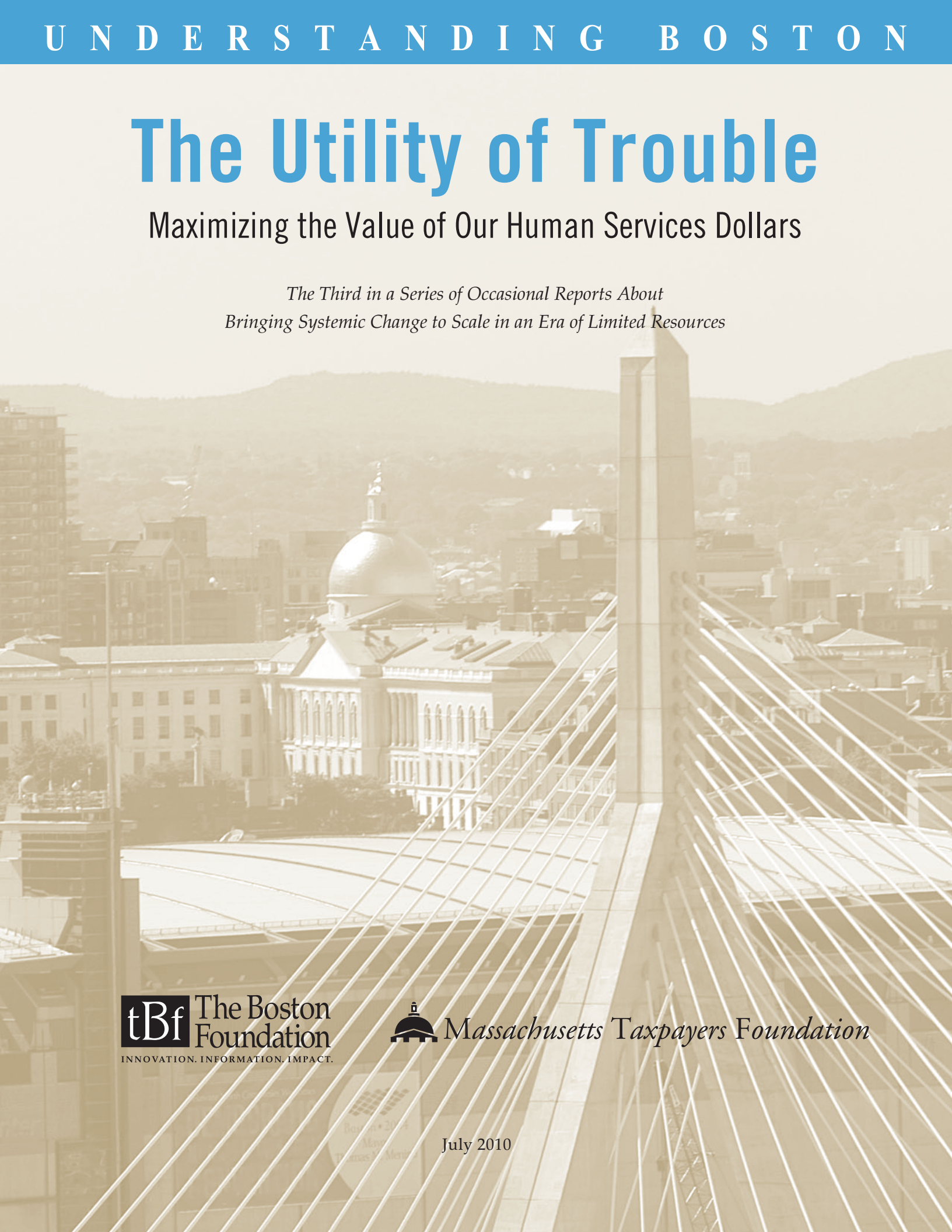
UNDERSTANDING BOSTON

The Utility of Trouble

Maximizing the Value of Our Human Services Dollars

The Third in a Series of Occasional Reports About
Bringing Systemic Change to Scale in an Era of Limited Resources



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July 2010

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The Utility of Trouble

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Executive Summary

The delivery of human services has been revolutionized over the past 40 years, but in at least two important aspects Massachusetts has lagged—failing to reform the administrative structure of the human services agencies, and retaining too many large institutions for clients who could be better treated in community settings.

When the Executive Office of Human Services was formed in the early 1970s, the plan was to streamline and coordinate the disparate configuration of regional and area offices of the human services agencies. While some refinements have been made over the years, today there are 149 area offices spread often randomly across the Commonwealth under the umbrella of the Executive Office of Health and Human Services (EOHHS).

Similarly, four decades ago Massachusetts led the nation in moving clients out of large isolated institutions into community treatment, the policy known as deinstitutionalization. But the Commonwealth now trails many other states with its continued undue reliance on institutions at great expense and with lost opportunities for clients to live in the community.

The current administration deserves credit for taking significant constructive steps in both of these areas. However, the recommendations in this paper urge more sweeping initiatives. The state is experiencing an unprecedented fiscal crisis which demands urgent action. To the maximum extent, every human services dollar should be spent on care for clients.

The analysis in this paper focuses on the seven largest human services agencies within EOHHS: the Departments of Mental Health (DMH), Public Health (DPH), Transitional Assistance (DTA), Children and Families (DCF, formerly the Department of Social Services), Developmental Services (DDS, formerly the Department of Mental Retardation) and Youth Services (DYS), as well as the Massachusetts Rehabilitation Commission (MRC). MassHealth, the Commonwealth's Medicaid program, is included in some of our analysis, but does not use area or regional offices or operate institutions.

Recommendations

I. EOHHS should consolidate its 149 individual area offices into 20 to 24 comprehensive EOHHS centers serving consistently defined service delivery areas, which would save approximately $15 million annually and improve services to clients.

II. The Department of Developmental Services and the Department of Mental Health should close ten antiquated and expensive institutions, which would reduce expenditures by an estimated $50 million annually and ensure that all clients live, receive services and participate in their communities near their families.

These changes are necessary to improve the quality of services delivered by EOHHS agencies. Adopting these recommendations would ensure that every possible human services dollar goes to direct service delivery rather than to state infrastructure, administration, real estate costs and energy bills. These savings should be reinvested to maintain the human services that are vital to Massachusetts residents.

What are the human services addressed in this paper?

- Rehabilitative, supportive, vocational and residential services for adults with physical, developmental and mental health disabilities (DDS and MRC).
- Treatment to promote recovery from serious mental health, substance abuse and chronic or complex medical problems (DMH and DPH).
- Protection for children who have been abused or neglected (DCF).
- Rehabilitation for juveniles who engage in delinquent behavior and protection of the community from those juveniles (DYS).
- A financial safety net for families (DTA).

Recommendation I: Standardize Service Delivery Areas and Consolidate Area Offices

EOHHS agencies operate a total of 149 area (local)[1] offices, housing approximately 5,500 staff. The most important functions of area offices are to establish eligibility for clients, to investigate abuse, to plan, coordinate and deliver services, and to collaborate with community organizations. EOHHS agencies serve many common clients who would benefit from being able to apply for, plan and coordinate all their services in one location. Rationalizing and consolidating area offices would improve access for clients, offer economies of scale, and lead to savings in service coordination. EOHHS should consolidate its 149 individual area offices into 20 to 24 comprehensive EOHHS centers serving consistently defined areas.

