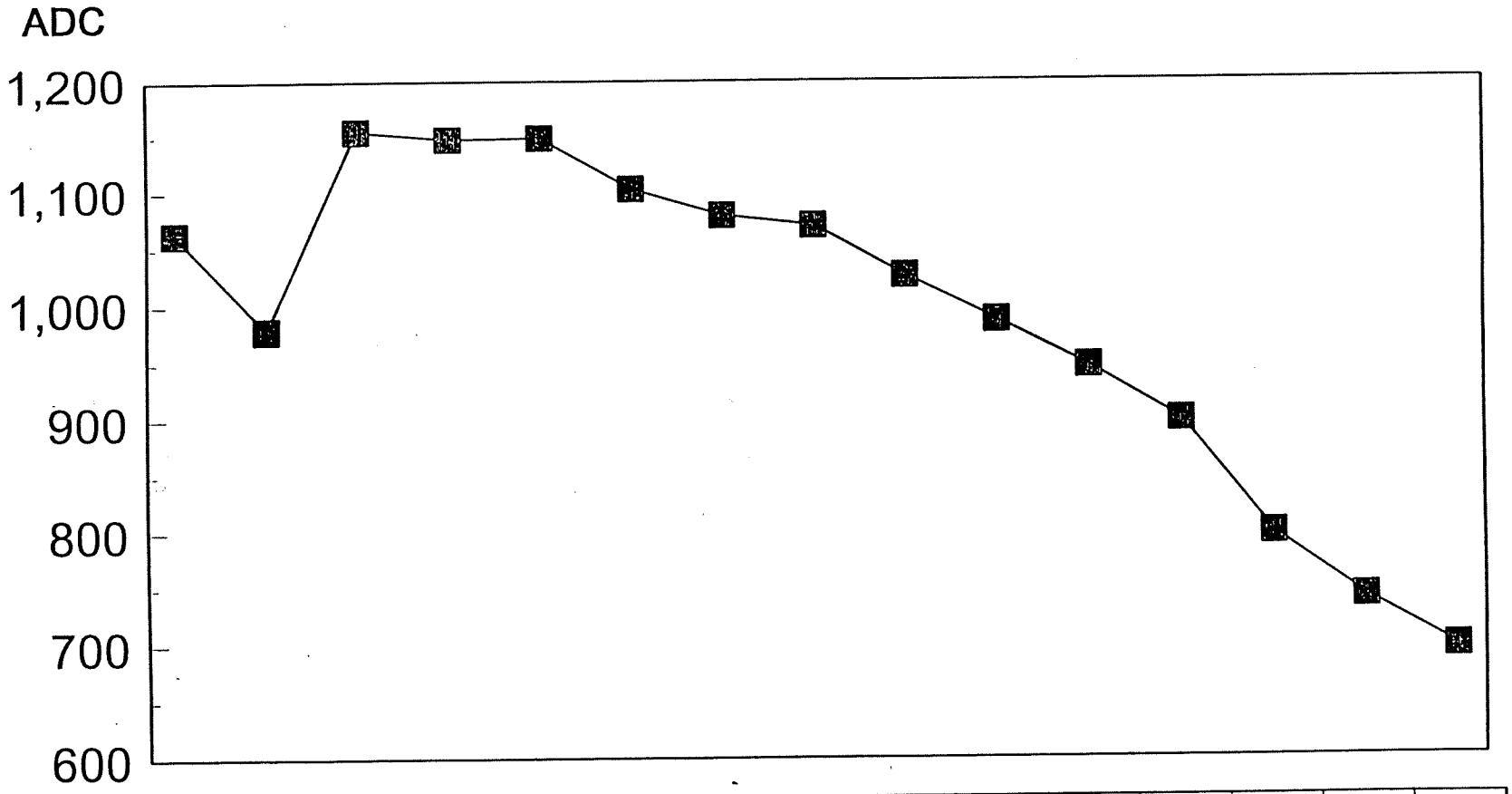
■ Kansas Neurological Institute	$25.0 Million	236 ADC
■ Parsons State Hospital	$18.3 Million	213 ADC
■ Winfield State Hospital	$27.3 Million	247 ADC
■ Total	$70.6 Million	696 ADC

State Mental Retardadtion Hospitals
FY 1982 -- FY 1996
Annual Operating Expenditures



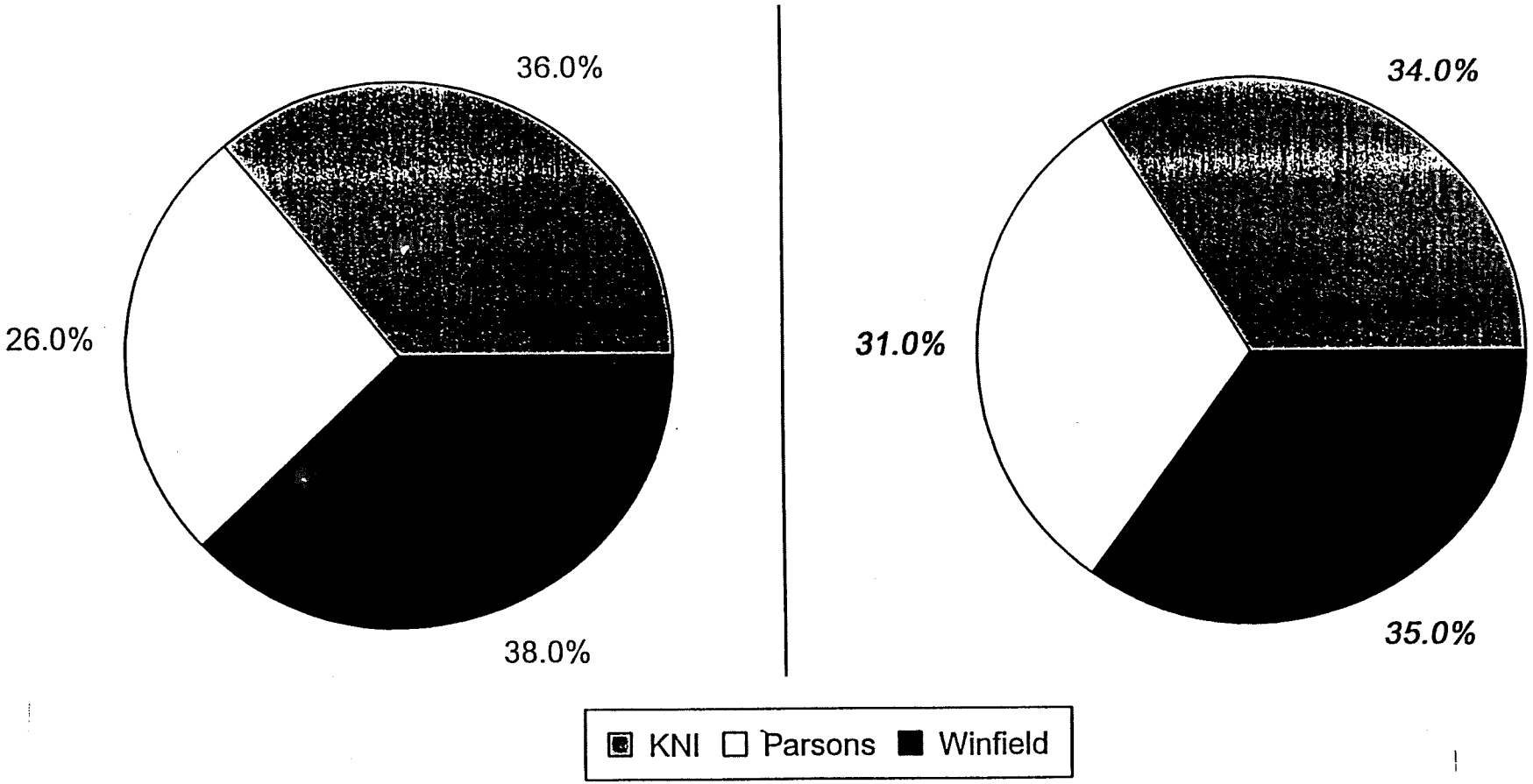
	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
All Fund	31,971,233	34,909,921	36,822,746	40,379,526	45,499,043	48,953,113	54,463,390	64,037,609	70,664,489	73,531,435	73,438,566	71,593,927	70,419,096	70,589,913	70,574,649

