

Restructuring Capital Assets in the MHMR System

Susan Massart, Staff
House Appropriations Committee
November 16, 2005



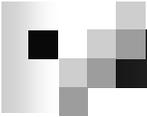
Restructuring the MHMRSAS System

- Restructuring efforts prompted by:
 - U.S. Department of Justice (DOJ) investigations of five facilities under the Civil Rights of Institutionalized Persons Act (CRIPA) in the 1990s
 - Expert assessments of facility care (Geller reports)
 - Perception that system was overly reliant on institutional care
 - Uneven distribution of resources and services
 - Questions regarding service quality, accessibility and accountability
 - Frustration that system was unresponsive to consumers and families



Restructuring the MHMRSAS System

- Studies and initiatives to begin system reform:
 - HJR 240 (1996) and HJR 225 (1998) comprehensive evaluation of the publicly funded MHMRSAS system
 - 1998 Governor's Commission on Community Services and Inpatient Care (Hammond/Anderson)
 - Development of a Community and Facility Master Plan (1998-99)
 - Gubernatorial proposals to close several state facilities (1998 & 2001 Sessions)
 - Legislative action to promote accountability in system, address shortcomings in state facility care, expand community-based services and strengthen consumers role in care (1998-2001)
 - HB 995 (2002 Session) statutory process for restructuring the mental health system and creation of a MHMRSAS trust fund
 - 2003 General Assembly budget language established a framework for community reinvestment plans for discharging and diverting patients from state facilities
 - 2004 DMHMRSAS regional strategic planning process
 - 2005 DMHMRSAS integrated strategic plan



Where Do We Stand Today with Restructuring the MHMRSAS System?

- System is moving toward a recovery model with heavy emphasis on community integration and treatment
- There will be a continuing need for state facility care for some MHMRSAS consumers
 - Decline in the availability of private psychiatric beds
 - Decline in 3rd party coverage of psychiatric services puts pressure on state facilities to serve uninsured or underinsured patients of private hospitals
 - Population growth
- Continued effort to restructure the system of care from a facility-based system to a community-based system will require significant restructuring of our capital assets
- Restructuring capital assets could free up dollars to reinvest in community treatment



Restructuring Capital Assets

- Current MHMR facilities do not support state-of-the-art care for the population we are serving
- Current and projected census do not require the number of buildings we are operating and/or maintaining
- Obstacles to restructuring
 - Every region feels the state facility serving its geographical area is critically needed
 - Parents and advocates for institutionalized persons may oppose continued deinstitutionalization efforts
 - Possible opposition from state facility employees
 - Need for community reinvestment



Status of Current Capital Assets

- Current facilities are large, sprawling campuses with vacant buildings
- Many buildings do not meet current building code requirements
- Critical life, health and safety improvements needed for several facilities
- Backlog of deferred maintenance
- Current facility designs do not meet programmatic and care needs
- Buildings do not promote staffing efficiencies
- Facility design and equipment do not minimize work-related injuries of staff



Restructuring Capital Assets May Make Economic Sense

- New facilities should result in more efficient operating costs
 - Ongoing savings could be used for community reinvestment

- Potential for reuse of land and/or buildings
 - Benefits to local economy
 - Opportunities to trade assets for new facility and/or community reinvestment