Improved Accessibility. Currently, each EOHHS agency creates its own area boundaries, and area staff work in 149 separate offices. This system is confusing and inconvenient for clients and difficult for them to navigate. Sharon residents, for example, must go to Arlington for DCF services and Brockton for DTA services. Even when area offices are in the same community, they are often far apart, 3.7 miles in the case of New Bedford. The current arrangement is particularly burdensome for people who lack public transportation or their own car and for parents traveling with children. This seemingly random organization impedes the capacity of area office staff to serve residents who need help from more than one agency, inhibits collaboration across agencies, and makes it harder to gather and report consistent data on needs and service delivery. A comprehensive office housing all services would be more convenient for clients with multiple needs, and would foster closer coordination among area staff of the different state agencies who serve them.

Realizing Economies of Scale. With 149 local offices, many of them quite small, the state is unable to take advantage of economies of scale or share common resources or space. For example, each office needs space for meeting with clients, providers or community organizations, and each office requires telecommunications and other office equipment. In addition, a recent study[2] found that square footage allowances in many locations exceed industry standards. Combining area offices would create savings through shared space and resources, while reducing management and administrative staffing. Twenty to 24 standard areas, each served by a comprehensive office including all EOHHS area staff, would be an appropriate balance between providing geographic accessibility for clients and cost effectiveness for the state.

Savings in Service Coordination. Staffing for DDS service coordination could be reduced by giving state-contracted providers responsibility for such coordination. Providers who are responsible for delivering direct care, such as 24-hour residential services and day services, could also assume responsibility for coordinating with outside medical, rehabilitation and recreational programs on behalf of their clients. In DDS area offices, service coordinators currently perform service coordination for these clients. Instead, service coordinators should focus their attention on clients who are not receiving 24-hour care and those who do not have another source of service coordination. Some responsibilities of service coordinators cannot be delegated, but the time spent on residential clients could certainly be reduced. This would result in savings in personnel costs and also in space in new EOHHS area offices. Both DMH and DCF should also carefully consider how to reduce any unnecessary overlap between the work of their own staff and that of their contracted providers.

Overall Savings from Combined Area Offices. We estimate that streamlining area offices and prioritizing service coordination can save between $12 and $16 million each year, as shown in **Table 1** and described in more detail in the body of the report.

1 In this paper, we use the term area offices to refer to local offices of EOHHS agencies. Agencies may use different terminology for these offices. This term is not intended to refer to DMH designated areas, which are more akin to the regions of other agencies.

2 Accenture, *Strategic Cost Management Project: Facilities & Services Case for Change*, Workshop #2. February 4, 2009.

TABLE 1

Savings from Consolidation of EOHHS Areas Offices

Type of Saving	20 Offices		24 Offices	
	FTE Reduction	Estimated Savings	FTE Reduction	Estimated Savings
Savings in reduced square footage	n/a	$3,096,396	n/a	$2,888,264
Salary/fringe from reduction in management and clerical positions	97.5	$7,475,780	54.0	$3,735,473
Salary/fringe from reduction in DDS service coordinators	75.0	$5,333,492	75.0	$5,333,492
Total area office consolidation	172.5	$15,905,668	129.0	$11,957,229

Sources: EHS_HR Data Request to DMA 3.3.10. Commonwealth Of Massachusetts Office Of The State Comptroller: Approved Fy2011 Fringe Benefit Rate Based On Fy2009 Actual Costs For Roll Forward And Budgeted Fy2010 Costs For Cost Basis. Lease information as of 2008. EHS_HR Data Request to DMA 3.3.10. EHS Centers Cost Savings Spreadsheet. EOHHS, Strategic Cost Management Project Facilities & Services Case for Change Workshop #2 February 4, 2009. DDS MTF Foundation Savings in EOHHS Administration Request 3,19,2010

Recommendation II: Closure of Antiquated Institutions

As shown in **Table 2**, EOHHS agencies operated a total of 18 institutional facilities with 2,179 beds at a cost of $454 million in FY2009. DDS and DMH should close ten antiquated and expensive institutions, saving tens of millions of dollars each year and ensuring that all clients can live, receive services and participate in their communities near their families. All six remaining DDS Developmental Centers and DMH's two acute psychiatric units should be closed. DMH should determine which longer term units could be closed and their clients transferred into the new Worcester state facility when it is completed. DMH's remaining longer term care beds and DPH's public health hospitals provide services that the private sector is unable or unwilling to meet.

Providing a Life in the Community for People with Disabilities. Forty years ago, Massachusetts was a leader in closing institutions to serve people in the community, but we have now fallen behind other states. Today human services systems strive to serve people in the least restrictive setting that meets their needs. Indeed, states are now required to implement the U.S. Supreme Court's 1999 Olmstead decision[3] mandating that they provide community-based services rather than institutional placements for most individuals with disabilities.[4] Four of the New England states serve people with developmental disabilities solely in the community, and Connecticut operates just one institution. In addition, new psychiatric treatments have drastically improved the prospects of people with serious mental illnesses

TABLE 2

Massachusetts State Institutions: FY2009

Agency	Number of Facilities	Number of Beds	Total Cost
DDS	6	869	$164M
DMH Long Term	6	788	$152M
DMH Acute	2	32	Approx $8M
DPH	4	490	$129M
Total	18	2,179	$454M

Calculation error due to rounding.

Sources: DMR Community Services Expansion and Facilities Restructuring Plan, (Revised March 9, 2009). DDS email update of enrollment dated 5/6/2010. DMH Inpatient Facilities: 2009 Projected Expenditures. DPH Presentation Summaries prepared for the EOHHS Facilities Study Commission, 2010

3 See http://www.bazelon.org/issues/disabilityrights/incourt/olmstead/index.htm. Accessed May 17, 2010.

4 Community based services must be provided when the state's treatment professionals have determined that community placement is appropriate, the affected individual does not oppose the transfer from institutional care to a less restrictive setting, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. See http://supct.law.cornell.edu/supct/html/98-536.ZS.html. Accessed May 17, 2010.

over the past 20 years. DMH has recently closed a large number of beds at Westborough by moving more clients into the community.

Successful Transitions. Both DDS and DMH have closed institutions and successfully moved residents into community-based settings over the last several decades. DDS's transitions have been closely monitored by the court, and surveys of participating families have found high levels of satisfaction with their family member's new placement.

Closing Costly Facilities. Many state facilities are over 100 years old, in poor repair, with inefficient heating and other systems. A number of them are located on multi-building campuses in rural areas, making them hard to reach without a car, isolating clients from their families and communities and making it difficult for families to visit or participate in treatment. The smaller institutions, those with 60 beds or less, are especially expensive to operate because of the challenges entailed in providing round-the-clock care.

Union work rules also reduce managers' flexibility. As a consequence, staffing and overtime costs are high. The costs of providing equal or better services in the community are far less than in a state institution. **Table 3** compares the average cost for DDS and DMH institutions with the average cost of comprehensive community services.

TABLE 3

Comparative Costs of Institution and Community Care

Agency	Cost per Institutional Bed per Year	Cost per Community Bed per Year
DDS	$183,000	$95,000 -$150,000
DMH	$192,000	$55,000 average cost per client for residential and Program for Assertive Community Treatment

Source: DMR Community Services Expansion and Facilities Restructuring Plan, Revised March 9, 2009. DMH Average Median Costs of Adult Community Based Services, http://www.mass.gov/Eeohhs2/docs/eohhs/inpatient_commission/costs_adult_community_based_services.pdf accessed 6/7/2010.