State Mental Retardation Hospitals
FY 1982 -- FY 1996
Average Daily Census



	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
ADC	1,063	979	1,155	1,148	1,149	1,103	1,079	1,070	1,026	987	947	899	798	741	696

State Mental Retardation Hospitals
FY 1996
Percentage of Operating Expenditures and Average Daily Census

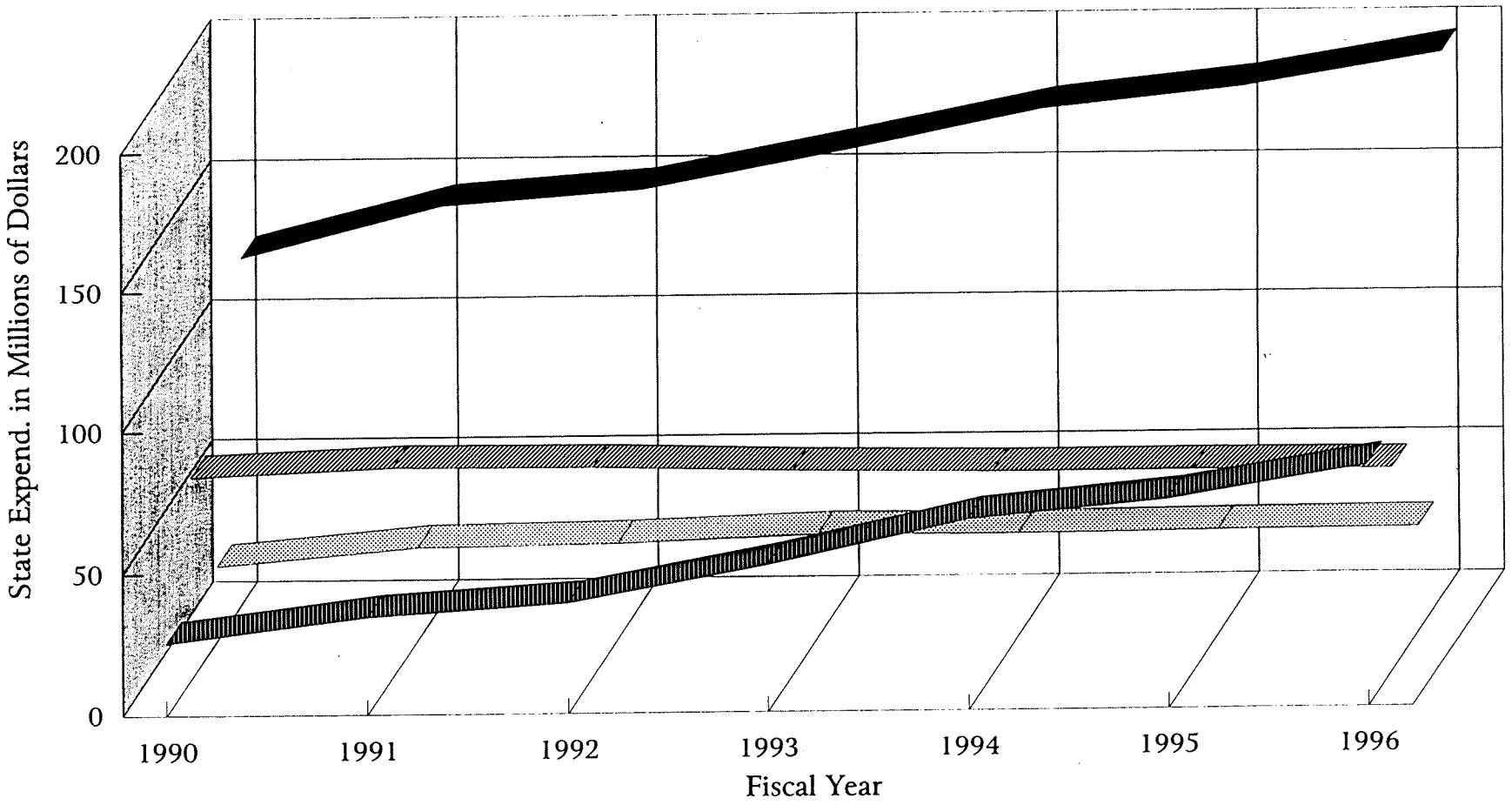


Operating Expenditures

Average Daily Census

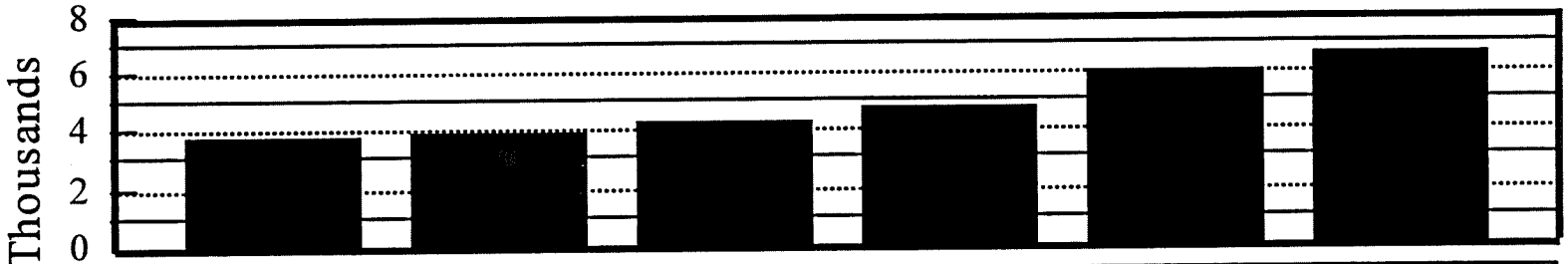
State Expenditures for Developmental Disabilities