Projected Cost Savings

This section summarizes the estimated $50 million reduction in expenditures that would result from our recommendations. Complete data on institutional revenues from federal sources was not available to include in this analysis. Nor does the report account for savings in fringe benefits associated with savings in salaries.

DDS Developmental Centers. DDS is currently on track to close four of its six Developmental Centers by 2013, projecting annual cost savings of almost $40 million, of which $20 million has already been realized. When this transition is complete, DDS should close its two remaining institutions, the Hogan Regional Center and the Wrentham Developmental Center, over a four-year period (2014 to 2018), offering families choices that provide equal or better care in the community. Based on the average savings from the four closures that are already underway, we estimate that closing the remaining two facilities could save approximately $30 million in annual expenditures, after reinvesting savings to create needed services in the community.

DMH Acute Hospital Units. DMH recently closed a 16-bed acute psychiatric facility in Quincy but continues to operate two other 16-bed acute psychiatric inpatient units (Pocasset and Corrigan). Closing them would save approximately $8 million in costs annually. Half of the amount saved should be dedicated to increasing community capacity for services to prevent acute hospitalization.

DMH Long Term Units. DMH's longer term care hospitals include several units that meet special needs, such as services to people who are deaf and have serious mental illness. In addition, DMH is responsible for serving people with serious mental illness who have committed crimes. These services, which are not covered in private health plans or by Medicaid, are traditionally the responsibility of states and counties. Aggressive treatment and community supports can reduce the need for longer term inpatient care, but some longer term capacity will always be required.

DMH is currently in the process of closing Westborough State Hospital, spending $15 million to create and expand community services for individuals being discharged, and saving approximately $10 million in expenditures annually. DMH also estimates that $100 million in capital expenditures will be avoided, net of

demolition and remediation costs for vacating Westborough. DMH is building a new 320-bed facility on the grounds of Worcester State Hospital to be opened in 2012. At that time, DMH should close the 60-bed Lindemann Center (in downtown Boston) and move those clients to Worcester. This will allow for the transfer of operating funds to the new facility, but there would be minimal savings. DMH should then determine how best to reduce capacity at its remaining facilities to reach a total of approximately 625 beds.

Public Health Hospital Services. DPH's four public health hospitals serve a number of distinct populations with health needs that private facilities do not meet. Some facilities face significant maintenance and repair costs. DPH has no current plans to close or consolidate its facilities, though recent cuts have required it to reduce capacity in each of them; between ten and 122 beds in each facility are not currently used.

DPH should develop a comprehensive plan for consolidating its services into its least costly facilities. The plan should incorporate the data generated by an EOHHS review of state-owned facilities that is currently underway. It should incorporate three options: continued state operation; use of leased space; and contracting out for some services. Because data from EOHHS' comprehensive facilities review is not yet available, we have not made specific recommendations nor estimated potential savings.

Overall Institutional Savings. **Table 4** summarizes the cost savings that can be expected from the recommended closures. These calculations all assume that significant funds are used to create alternative services in the community and show the savings that remain after this community investment.

TABLE 4

Cost Savings from Present and Future Institutional Closures After Investment in Community Care ($ Millions)

	Annual Savings Already Taken	Annual Future Savings	Total Past and Future Savings
DDS Closure of Fernald	$20M		
DMH Closure of Westborough and Quincy	$14M		
DDS Planned Closure of 3 additional ICF's		$19M	
Recommended closure of Hogan		$11.3M	
Recommended closure of Wrentham		$21.5M	
Recommended closure of Pocasset and Corrigan		$4M	
Total	**$34M**	**$55.8M**	**$89.8M**

Source: DMR Community Services Expansion and Facilities Restructuring Plan, Revised March 9, 2009. Conversations with DMH Financial Staff.

Recommendation I:

Standardize Service Delivery Areas and Consolidate Area Offices

Description of Recommendation

Consolidation and Common Area Boundaries

EOHHS agencies' 149 area offices each serve different groups of communities. Area functions differ somewhat among agencies, but the most important are to house staff who interact with clients to establish eligibility, investigate abuse, and plan, deliver, coordinate and monitor services. Area staff also coordinate with contracted providers and community organizations that provide most of the actual services for clients. EOHHS agencies serve many common clients who would benefit from being able to apply for, plan and coordinate all their services in one location.

EOHHS has begun to establish such combined area offices, when termination dates for leases can be coordinated, in communities that already have several area offices. These EOHHS centers will house all staff from the several area offices, facilitating informal communication and providing shared space. Other processes for sharing resources are being developed in the first EOHHS centers and will guide future centers as they are established. EOHHS' efforts do not address the differences in area boundaries nor seek savings in staffing.

EOHHS should establish standard areas applicable to all of its agencies and should locate an EOHHS center with area staff from all its agencies in an accessible location in each of these standard areas. Agencies would not have to establish a full local office in each site if they lack sufficient clients to warrant it, but ideally they should maintain some regular office hours in every EOHHS center to allow their local clients to access services there. Shared office settings should be designed to accommodate appropriately the needs of the populations served by all agencies. Space should facilitate both formal and informal communication among staff of different agencies. Leases should include options for increasing or decreasing square footage as needs change.

The Commonwealth should build on its Virtual Gateway initiative that provides a common eligibility system for all EOHHS agencies, expanding it to provide a common framework for reporting and planning by standard areas. Reporting on service delivery should identify the area in which the service took place, which will enable comprehensive needs assessment and planning across agencies.

Consolidating Administrative Functions

Establishing EOHHS centers creates the opportunity for agencies to share administrative functions such as information systems and support staff, as well as meeting areas, copy machines and other equipment. Consolidating into fewer offices should allow for a reduction of some managerial and clerical staff; we have assumed that social service staff will be shared among the remaining offices in proportion to the caseload in each area.

Expand Alternatives to Office-Based Service Delivery

As it implements these recommendations, EOHHS should develop alternatives for clients to access agencies and services. For example, DTA is making more use of phone and computer communication and creating satel-

A Note on Terminology

EOHHS agencies use different terms to refer to their local offices which are responsible for interacting with clients and local communities. They are called area offices, site offices, and other terms. This paper uses the term area offices to refer to local offices and the term region to refer to the larger geographic designations containing several areas. This differs from DMH, which refers to larger regions as areas and local offices as sites.

lite and outreach sites hosted by community agencies, improving client access without requiring additional state offices.

Common EOHHS Regional Boundaries

Moving toward consistent regional boundaries and oversight structures will further strengthen the value of rationalizing and combining area office functions. Housing regional staff together and standardizing regional boundaries offer advantages when the agencies contract with many of the same providers. EOHHS should develop six standard regions with common boundaries and encourage all of its constituent agencies to follow them. Agencies could combine regions if they need a less robust intermediate structure between their local and central offices. Agencies should maintain reporting for each standard area and the capacity to compile data into EOHHS's standard regions in order to aid in area, regional and statewide needs assessment across agency populations. Given the variation in regional functions and staffing, and lack of data on them, we have not estimated what savings might be realized from making these changes.

Eliminate Duplication in Service Coordination

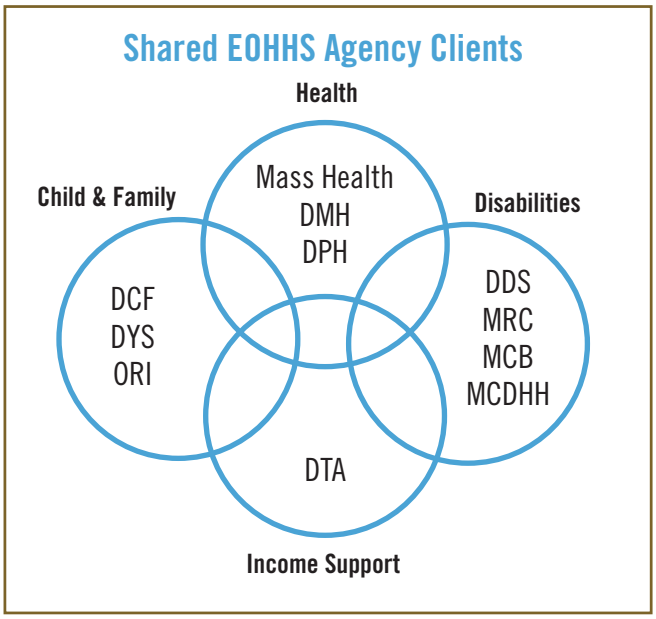
The state should better distinguish the roles of state staff and provider staff who have similar responsibilities. DDS should decrease the time its service coordinators spend on clients in residential programs where many providers already coordinate with outside medical, vocational rehabilitation, and recreational programs on behalf of their clients. DMH and DCF have also increased the responsibility of providers for case management and service coordination, and they should consider how to reduce any unnecessary overlap in this function between state staff and providers.

Rationale

These recommendations will make agencies more accessible and responsive to their consumers while facilitating collaboration and coordination of services for shared clients. Over time, they will increase consistency and improve supervision while encouraging agencies to share common administrative functions and resources. Implementing them will lead to a more responsive and cost effective local human services structure.

FIGURE 1

Interrelationships among EOHHS Agency Clients



Improving Accessibility and Coordination for Shared Clients

As **Figure 1** illustrates, EOHHS agencies serve many common clients. The child serving agencies, DCF, DYS and the Children's Division of DMH, serve many of the same children and families. MRC, the Massachusetts Commission for the Blind (MCB), the Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH) and DMH also serve many adult clients who have more than one type of disability. Children, their families, and adults with disabilities often get some form of income support from DTA and/or health care from MassHealth or DPH. For example:

- MRC estimates that 40 to 45 percent of its clients receive SSI or SSDI for which DTA administers eligibility.
- All children in foster care are enrolled in MassHealth, and 70 percent of families involved with DCF are estimated to have a substance abuse problem (potentially receiving services from DPH).

A comprehensive office housing all services would be more convenient for clients with more than one need, and would foster closer communication among area staff of the different state agencies who serve them.

Currently clients must negotiate a system with 149 separate area offices, each serving a slightly different area. In a decentralized manner, each EOHHS agency has developed its own unique area and regional structure; they have different numbers of local areas as well as different numbers of regions (which encompass several areas). The number of local areas into which the various agencies are divided ranges from zero (DPH) to 29 (DCF), while the number of regions ranges from three (MRC) to six (DPH and DCF). This decentralization has resulted in a proliferation of 149 area offices, not including several satellites. The inconsistency of area boundaries significantly complicates joint planning, data collection, staff cooperation and other community activities, while also increasing complexity and inconvenience for clients.

Because agencies differ in their numbers of areas and regions the same town can be part of different local areas for different agencies. This complicates interagency coordination and necessitates extensive travel for clients who need services from more than one state agency. For example:

- Sharon and Canton residents must go to an Arlington area office for DCF services, Brockton offices for DTA and MRC, and Walpole for DDS.
- Revere and Winthrop residents go to Chelsea for DCF services, Revere for DTA, downtown Boston for MRC, and Hyde Park for DDS.

Even when area offices of different agencies are based in the same community, they are usually located separately. For example, eight EOHHS agencies have local offices within the city of New Bedford, but only two share space. All others are in different buildings, with 3.7 miles between the furthest locations. Even when offices are located in the same building, they rarely share resources.

Twenty to 24 standard areas will offer sufficient accessibility. Any effective solution must balance geographic accessibility for clients and cost effectiveness for the state. Based on a review of the area maps of all the agencies, we believe that EOHHS agencies can continue to offer good access with 20 to 24 combined area offices, each serving an area that is defined consistently by all agencies.

Table 6 shows the current configuration of area offices serving the major geographic regions of the state, as well as how our proposed 24 or 20 standard areas could serve these regions. The specific number of areas and their boundaries should be determined after a process that gives agencies and advocates the opportunity to provide information about local service needs, existing service networks, and accessibility for clients while ultimately balancing the potentially competing goals of access and cost.

TABLE 5

Area and Regional Offices of the Largest EOHHS Agencies*

	DMH	DPH	DYS	DTA	DCF	DDS	MRC	Total
Current Local Areas	29	None	20	24	29	23	25	149
Current Local Office FTE	398	0	122	1,233	2,797	693	351	5,594
Number of regions	6 being reduced to 3	6	5	5	6	4	3	35 being reduced to 32

Source: EHS_HR Data Request to DMA 3.3.10 and DYS email, 6/17/2010.

* DMH uses different terminology for areas and regions. DMH "sites" correspond to other agency "areas" and DMH areas correspond to other agency "regions." DYS refers to "district" rather than "area" offices. For the sake of convenience this paper will use the term "area" to refer to all local offices.

TABLE 6

Current Area Offices by Region* compared to Recommended Options

Geographic Region/County	Current Area Configuration					Recommendations	
	DMH	DCF	DDS	MRC	DTA	24 Office Option	20 Office Option
Western MA – Berkshire, Franklin, Hampshire, Hampden	6	5**	4	5	6**	4	4
Central MA – Worcester County	5	4	3***	4	5	4	3
Southeast MA – Norfolk, Bristol, Plymouth, Barnstable, Nantucket, Dukes	5	6	7	7	6	6	4
Northeast MA – Essex and parts of Middlesex	5	5	5	3	2	3	3
Metro Suburban – Middlesex and parts of Norfolk	4	5	3	3	2	4	3
City of Boston and immediate area	4	4	1	3	3	3	3

* Geographic regions do not exactly correspond to each agency's regions, since they all differ.

** These agencies each have two separate offices in Springfield, serving different parts of the city and surrounding area.

*** DDS has an additional satellite office in this region.

With 24 sites, DMH, DCF and MRC would have to reconfigure staff to eliminate one to five offices each. DTA and DDS, which currently have fewer than 24 local offices, might operate one or two of the office sites as satellites, that is, with staff who work out of certain offices part time.[5] The option we defined in the table would allow most agencies to maintain the same number of offices in most regions, though their boundaries and locations might have to change. Several agencies would have to cut an office in western Massachusetts and/or northeastern Massachusetts under this option, while some agencies would be able to add a site. This may be a less significant change than it seems; DCF and DTA both operate two offices in the city of Springfield. These staff could easily be located in a single site without significantly compromising geographic access.

If EOHHS established 20 local areas, more change would be required; all agencies would need to reconfigure their local staffing to eliminate between three and nine offices. Agencies would find that they would lose a local site in most of the state's major regions. However, this modest reduction in the number of locations could be offset by increasing staff mobility to serve clients in other community locations as well as by increased reliance on phone and Internet. For example, MRC has plans for sending staff to meet with clients in schools and vocational programs. Other agencies need to develop similar strategies, which are consistent with a movement toward home and community-based services that reach clients where they live.