Fiscal Years 1990 - 1996



Kansas Legislative Research Department
August 23, 1995

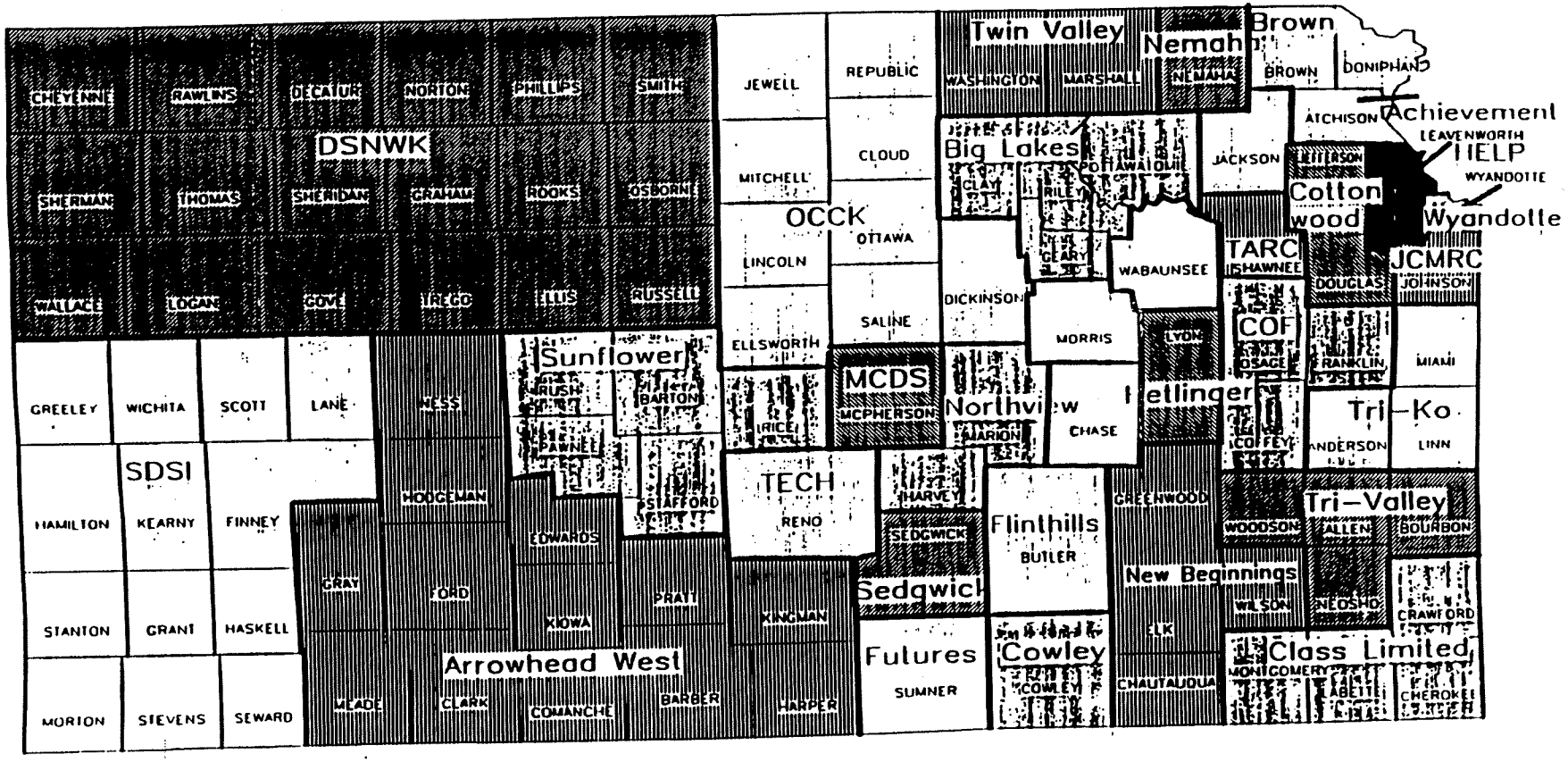
Persons Served In Community Settings



FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	FY 1995
3,782	3,870	4,244	4,734	6,034	6,584

Does Not Include Persons in ICFs-MR

COMMUNITY DEVELOPMENTAL DISABILITIES ORGANIZATIONS IN KANSAS



Attachment I

Services Offered by Community Developmental Disabilities Organizations

Residential Services
- Supported Living
- Semi-Independent Living
- Group Living
- Recreation and Leisure Activities

Life Enrichment Services
- Retirement Services
- Work-Enrichment Services

Support and Ancillary Services
- Targeted Case Management
- Health Support Services
- Supported Family Living
- Respite Care
- Home- and Community-Based Services (Medical Waiver)
- DDP Screenings
- Psychosocial Services

Employment Services
- Supported Employment
- Independent Employment
- Structured Employment
- Industry-Based Employment
- Center-Based Work Sites ("Sheltered Workshops")
- Work Skills Training
- Job Development
- Job Match
- On-Site Job Training
- Follow-Up Support

Other Services
- Pre-School Services
- Personal, Social and Community-Living Skills Training
- Services for People with Dual Diagnosis
- Transportation
- Americans with Disabilities Act Referrals
- Consulting
- Family Support Services
- Community Education

Attachment V

State Expenditures for Community Mental Retardation Services[a] (In Millions)

	Fiscal Year							% Change
	1990	1991	1992	1993	1994	Est. 1995	Rec. 1996	FY 90-96
Mental Retardation Grants These are awarded to community facilities to provide specific services	$7.5	$11.5	$13.7	$15.5	$13.4	$13.0	$15.1	101.3%
Community and Day/Living	9.9	10.3	10.3	10.3	10.2	10.1	10.1	2.0
State Aid This money is distributed to community mental retardation facilities on the basis of population	6.1	6.0	6.0	6.0	6.0	6.0	6.0	(1.6)
Medicaid This money is used to provide community services, and includes both state and federal moneys (59% federal, 41% state)	2.0	6.8	8.7	18.6	35.2	41.9	50.8	244.0
Family Subsidy/Support(b These grants are provided to families to help them pay for extraordinary expenses incurred in caring for their mentally retarded children	0.0	0.0	0.4	1.5	2.4	2.6	2.9	625.0
Parent Assistance Network	0.0	0.0	0.0	0.0	0.0	0.1	0.1	--
TOTAL	**$25.5**	**$34.6**	**$39.1**	**$51.9**	**$67.2**	**$73.7**	**$85.0**	**233.3%**

a) In addition to these expenditures, the state also pays for medical expenses for mentally retarded Kansans who are eligible for Medicaid.

b) The Family Subsidy/Support percentage change is from fiscal years 1992 to 1996.