5 DYS's area ("district") staff are now located at provider sites, in communities where most DYS youth reside, allowing DYS and provider staff to work with youth where they live; in order to coordinate care, DYS staff would have to develop relationships with EOHHS centers.

Reducing Excess Space of Area Offices

An analysis by Accenture of the use of leased space by human services agencies found relatively high rates of space per FTE staff in comparison to industry benchmarks.[6] Accenture estimates that $7.5 to $13 million of total leasing and energy costs could be saved through consolidation of EOHHS offices, even with the same number of staff. As area offices are consolidated, they can reduce excess space while still meeting the needs of staff and clients. In addition, as needs change, space no longer required by one agency could be utilized by another. This kind of sharing is not possible in separate offices.

Prioritizing Service Coordination

Some clients who are aided in coordinating their services by DMH and DDS staff are also assisted in such coordination by their residential or community support providers. These clients need intensive supports on a long-term basis and generally see their providers daily. The state should prioritize its increasingly limited staff resources on coordinating services for clients who do not already get such intensive support.

DMH Case Managers help eligible clients plan, access and coordinate the services they need from DMH, Medicaid and community organizations. DMH purchases additional case management services as part of its new Community Based Flexible Supports (CBFS) service, its Program for Assertive Community Treatment teams (PACT), and its peer-operated Club Houses. MassHealth contractors also provide some level of care coordination for their enrollees, some of whom are DMH clients. Budget cuts resulted in the loss of 127 adult case managers for DMH over the past two fiscal years, and the number of adults who received case management from DMH staff has fallen from more than 10,000 in FY09 to 7,000 in FY10.

To best use its now more limited case management resources, DMH has established a policy that clients should receive case management from only one source. Therefore, clients enrolled in PACT teams, Club Houses or CBFS do not generally receive DMH case management. We applaud this policy and urge DMH to monitor its implementation and eliminate any remaining duplication.

DDS Service Coordinators act as the independent agents responsible for approving service plans for Medicaid home and community-based waiver services, the core of the community services DDS offers. It is important to distinguish between the service planning and service coordination roles for DDS clients. Service planning describes responsibilities required by state regulations and Medicaid that each DDS client have an Individual Support Plan (ISP) developed by an "independent" service coordinator, i.e. one not working for an agency also providing community services. The Commonwealth has elected to have state staff perform this function, while other states have used service brokers and advocates (e.g. Michigan). DDS service coordinators also have the responsibility for coordinating services in the community, i.e. helping clients to access other community resources and other providers to fulfill the goals of their service plan. The 7,500 DDS clients in residential programs operated by contracted providers and the 1,065 clients in state-operated residences often receive service coordination from their residential providers. In addition, many have families involved in their care, and the services are monitored by citizen boards and subject to accreditation and licensing standards. Furthermore, most of these clients are in very stable, long-term living situations and their services do not often change. We recommend that state service coordination for clients receiving these residential services should only include the facilitation and approval of service plans required to comply with Medicaid regulations and that residential programs be explicitly held responsible for coordinating services for their residents. Residential clients should not receive service coordination by DDS staff, whose caseloads should be adjusted accordingly.

6 Accenture, *Strategic Cost Management Project: Facilities & Services Case for Change, Workshop #2*. February 4, 2009.

Implementation Challenges

Current EOHHS Steps to Consolidate Offices

Implementing these changes will require the state to address a number of challenges. EOHHS has already begun by creating EOHHS centers. Staff in the combined offices are developing protocols for effective use of shared space, coordinating and streamlining operations, and organizing case management and other direct service staff to promote communication within these centers. In addition, EOHHS has enhanced its specifications for space to create more desirable work places. It has included a clause in its new leases that allows it to decrease square footage by up to 25 percent after the first two years of occupancy, creating more flexibility to respond to changing needs.

An EOHHS center combining four area offices recently opened in Barnstable and is expected to generate savings of $80,000 annually compared to housing these offices separately. A consolidated office center for Malden is also in development. EOHHS expects to open a total of 11 such centers by the end of 2010. As these centers are planned and opened, a number of significant issues must be addressed. These include use of shared space including reception areas, client confidentiality, office equipment, mail delivery, and cost allocation to support federal reimbursements, among others.

In the last two years EOHHS has made progress toward consolidation of common functions of its constituent agencies. Nonetheless, its progress has been guided by tactical considerations, most often arranging common lease expiration dates in offices located close to one another. This paper suggests a more strategic approach to developing an overarching plan that can guide the state's efforts over the next five years.

Ongoing Challenges

Rationalizing agency structure and streamlining and consolidating area offices will entail extensive planning, negotiation and clear authorization. Savings cannot be realized immediately because of the constraints of existing leases, the need for planning, and managing the "bumping"[7] process when members of employee unions are laid off. The following strategic considerations have emerged from our research.

- **Managing lease terms and procuring space.** As a result of a legislative mandate, the Commonwealth requires all agencies to use a standard lease form that prohibits cancellation within the first five years. Because office leases expire at different times, EOHHS may not be free to vacate an office it wishes to consolidate with others. Landlords are sometimes, but not always, willing to renegotiate lease terms with the state. EOHHS has extended some leases so that they expire at the same time as those of other nearby EOHHS offices. However, expanding this effort throughout EOHHS will take time, including finding additional space sufficient to meet the agencies' combined needs in an accessible and central location.
- **Sharing space.** There will be challenges related to different agencies sharing a common waiting area, including confidentiality issues (e.g., an individual on food stamps sees a neighbor waiting for a DCF worker) and interactions among different clienteles (e.g., fragile adults with a disability along with many young children). Safety requirements of DCF and DYS impose a need for police presence, bulletproof glass and panic buttons, which may be unsettling for clients of other agencies. Waiting areas may have to be separate for some of these offices. EOHHS is already using teams of state employees to develop solutions to such issues.
- **Accounting for shared resources.** Some state agencies receive federal reimbursement for local office functions. Their share of expenses must therefore be appropriately documented, which will require the creation of detailed accounting systems. A shared service administrator can help to manage common administrative functions and ensure that neces-

7 When a state staff position is eliminated, the person filling it can "bump" (take the job of) someone in the same position with less time on the job or in a lower job grade. The person who is bumped then has bumping rights over others with less seniority. Thus, one staff reduction can set off a long chain of job changes that take time to work out.

TABLE 7

Average Area Office FTE by Personnel Category

Agency/FTE	Management	Admin. Support*	Social Services	Other**	Total
MRC Total	0.8	3.0	10.2	0.0	14.0
DMH Total	0.8	1.5	11.2	0.2	13.7
DDS Total	1.6	3.2	22.7	2.7	30.1
DTA Total	2.4	6.8	40.0	0.0	49.3
DCF Total	5.5	4.4	86.0	0.0	96.0
Total	**11.1**	**19.0**	**170.2**	**2.9**	**203.2**
Weighted Average	**2.3**	**3.8**	**35.1**	**0.6**	**41.7**

Source: EHS_HR Data Request to DMA 3.3.10
*Includes clerical and administrative categories **Includes direct care, health care and education categories

TABLE 8

Savings from Streamlining Area Office Management and Clerical Staff

	Office and Staff Cuts							
	20 EOHHS Area Centers				24 EOHHS Area Centers			
	# offices	# FTE Managers	# FTE Clerical Staff	Total Positions and Costs	# Offices	# FTE Managers	# FTE Clerical Staff	Total
DMH	9	13.5	9.0	22.5	5	7.5	5.0	12.5
DTA	5	7.5	5.0	12.5	1	1.5	1.0	2.5
DCF	9	13.5	9.0	22.5	5	7.5	5.0	12.5
DDS	3	4.5	3.0	7.5	0	-	-	-
MRC	5	7.5	5.0	12.5	1	1.5	1.0	2.5
From combined offices			20.0	20.0			24.0	24.0
Total Offices/ FTE	**31**	**46.5**	**51.0**	**97.5**	**12**	**18.0**	**36.0**	**54.0**
Salary plus fringe (35.03% FY10)		$103,993	$51,766					
Total Savings		**$4,835,691**	**$2,640,089**	**$7,475,780**		**$1,871,880**	**$1,863,592**	**$3,735,473**

Calculation errors due to rounding
Sources: EHS_HR Data Request to DMA 3.3.10. Commonwealth Of Massachusetts Office Of The State Comptroller: Approved FY2011 Fringe Benefit Rate Based On FY2009 Actual Costs For Roll Forward And Budgeted FY2010 Costs For Cost Basis

sary records are maintained for allocation of costs, although federal and union requirements may make it challenging to create shared staff positions that support more than one agency. Over time, we are confident that systems can be developed to deal with this issue.

- **Staff and unions must be involved in planning.** Some issues, such as changes in travel time and job responsibilities and reductions in the number of staff positions, need to be discussed and/or negotiated with the unions that represent human services workers. Work rules and bumping provisions for more senior workers significantly complicate any change of this magnitude. At least six unions represent staff working in local offices, though most employees are represented by three of them.
- **Involve stakeholders in planning for change.** It is important for clients, communities and other stakeholders to be involved in planning these changes. Resistance may come from landlords and agency clients who have been working with area staff. It may come from community stakeholders who serve in advisory and support functions for their local offices and act on behalf of the service populations they represent. Clients and communities who might benefit from relocation or reconfiguration may not even be aware of the potential for improvements in access or participation, and their voices need to be heard as well. Conviction and clarity of mission on the part of senior managers will be necessary in order to overcome resistance both from within and without.

Estimated Savings

Optimized Staffing Levels

Reducing the number of area offices would create opportunities for reducing management and administrative staff. **Table 7** (top, opposite page) shows the average area office staffing for each agency.

With an average of more than two full time equivalent (FTE) managers for each area office, we have assumed that 1.5 FTE can be eliminated from the area offices that will be closed. Their responsibilities could be apportioned among the remaining .8 FTE manager and other area management staff. We have also assumed that one administrative support position (clerical or administrative) could be cut from each of the area offices to be closed. In addition, with 19 FTE administrative support staff in an average combined area office, we have assumed that methods for streamlining administrative work and sharing common administrative functions will allow the reduction of an additional FTE in each combined office. Assuming average salaries for these positions and applying the state's FY2010 fringe benefit rate, **Table 8** (bottom, opposite page) shows the savings that would be realized.

Service Coordination

There are approximately 8,500 DDS clients in provider or state-operated residential programs, many of whom receive service coordination from both provider staff and DSS service coordinators. Residential programs could assume responsibility for coordinating services to free DDS service coordinators of some responsibilities. We have assumed that 66 service coordinator positions could be eliminated, approximately 13 percent of the total number of DDS service coordinators. We are confident that DDS can responsibly manage a cut of this size. In addition, with approximately one clerical position for every seven service coordinator positions, nine clerical positions could be eliminated. We estimated the value of these savings in **Table 9**. Additional savings on overhead and space would also be realized. Identification of additional non-residential clients who receive intensive day services might increase the number of clients for whom service coordination responsibilities could be delegated to providers.

TABLE 9

Savings in Service Coordination Staff

	DDS Service Coordination	DDS Clerical
Average salary	$54,855	$36,603
Salary plus fringe	$74,071	$49,425
# to be cut	66	9
Total Salary plus Fringe	**$4,888,667**	**$444,825**
Total All Positions	**$5,333,492**	

Source: EHS_HR Data Request to DMA 3.3.10
Commonwealth Of Massachusetts Office Of The State Comptroller: Approved FY2011 Fringe Benefit Rate Based On FY2009 Actual Costs For Roll Forward And Budgeted FY2010 Costs For Cost Basis

TABLE 10

Savings in Rent and Energy from Consolidation of Area Offices

	Square Footage	Total Current Cost	Price per Square Foot	Area Office Staff*	Square Foot per FTE
SUMMARY OF CURRENT LEASE COSTS AND SPACE USAGE					
Current lease cost for five EOHHS agencies	1,150,608	$20,502,037	$17.82	5,152	223.32
ESTIMATED COST OF HOUSING ALL AREA STAFF IN SEPARATE OFFICES AT UPDATED LEASE RATES					
Estimated cost of housing all area office staff in separate leased facilities with an updated 10.75% price/foot increase	1,218,997	$24,057,692	$19.74	5,458.5	223.32
DECREASE TO 20 OFFICES					
Est. lease cost for 20 offices with reduced staffing	1,086,036	$21,433,628	$19.74	5,286.0	205.45
Savings over separate offices		$2,624,064			
Energy savings @ 18%		$472,332			
Total Savings		**$3,096,396**			
DECREASE TO 24 OFFICES					
Est. lease cost for 24 offices with reduced staffing	1,094,973	$21,610,010	$19.74	5,329.5	205.45
Savings over separate offices		$2,447,681			
Energy savings @ 18%		$440,583			
Total Savings		**$2,888,264**			

Calculation errors due to rounding
Sources: lease information as of 2008, EHS_HR Data Request to DMA 3.3.10, EHS Centers Cost Savings Spreadsheet

Rent and Energy

As mentioned earlier, 11 EOHHS centers are currently in the planning stages, serving communities all across the state. With no reductions planned in area office staffing, EOHHS estimates an average eight percent reduction in square footage for the EOHHS centers compared to the square footage in current leases. At the same time, EOHHS estimates that square footage costs will increase by an average of 10.75 percent in newly negotiated leases. Based on these estimates, and taking into account our recommended reductions in management, clerical and DDS service coordination staff, **Table 10** summarizes the potential savings in rent and energy from consolidation of area offices.

Some DMH site offices are not leased because they are located in state institutions. Although these state-owned buildings may have low "rental" costs, they are often inconvenient for clients to get to, as well as being obsolete, inefficient and expensive to operate. With the available data, it is not possible to estimate costs or savings related to offices in state-owned facilities. This analysis calculates the cost of current space needs as though all area office staff were housed in leased facilities, at the average cost and square footage allowance of current leases (see line 2 of **Table 10**). EOHHS has initiated a comprehensive study of the facilities it owns that will provide the cost data needed to make decisions on the best use of state-owned buildings and campuses.[8]

Overall Savings

Reducing the number of separate local offices from 149 to no more than 24, and the amount of leased square feet from over 1.2 million to 1.1 million, will result in total annual savings for the Commonwealth of between $12 and $16 million (see **Table 11**), depending on the number of local areas the Commonwealth ultimately establishes. In addition to achieving savings, these changes will improve access to services and coordination among agencies for those residents who need them.