Attachment VII

Placement Process for Clients Moving from State Hospitals into Community Settings

Movement of clients from institutions to the community is done on a voluntary basis and only with the consent of the client, or the client's family or legal guardian. The process of placing clients with mental retardation and/or developmental disabilities from state institutions has, essentially, four parts, *i.e.*:

Phase I Referral of a client for placement, development of an Essential Lifestyle Plan (identifying an individual's specific needs) plan for the client, and forwarding of the personal plan to a community provider. ***This step occurs at the institutions.***

Phase II Development of a support plan and a cost proposal for the implementation of the plan. ***This is done by the community provider.***

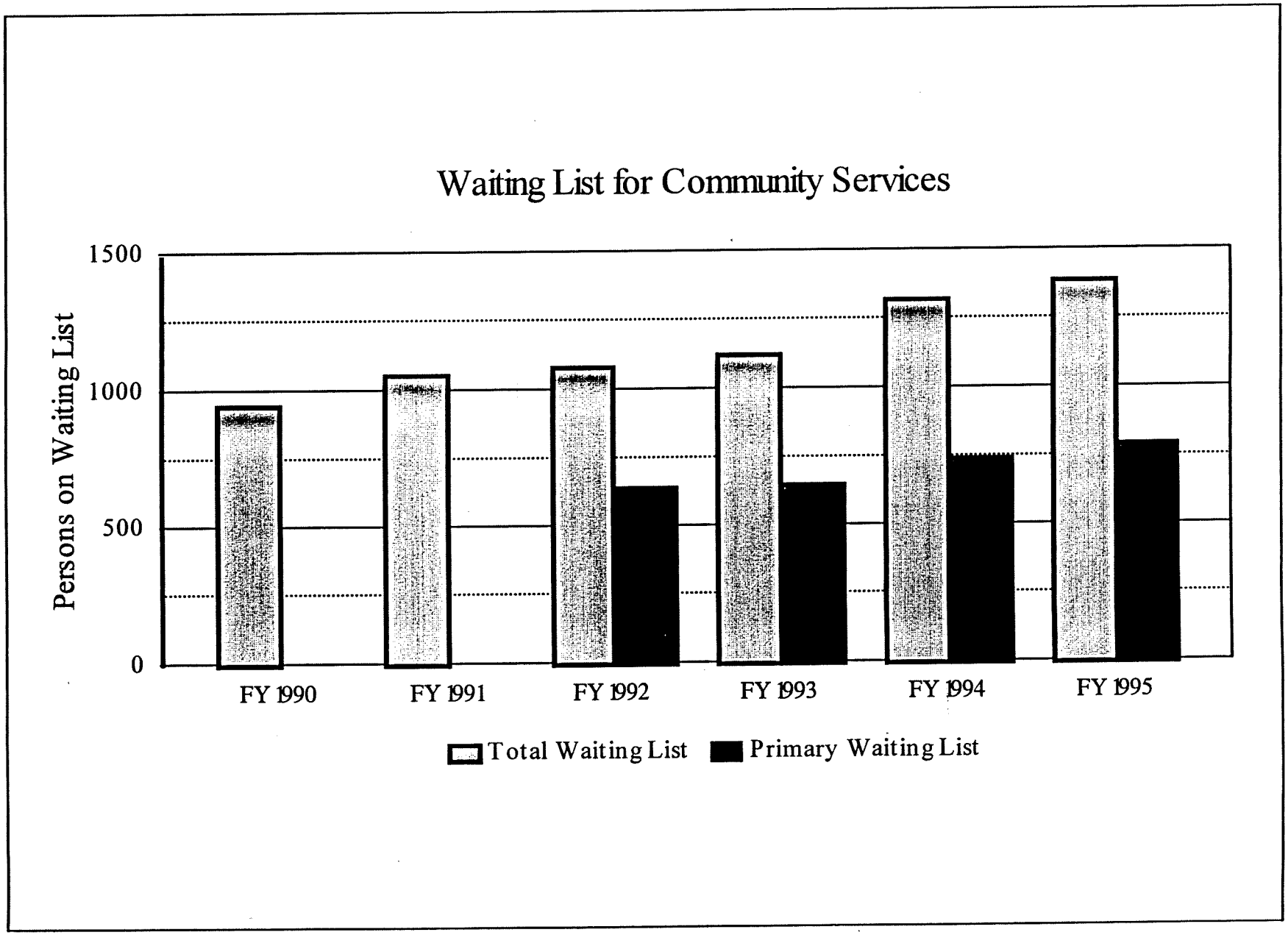
Phase III The support plan and cost proposal are reviewed by the hospital, and, if accepted, are forwarded to the ***Department of Social and Rehabilitation Services***. SRS reviews and, if appropriate, approves the support plan and cost proposal, ensuring that HCBS-MR waiver funding will be available for the placement.

Phase IV A transition plan is formulated for the client by the hospital and the community provider. Arrangements are made for the client to move from the institution into the community-care setting. This involves finding roommates for the client, hiring staff and making other living arrangements. ***The client will move in the immediate future.***

Number of Clients at Each Phase of Placement Process

Hospital	Phase I	Phase II	Phase III	Phase IV	Duplicated Total*	Unduplicated Total
KNI	9	74	0	2	85	55
Parsons	0	24	0	0	24	17
Winfield	21	121	1	0	143	100
TOTAL	31	220	1	2	254	174

* Individuals may be in the same step multiple times, indicating multiple referrals, or they may be in different steps in different agencies.


Waiting List for Community Services
Persons on Waiting List
1500
1000
500
0
FY 1990
FY 1991
FY 1992
FY 1993
FY 1994
FY 1995
Total Waiting List
Primary Waiting List

Kansas Council on Developmental Disabilities

BILL GRAVES, Governor
Tom Rose, Chairperson
JANE RHYS, Executive Director

Docking State Off. Bldg., Room 141, 915 Harrison
Topeka, KS 66612-1570
Phone (913) 296-2608, FAX (913) 296-2861

"To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities"

COMMITTEE ON WAYS AND MEANS
JANUARY 9, 1996

Testimony in Regard to Hospital Closure

To ensure the opportunity to make choices regarding participation in society and quality of life for individuals with developmental disabilities.