TABLE 11

Total Savings from Consolidation of Areas Offices

Type of Saving	20 Offices		24 Offices	
	FTE	$	FTE	$
Savings in reduced square footage	n/a	$3,096,396	n/a	$2,888,264
Salary/fringe from reduction in management and clerical positions	97.5	$7,475,780	54.0	$3,735,473
Salary/fringe from reduction in DDS service coordinators	75.0	$5,333,492	75.0	$5,333,492
Total area office consolidation	**172.5**	**$15,905,668**	**129.0**	**$11,957,229**

8 For further information on state facilities and their potential for closure, see the discussion in Recommendation II.

Recommendation II:
Closure of Antiquated Institutions

Description of Recommendation

The Massachusetts Departments of Developmental Services, Mental Health and Public Health currently operate a total of 18 facilities with 2,179 beds at an annual cost of approximately $450 million (see **Table 12**). The populations served and types of services provided differ for each agency.

DDS Developmental Centers

DDS currently operates six Developmental Centers, known technically as Intermediate Care Facilities (ICFs), and it intends to close four of these facilities (Fernald, Monson, Templeton and Glavin). Clients with developmental disabilities, even those who are aging or have additional disabilities or medical conditions, have been successfully served in community settings. We strongly support DDS's plans to close these four centers by 2013 and recommend that DDS close both remaining institutions, the Hogan Regional Center and the Wrentham Developmental Center, by 2018.

TABLE 12

Massachusetts State Institutions – FY2009

Agency	Number of Facilities	Number of Beds	Total Cost
DDS	6	869	$164M
DMH Long Term	6	788	$152M
DMH Acute	2	32	Approx $8M
DPH	4	490	$129M
Total	**18**	**2,179**	**$454M**

Sources: DMR Community Services Expansion and Facilities Restructuring Plan, (Revised March 9, 2009). DMH Inpatient Facilities: 2009 Projected Expenditures. DPH Presentation Summaries prepared for the EOHHS Facilities Study Commission, 2010

Calculation errors due to rounding

DMH State Psychiatric Hospitals

DMH operates eight inpatient psychiatric facilities that serve adults and some adolescents. Two are small 16-bed acute treatment units that treat people for short stays (usually days or weeks). A unit similar to these (in Quincy) was closed during fiscal 2010.

DMH is responsible for providing longer term inpatient care of individuals with serious mental illness; this care is not covered by private health plans or by Medicaid. Some of the longer term units meet special needs, such as services to people who are deaf and have serious mental illness; individuals with serious medical complications, addictions and/or behavior problems; and forensic services for people with serious mental illness who have committed crimes. These are obligations that the Commonwealth will always be required to meet.

DMH will complete the closure of Westborough State Hospital in July, reducing the department's longer term inpatient beds to approximately 625. In 2012, DMH will complete a new state-of-the-art facility in Worcester and close the current Worcester State Hospital. The net effect of these changes will be to increase DMH's total bed capacity to 820. To afford its newest facility, DMH should close its Lindemann Center facility in Boston, the most expensive of the remaining hospitals, and determine how best to reduce capacity in its remaining facilities to bring its total bed capacity back to the level of 625. The clients, staff and operating budgets of closed units should be transferred to the new Worcester State Hospital to support its operation.

DPH Public Health Hospitals

DPH operates four public health hospitals that serve a number of distinct populations whose needs are not met in community or other hospitals; most are managed in conjunction with other departments. These populations include inmates of Massachusetts correctional institutions, individuals with long term and complex medi-

cal needs, and those who exhibit disruptive behaviors requiring one-to-one supervision, who actively abuse substances, who have been denied care by multiple facilities, or who have a criminal offender or sexual offender record that makes them ineligible or inappropriate for admission to nursing or other facilities. As DPH has eliminated beds and units in each of these facilities in response to budget cuts, all facilities are operating at less than capacity (see **Table 13**). Some face significant maintenance and repair costs.

TABLE 13

DPH Public Health Bed Capacity – FY2009

Facility	Service	Bed Capacity	Current Beds Utilized
Lemuel Shattuck	DPH Medical	125	115
	Correctional Health	28	28
Shattuck subtotal		*153*	*143*
MA Hospital School	Pediatric	120	66
Tewksbury	DPH Medical	339	213
Western MA	DPH Medical	100	68
Total		**712**	**490**

Source: DPH Presentation Summaries prepared for the EOHHS Facilities Study Commission, 2010

DPH should develop a comprehensive plan, based on an anticipated EOHHS review of all its facilities, for fulfilling its responsibilities as the provider of last resort in the most cost effective manner possible. The plan should consider the staffing and operating costs of the facilities, the degree to which services may be provided in private settings, the requirements of other state agencies like DMH, and a projection of emerging needs. Because some of its facilities are expensive to operate and maintain, and none currently operates at full capacity, DPH should consolidate its services into its least costly facilities and/or contract with private providers where appropriate.

Rationale

Closing antiquated facilities will help ensure that the maximum number of individuals have a meaningful life in the community. State agencies can build on the successes they have already experienced in moving people from institutions to the community where care is at least as good while costing far less.

Providing a Life in the Community for People with Disabilities

Typically, state-operated institutions date from a time when individuals with disabilities were stigmatized and hidden away, and there was little hope that they could return to life in the community. As a result, many institutions are located on multi-building campuses in rural areas, making them hard to reach without a car, isolating those being served from their families and communities, and making it difficult for families to visit or participate in treatment or planning for aftercare. In the past several decades, however, both the ability and desire of people with serious mental illnesses and developmental disabilities to live in the community have improved dramatically. Moreover, states are required to implement the U.S. Supreme Court's 1999 Olmstead decision[9] by serving most individuals with disabilities in community-based rather than institutional settings.[10]

Since the Sargent administration in the early 1970s, when Massachusetts was a pioneer in moving clients out of large public institutions and treating them in the community, the Commonwealth has increasingly fallen behind other states in closing these institutions. Most other states in New England—Maine, Vermont, New Hampshire, and Rhode Island—serve people with developmental disabilities solely in the community; they have no institutions. Connecticut operates just one. In contrast, Massachusetts continues to serve over 800 individuals in institutional settings.

9 See http://www.bazelon.org/issues/disabilityrights/incourt/olmstead/index.htm. Accessed May 17, 2010.

10 Community-based services must be provided when the state's treatment professionals have determined that community placement is appropriate, the affected individual does not oppose the transfer from institutional care to a less restrictive setting, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities. See http://supct.law.cornell.edu/supct/html/98-536.ZS.html. Accessed May 17, 2010.

State mental health authorities are striving to promote faster recovery and shorten lengths of stay in their longer term psychiatric facilities while developing increasingly sophisticated community services for people with serious forms of mental illness. These factors can reduce the need for longer term inpatient care. But the state will always need to serve individuals with serious mental illness who are involved with the courts and corrections system, as well as individuals with serious medical complications, addictions and/or behavior problems who need longer term inpatient care.

Successful Transitions

Massachusetts has demonstrated the ability to move people who have lived in institutional settings for very long periods of time into community settings. Laws regarding the siting of human services programs have greatly strengthened the ability of providers to overcome the opposition of neighbors, which was often a significant barrier to developing community-based programs. Many providers as well as state agencies have developed open communications that effectively address neighbors' concerns.

In the past two decades DDS has closed two large institutions (Belchertown and Dever), successfully moving more than 500 residents into community settings, including provider-operated or state-operated community residences. By creating state-operated residential programs in the community, the Commonwealth can often offer continuity of care, with many clients moving to new programs with their long-time caregivers. This practice has also maintained state jobs. Prior transitions have been closely monitored by the court, and surveys of participating families have found high levels of satisfaction with their family members' new placements.