Mr. Chairman, Members of the Committee, I am appearing today on behalf of the Kansas Developmental Disabilities Network and the Council on Developmental Disabilities regarding hospital closure.

The Developmental Disabilities Network consists of the three entities in Kansas who function under the federal Developmental Disabilities Assistance and Bill of Rights Act of 1994. These entities are: **Kansas Advocacy and Protective Services** (KAPS), represented by Mr. Jim Germer, Executive Director; **University Affiliated Programs, University of Kansas** (UAP), represented by Dr. Wayne Sailor, Director of the Lawrence campus UAP; and the **Kansas Council on Developmental Disabilities** (KCDD), which I represent. Last year this Legislature did two things for people with disabilities for which you are to be congratulated. You passed the Developmental Disabilities Reform Act which will have significant impact on the service delivery system for individuals with developmental disabilities in Kansas. This Act had the support of service providers, advocacy organizations and family members who spent many hours working with your colleagues in the House to develop the bill and who also worked collaboratively with SRS in the development of the accompanying regulations. You also passed legislation which enacted the Hospital Closure Commission whose recommendations we are discussing today. We appreciate the opportunity to review these issues with you and we thank you for the invitation. We believe that the Network has considerable expertise in this area and we are more than willing to extend our collaboration with Social and Rehabilitation Services in this process.

Hospital closure is not a new phenomenon. A lawsuit begun in 1974 resulted in the closure of the Pennhurst Center in Pennsylvania, which once housed over 3,000 residents with mental retardation. Numerous other states, Oklahoma, Wyoming, New Hampshire, Vermont, New York, California,

SWAM
January 8, 1996
Attachment 4

Washington, Texas to name a few, have closed their institutions. As a result, appropriate procedures and best practices for hospital closure can be identified. In addition, Kansas has a new Developmental Disabilities Reform Act which describes procedures for the provision of community based services to individuals with developmental disabilities.

The Hospital Closure Commission's Recommendations to the Governor are excellent. We applaud the Governor's support of the Closure Commission and the additional funds he recommends for transition. However, we would like to make some additional recommendations regarding the procedure. With my testimony I provided you with the *Planning Document For The Closure Process Affecting Winfield State Hospital.* I would like to direct your attention to this document.

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Developmental Disabilities Network

Planning Document For The Closure Process Affecting Winfield State Hospital

Developmental Disabilities Network - History

The Developmental Disabilities Network consists of the three entities in Kansas who function under the Developmental Disabilities Assistance and Bill of Rights Act of 1994. These entities are:

Kansas Advocacy and Protective Services (KAPS)
Kansas Council on Developmental Disabilities (KCDD)
University Affiliated Programs, University of Kansas (UAP)

KAPS is the legal branch of the Act. Their role is to ensure, by use of legal, administrative and other appropriate remedies, that the rights of persons with disabilities are protected. They employ attorneys who work on behalf of individuals with disabilities.

The **UAP** functions as the training and technical assistance branch, providing pre-service and in-service training for providers, policy makers and others who works with individuals with developmental disabilities. The Kansas UAP is based on three sites: the KU campus in Lawrence; Parsons State Hospital and Training Center; and the KU Medical Center campus in Kansas City. The UAP functions to provide personnel training, technical assistance, direct services (early childhood), and research and information dissemination to the community of families and service providers. Kansas UAP personnel represent one of the largest concentrations of expertise in the country on the topic of persons with severe disabilities and have been extensively involved with deinstitutionalization efforts in Nebraska, Oklahoma, Pennsylvania, California and Oregon in addition to Kansas.

The **KCDD** is the policy branch. They advocate for systems change, working with the Kansas Legislature, Congress, and other policy makers in the development of policy and procedure that affect individuals with developmental disabilities. The Council has fifteen members appointed by the Governor with the majority being consumers. There are also representatives from the agencies who serve individuals with DD. Through its triennial State Plan, the KCDD is responsible for reviewing and monitoring federally-assisted programs affecting people with disabilities, assuring that the programs are meeting people's needs, implemented effectively, and coordinated with other programs. The KCDD uses it's federal funds to support innovation, planning, coordination and education of policy makers.

All three Kansas organizations pool their resources to effect change in the Developmental Disabilities service system.

The Reason for this Report

The Network has closely followed the debate and discussion that has been concerned with state hospital closure over the past two years. The Network leadership has an abiding concern that the primary consideration in the closure of state hospitals be the *rights*, *dignity* and *well-being* of hospital residents and that fiscal and personnel issues, while important, remain secondary issues in this process.

The sum of literature amassed over the past twenty years clearly suggests that the following basic assumptions concerning the deinstitutionalization process are warranted:

- Appropriate community placement options *are preferable* in all cases to institutional placements;
- Inter-institutional transfers of residents to accomplish hospital closure *are harmful* to hospital residents and potentially harmful to residents in the receiving institution as well; and pose the risk of inconvenience and difficulties for parents and family of residents.

- Waiting lists for community placement *are nonviable* because funds needed to establish and support community placement are tied up in support for state hospitals. The condition of residents on waiting lists worsens during the waiting period making community placement more difficult. For that reason additional funds may be necessary in the first phase of closure for start-up costs for community services;

- All hospital residents *can be served* in appropriate community placements, including those with the most severe medical, cognitive, and/or behavioral disabilities;

- Community placements *afford a better quality of life* for DD residents at a lower average cost, compared with institutional placements.

Each of the above assumptions has been the subject of extensive study and each is documented in the research literature. Kansas is far ahead of most states in the potential for successful community placement of hospital residents because of the breadth of expertise that exists in the state to support the effort. Kansas experts are regularly called upon to assist similar efforts in other states and have participated in a number of deinstitutionalization procedures in other states.

The Network is prepared to commit the resources of its constituent systems to support the Kansas deinstitutionalization effort. It is the Network's position that the closure of Winfield State Hospital can be effected over a two-year period commencing January 1, 1996, with all present residents accommodated in appropriate community placements. Furthermore, the Network will work to ensure that the quality of community care and support afforded to former residents will be the equal of the best to be found in the nation, and at a lower average cost than incurred in the State Hospital.

Toward this end, the DD Network agencies have endorsed the following position statement:

> Individuals with developmental disabilities have the rights and responsibilities of making choices through their support participation in society.
>
> Individuals with developmental disabilities have the rights and responsibilities to full inclusion; to live, work, recreate, and develop relationships in the community of their choice and to participate to the fullest extent possible, including the choice of where they wish to live.
>
> An essential component of choice and community inclusion is supporting and promoting self-advocacy and citizens advocacy on behalf of persons with developmental disabilities.
>
> In order to achieve community inclusion, we recognize the fundamental importance of family, friends, neighbors, and other community members necessary for interdependence. These supports and relationships are essential to a full life for persons with developmental disabilities.

The Developmental Disabilities Network supports the movement of individuals from hospitals to the community. The transition must occur in a prompt manner and in accordance with a transition plan developed under the auspices of the Community Developmental Disabilities Organizations (CDDO) from the region to which the person is moving. Under the DD Reform Act the newly named Community Developmental Disabilities Organizations (CDDOs) are the gatekeepers for community services. An individual seeking services applies to their local CDDO who determines eligibility and works with the consumer and their support network in deciding what services are needed and from whom the services will come. The emphasis is on opportunities of choice for the individual with developmental disabilities and on community responsibility for the provision of services.

In the attachment, *The Texas State School Closure Plan*, on page 11 they discuss the planning process they will use and indicate that using local responsible entities empowers decision makers at the community

level to respond to the specific needs of the individual site. Central office staff provide general oversight and coordination but the actual planning is done by teams composed of local community service providers (in our case, the CDDO, independent living center and other affiliates), consumers and their support networks, representatives from advocacy groups, and hospital staff. Kansas should replicate this strategy.

Proposal

We propose that the closure of Winfield State Hospital be effected in accordance with a management plan developed by a closure task force appointed by the Secretary of SRS. This task force must include representatives of the DD consumer community, representatives from the appropriate communities (CDDOs, Affiliates, family members, and employee councils), SRS staff, and the DD Network. The task force should utilize outside consultants on key technical issues as needed.

This Task Force Plan should be sufficiently detailed to accomplish community placement of one-third to one-half of Winfield's resident population in 1996. For the second year the Plan should be updated to place the remainder of the original 1995 resident population to effect closure at the end of the two-year period.

The Management Plan should address at least the following:

1. The target community for each resident - Preferences should be given to geographic relocation of the individual to be as close to *family* members as possible. This brings up several issues. First is the principle of *informed* choice for consumers and their family members. Research findings from Oregon and elsewhere show that some family members have little experience with community settings. However, after experiencing the family member living in a small community-based setting, they have expressed very positive feelings towards those programs. Kansas must strike a balance on the issue of choice between the small community living arrangement options supported by research, the interests of the resident, and the choice of the family member/guardian which may not be grounded in familiarity with research literature. Neither alternative should be ideologically driven.

   Second is the issue of living close to family members. The Kansas Guardianship Program worked very hard to locate and train guardians in the Winfield area. That was the best solution at the time for persons whose parents or relatives were unable to be their guardian. However, research shows that individuals with disabilities who are placed in their home community have more natural supports, community integration, and community responsibility.

2. Use of an individualized, person by person, transition plan for each resident - this assists the movement to the community through a team approach. SRS has developed the Community Integration Demonstration Project which facilitates transition into the community by providing with wrap-around, community-based supports. The Essential Lifestyle Plan is an integral component of this process.

3. The enhancement of facilities and capacities in the target community - at present, DD reform and its accompanying regulations will provide some safeguards; also of assistance are the establishment of Targeted Case Management, DD Regional Coordinators, and the self-advocacy and citizen advocacy programs.

4. The staff training needs in each community - the nationally recognized KUAP Direct Care Staff Training Curriculum will be of assistance as will the continued use of training requirements for CDDOs. The Positive Behavior Support Project, sponsored by SRS, KCDD, and the State Board of Education, will also assist in training for persons who work with those with behavior problems. Training for CDDO staff must be a priority and the Network is very willing to provide assistance in this area.

5. The support for parents and families of residents;

6. Staff relocation and support needs of classified employees;

7. Finance issues - financing the transition and required services, including reallocation of the hospital budgets must be addressed. Funding must remain intact and accompany the person with a disability into the community;

8. Alternative use options for the sites;

9. Evaluation of the plan - Network members are aware of many sources both in the State and beyond who would serve as excellent resources. These persons have great experience in dealing with the issues of deinstitutionalization and the implementation of appropriate community-based support. The Kansas DD Council may be able to assist with funding for this;

10. Longitudinal study of the results of the closures - follow up on the well being and adjustment of individuals who have moved from the institution to reside in the community is critical. Important issues to study include the level of community supports, progress compared to those remaining in the institution, and the condition of those who transfer to other institutions. A number of states have shown that people who moved to the community fare better than people who remained in institutions.

11. Public communication - the process needs to be open with frequent, formal communication between the closure group and consumers and their support networks as well as between hospital staff. This will reduce anxiety for both groups who are concerned with the closure.

For the two-year close-out period, the Winfield operating budget should be dedicated to the placement program. Each year one-half of the budget should be directed to community placement with appropriate supports and work force development. Beginning in Year Three, community placement expenses should reduce the actual cost of community support and the savings (relative to the hospital costs) redirected within the State's DD support system to prepare for further hospital closures. Additional funding may be needed in the first two years for service start-up costs, especially for housing, staff training, and other one time expenses. We recommend that the closure task force study this issue to determine what is needed and that the budget be flexible enough to respond to the needs identified.

In closing, I wish to emphasize our willingness to continue our collaborative efforts with Social and Rehabilitation Services and the Legislature in this process and our support for the directions you have provided to create an organized network of community services and alternatives to institutional services for persons with developmental disabilities.

als in the community in a number equal to 300 placements a year from the date of the agreement to the date of the closure of the first state school (but not fewer than 600 placements in total).

At least 95% of these placements will be into homes of no more than six residents. The Settlement Agreement mandated that Governor Ann Richards appoint a task force to make recommendations regarding closure or consolidation of state schools for the mentally retarded. The necessary legislation for this was entered as House Bill 7 (1 HB 7), 72nd Legislature, and was signed by the Governor in August 1991.

After months of reviews, the task force submitted five

Principles Regarding Closure

- ✓ The relocation of people served shall occur through a smooth transition accomplished in a sensitive manner and on an individual basis.
- ✓ The person served and their family shall be involved with the interdisciplinary team in making decisions about relocation and shall be informed of options as appropriate depending on the recommendation for transfer to another facility or community placement. People in need of advocacy services will be provided assistance to participate in relocation decisions.
- ✓ Site preferences of the person served and their family for transfer to other state facilities shall be honored.
- ✓ To the greatest extent possible, and consistent with individual and family preference, the geographic relocation of a person to be close to family members shall occur.
- ✓ Planning for relocation shall include considerations of maintaining friendships and relationships to other significant people, including employees.
- ✓ A timely, accessible, and responsive appeal mechanism shall be available to individuals and their families when relocation decisions are viewed as unsatisfactory.
- ✓ Relocation shall occur only when appropriate transition planning has occurred and it has been determined that a person's individual needs can be adequately met in the new setting.
- ✓ Individuals, families, and employees shall be provided the necessary supports and assistance as desired in adjusting to change created through facility downsizing and relocation.
- ✓ A method and forum of on-going communication shall be utilized to promote timely and accurate information throughout the transition process to dispel the misinformation that often accompanies significant change.
- ✓ The development of quality community placements and supports which are individually designed and delivered shall be planned and implemented through a collaborative process involving public and private entities.
- ✓ Various levels of monitoring after relocation shall occur at appropriate intervals to ensure continued appropriateness and quality of services provided.
- ✓ Every effort shall be made to maintain in the service delivery system the experienced and dedicated employees currently providing services in the facilities transitioning to closure.
- ✓ Transition of the facilities for alternate use shall be coordinated to ensure proper maintenance during downsizing, facilitate needed conversions, and to dispose of property and assets.

PLANNING PROCESS

TXMHMR has adopted a planning process which incorporates the management principles of continuous quality improvement.

Although general oversight and coordination will be conducted through Central Office, the department has striven to create a process which empowers decision makers at the local level to respond to the specific needs of the individual site. Additionally, every effort has been made to include all interested and affected parties in the planning process.

The planning process will generally be directed through two major components — the facility level, and the regional level. Representatives of advocacy groups will participate in planning activities in an advisory capacity at the facility and regional levels; a group of family members will participate in an advisory capacity at each of the two state schools.

Facility Planning

Within weeks of the announcement of closure, a number of workgroups and committees were established at both Fort Worth and Travis and charged with reviewing different aspects of the closure.

The facility leadership team/ executive staff established the focus of each of these workgroups, appointed the staff to participate, and provides the necessary oversight and coordination. The various workgroups and committees and their general charges are outlined in the box on the following page.

The structure of each workgroup is cross-functional; where appropriate, staff from MHMR centers are included as participants. The work done by these workgroups to date has been significant and serves as the basis of this document. Throughout the transition to close, they will continue to develop plans and implementation steps which will be reviewed and executed by the leadership or executive staff of each of the two facilities.

These workgroups have typically met weekly, and have liaisons with staff of the Mental Retardation Services division. Planning activities between the two facilities have been coordinated through periodic meetings to share information and through exchange of newsletters, minutes, and other documents.

In addition to achieving the primary purpose of assisting in the development of the closure

See box on the following page regarding *Facility Workgroups - Committees and Charges.*

plan, these workgroups have yielded an additional benefit. The participation and representation of all levels of staff has been critical to gaining support and understanding for the process and facilitating communication within the facility — an immediate concern from the announcement of closure.

Facility Workgroups — Committees and Charges

Campus Operations — To maintain compliance with essential certification and operations standards and to ensure appropriate resource allocation and utilization.

Client and Family Relations — To develop and implement processes to provide information and support activities to individuals served and their families.

Closure Evaluation — To evaluate the processes used during closure and the outcomes of such.

Communications — To implement mechanisms whereby staff receives timely and accurate information.

Community Relations — To develop and implement strategies to assure accurate information is provided on an on-going basis to our external customers and suppliers regarding the status of the closing state schools.

Employee Relations — To propose employee benefit packages and implement employee assistance programs.

Transfers and Community Placement — To develop, implement, and monitor processes for the out-placement of all current residents of the closing state schools.

☆ Regional Planning

At the regional level, two regional planning teams comprising representatives of the state schools and MHMR centers most affected by the closure will develop plans related to community placements.

The North Regional Planning Team includes the superintendents of Fort Worth and Denton State Schools, and the executive directors of Dallas, Tarrant, and Denton County MHMR Centers. This team was established first since the North Texas region is clearly the area of the service delivery system most impacted by the planned closures; there are approximately 225 people in need of placement in the North Texas region from Fort Worth and Denton State Schools.

A Central Regional Planning Team will similarly be established to serve individuals returning to local communities in the Central Texas region from Travis State School. The Central Regional Planning Team includes the superintendents of Travis, Austin, and San Antonio State Schools, as well as the executive directors of Harris County and Austin/Travis County MHMR Centers.

Both of these teams are authorized to establish various workgroups as needed to address issues and formulate plans spe-

cific to their regions. The teams are responsible for determining the focus of each workgroup, appointing the membership, and providing needed oversight and coordination. In fact, the tremendous need for expansion of community services in Tarrant and Dallas Counties has already resulted in the establishment of two placement planning workgroups by the North Regional Planning Team. These workgroups have been charged with developing and implementing a plan to individually design and deliver services to people returning to these communities. Each will be staffed through newly created positions assigned to the two MHMR centers.

The primary responsibility for placement of people from state facilities lies with each person's Mental Retardation Authority (MRA). The planning and needed development of services will be locally driven by the responsible MRA in collaboration with state facility staff.

Oversight of Planning Process

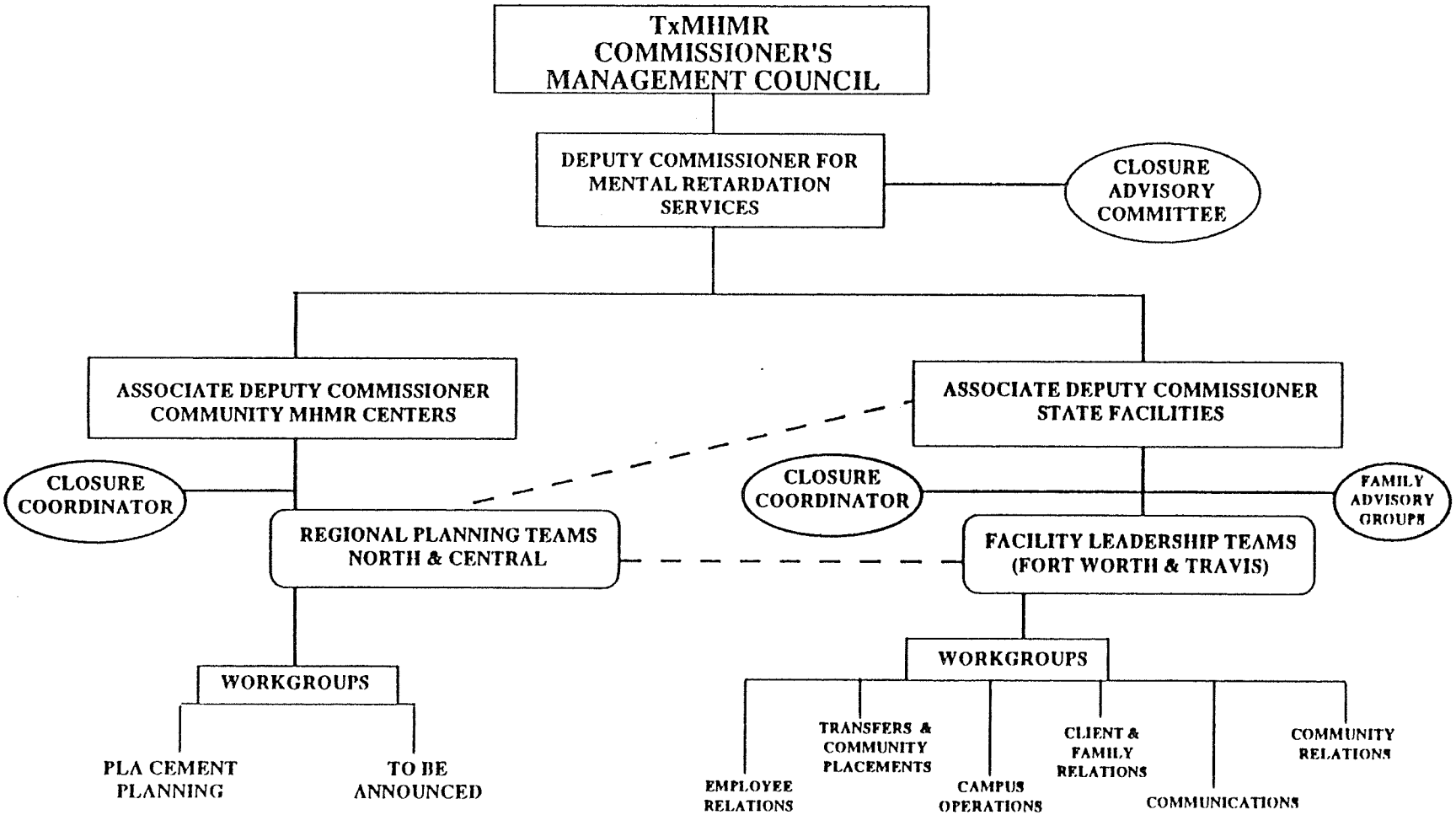
To oversee and advise the entire planning process, the Deputy Commissioner for Mental Retardation Services has established a closure advisory committee which includes members representing divisions of the TXMHMR Central Office, state schools, and MHMR centers.

In addition, the Mental Retardation Services division of TXMHMR has created two positions for "Closure Coordinators," who will be responsible for providing overall coordination, integration, and facilitation for the transition process. Finally, the TXMHMR management committee functions as the organizational structure used to make major departmental policy decisions, ensure system-wide coordination of the transition, and facilitate implementation and removal of barriers to transition.

The entire planning process is a rather extensive one, and an organization chart is provided on the following page. It's worth pointing out once more, however, that in keeping with the goals of continuous quality improvement, it is the department's intent that Central Office simply provide central oversight and support of the closure process; the actual day-to-day management of the process lies with staff of the facilities and regions.

See chart on the following page regarding regarding *Planning Organization.*

PLANNING ORGANIZATION



InterHab
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Dear Jane:

Thank you for seeking our input as you prepare testimony for the Senate Ways and Means Committee regarding the issues of hospital closure. Attached is (1) InterHab testimony given to the Closure Commission and (2) a summary of program principles to which we believe the state should adhere in the implementation of closure plans.

I agree with the Senator Kerr's assessment that closure "issues" should be first on the agenda, prior to any discussion of financing. As we have long said, as regards MR/DD funds, it is not a question of "more" money, it is a question of where to allocate existing funds.

A decision to close one institution will be an enormously positive step toward the goal of re-allocating funds in a manner which would be consistent with state policy and with consumer preference. For too long, families were told that their children could best be served only in institutions. Then as we learned more as a state, we realized that community-based settings were the preferable service mode. Now, many years later, we have a chance to create a state funding stream that parallels what we know to be the better service mode.

Clearly, the best result from closure will be expanded opportunities for all consumers currently receiving services. And, for future generations of families, it is heartening that scarce state dollars, currently concentrated in specific regions of the state, will be increasingly available to Kansans in every region of the state. We must strive to make certain this is accomplished.

Please advise the chair that the members of our organization will be available at future hearings at which their input and expertise is requested.

Thank you for submitting this to the Chair.

Very truly yours,

Tom Laing
Executive Director

C: Chairman Kerr
Members of the Senate Ways and Means Committee

TO: The Senate Committee on Ways and Means
FROM: InterHab - The Resource Network for Kansans with Disabilities
Tom Laing, Executive Director
DATE: January 9, 1996

SUBJECT: Principles relating to Hospital Closure

Downsizing and closure are not new concepts. The current Kansas system has been shaped by more than twenty years of downsizing activities, implemented by CMRC's and their affiliated Community Service Providers.

The current model for placing residents of state institutions in private community-based settings is the Community Integration Program.

However, if the State intends to consider other plans to accomplish the closure of Winfield State Hospital and Training Center, the State should adhere to strict guidelines by which such plans would be evaluated, in consideration of legal, implementation and programmatic issues.

Legal Issues:

Are closure plans in keeping with the provisions of the DD Reform Act passed and signed into law in 1995, to be enacted January 1, 1996? Given that the Act was supported by parent groups, consumer advocacy groups and provider organizations, the following provisions must be considered:

(1) a consumer's "right to choose" service from among qualified service providers

(2) regional gatekeeping, evaluation and eligibility screening by locally designated community developmental disability organizations (CDDO's).

Legal Issues (continued):

(3) rates set as a result of an independent review of rates (and cost factors which enter into those rates).

(4) specific rate requirements for persons leaving institutional settings that are based on persons' needs, not organizational needs.

(5) outcomes which reduce the state's reliance on separate, segregated settings (whether such settings are state or private)

Implementation Issues:

Will the intent of the legislature be reflected in the operational activities surrounding closure? Will consumer interests be the highest priority interests? Will closure plans reflect the interests of all consumers in the reallocation of system funds? To affirm the executive and legislative goals for the MR/DD system, and to prevent this process from becoming dominated by narrow interests, it is imperative:

(1) that proposals be requested and welcomed from all qualified entities,

(2) that rates be set under the same policies affecting all persons, subject to the provisions of the DD Reform Act.

(3) that entities interested in submitting such proposals be qualified under the same laws, rules and regulations governing all other community providers of service.

(4) that all proposals be reviewed both by the state and the CDDO(s) in the geographical area(s) where persons would be seeking to relocate.

Program Issues:

Special privatization plans should meet the same state program expectations, as well as licensing and quality enhancement standards, required of all other community service providers, including:

(1) downsizing of separate segregated settings,

(2) strictly limited instances in which consumers are required to relocate more than once.

(3) adherence to the concept that persons leaving institutions be allowed to live in their home community or the community of their choice.

(4) assurance that consumers and families have information on all qualified community service providers and service options at their disposal, so that they can be fully informed as to the range of their choices.