RP is a man with spastic quadriparesis (a severe form of cerebral palsy) who requires total assistance for all activities of daily living. He uses a wheelchair, has very limited movement of his extremities, and requires regular nursing and therapy services. He communicates through facial expressions. Twenty-five years ago, staff at the Fernald School told staff of the private, not-for-profit agency taking over his care that "he can't do anything."

Nonetheless, R moved from Fernald into the community in August 1985 when he was 35 years old. Since then he has lived in two different houses while being supported by the same manager. In the community, R was exposed to a life he had never known while residing at the state school. A charismatic man who can light up a room with his smile, R quickly began to foster relationships with his housemates and the staff. He made friends through attending his day habilitation program, and began to enjoy dining out, going to the movies, shopping, and even vacationing. He is an avid Patriots fan and enjoys going to local high school football games where for two years he was the team's honorary "water guy." His life has been greatly enriched, as have the lives of the people who come in contact with him. The community embraced R, and he embraced them right back. R exhibits a remarkable flair for life.

On September 3, 2006 The Worcester Telegram & Gazette published a story about Edward Sanborn, a native of North Brookfield and a graduate of Quinsigamond Community College and Worcester State College. Mr. Sanborn was committed to Worcester State Hospital with bipolar illness in June of 2003 at the age of 51. When his commitment expired in May 2005 his treatment team agreed that he did not need to be in the hospital, but they could not find a place for him to live. Seven weeks later he moved to a local group home; he stayed there for eight and one-half months before he was able to move into an apartment of his own. At the time of the story he was doing office work four hours a day, five days a week, in a temporary position that a psychiatric rehabilitation clubhouse found for him, perhaps ironically at Worcester State Hospital. Mr. Sanborn also jogs regularly and spends time at the clubhouse. But best of all, he said, was going home to his own apartment at the end of the day. "I feel like the king of the castle," he said.

DMH has closed several longer term care facilities in the past, and available information suggests that even individuals who have spent years in a state hospital have adjusted happily to life in the community with appropriate housing and supports.

Moving clients from acute care facilities entails less planning since stays are for short-term problems and most clients can return home with referrals for appropriate follow-up care. DMH successfully transferred opera-

tion of most acute care to community hospitals and private psychiatric facilities in the 1990s, and it closed its 16-bed Quincy unit this year.

Community Care is Safe

The risk that salaried caretakers may abuse or neglect adults with disabilities who depend on them occurs in every type of setting and must always be taken seriously. Some critics erroneously state that residents are more likely to be abused or neglected in community programs than in state institutions. There is no evidence, however, that it occurs more frequently in one type of setting than in another.[11] A table in Appendix 2 showing three years of data from the Disabled Persons Protection Commission on sustained neglect and abuse allegations provides credible quantitative data to dispute the assertion that community care is less safe than institutional care.

Costly Facilities

Many of the state's institutions are over 100 years old, in poor repair, and have inefficient heating and other systems that make them expensive to operate. In addition, union work rules limit the flexibility of managers to maintain the necessary 24/7 coverage, which results in high staffing levels, overtime costs and costs for temporary workers, especially in facilities with 60 beds or less.

As shown in **Table 14**, the costs of providing high intensity services in the community are considerably lower than the costs of operating an institution. This explains why DDS and DMH have been able to provide equal or better services in the community while generating savings. It is important to note, however, that because institutions must continue to operate during the transition to community care, savings cannot be captured immediately.

Additional savings in capital costs can be anticipated from shuttering an obsolete facility and not having to repair and renovate it. These savings are not reflected in the operating costs shown in Table 14. DMH estimates that the closure of Westborough State Hospital will avoid the need for $100 million in repairs and maintenance.

TABLE 14

Comparative Costs of Institution and Community Care

Agency	Cost per Institutional Bed per Year	Cost per Community Bed per Year
DDS	$183,000	$95,000 -$150,000
DMH	$192,000	$55,000 average cost per client for residential and Program of Assertive Community Treatment

Source: DMR Community Services Expansion and Facilities Restructuring Plan, Revised March 9, 2009. DMH Average Median Costs of Adult Community Based Services, http://www.mass.gov/Eeohhs2/docs/eohhs/inpatient_commission/costs_adult_community_based_services.pdf accessed 6/7/2010.

Implementation Challenges

Implementing the recommended changes will require sensitive handling of the concerns of consumers and their families, state staff and host communities. If services are to be transferred from the public to the private sector, implementation may also require modification of the Commonwealth's privatization ("Pacheco") law.

Family Concerns

Care in state institutions, especially those operated by DDS, was once seriously substandard, as suggested by several successful class action lawsuits brought against the state. Those lawsuits led to significant improvements and eventually to today's higher quality care. Families who brought those suits and witnessed the

11 Opponents of the closure of the Fernald Developmental Center argued that incidence of abuse, including sexual abuse, reported to the Disabled Person's Protection Commission (DPPC) in private community residences was higher than those in DDS ICFs or state-operated residences. We analyzed DPPC data in relation to the number of DDS and DMH clients served in different types of settings and found that rates of substantiated abuse or neglect were similar or lower in community residences when they were compared to state institutions (see Appendix 2). A similar comparison conducted by DDS of its residential and developmental center clients found a substantially lower rate of substantiated instances in community residential programs in three of five years. It is important to note that these analyses did not adjust for differences in the caseload of clients served or the reporting practices in different settings that may contribute to different rates.

resulting improvements in their loved ones' care are understandably reluctant to see the state make changes in the system. They fear the continuity of care will be jeopardized in smaller community settings. The current occupants of ICFs have lived most of their lives in these settings, and the very low turnover among state staff leads to strong ties and a sense of community. DDS closure plans address the concerns expressed by clients' families, allowing families to choose where their loved ones will continue to receive care, including options that maintain relationships with certain staff.

The closure of the Walter E. Fernald Developmental Center in Waltham has been delayed for seven years as a result of family and staff concerns. In 2007 they obtained a court ruling[12] that halted the transfer of residents into alternative placements. Later that year, however, the Patrick administration successfully appealed the ruling[13] and Fernald is now scheduled to close before the end of 2010.

DDS has deferred a decision on the closure of Hogan, but has committed that clients transferred into Wrentham will be able to get care there for the remainder of their lives. It has a capital budget request of $1.75 million to renovate two unused buildings to house transferred clients. Offering families the option of continuing in institutional care as a permanent option is one way that DDS has obtained family agreement to make these transitions, but as DDS closes more institutions this commitment becomes more difficult to meet.

Families are also concerned about transitions from DMH and DPH hospitals, but their expectations of the state are different depending on whether needs are acute or chronic. DMH and DPH institutions are not usually expected to provide a permanent residence; clients and their families hope for their recovery and a safe return to a life in the community. However, these stakeholders have legitimate concerns about premature transitions and the ability of community resources to provide the necessary level of care.

Clients, families and staff should be included in planning for institutional closures and offered support as change is being implemented; substantive action should not, however, be delayed. When institutional facilities are closed, it is imperative that funds follow the clients to finance the services they need in the community.

Obstacles to Privatization of State-Operated Services

If the recommendations put forth in this paper are followed, the state will continue to fulfill its responsibility as the provider of last resort, but it should do so in the most cost effective manner. Contracting for services or leasing alternative space should be utilized if those options are less costly and similarly effective. To contract for a service rather than provide it directly, state agencies must meet the requirements of the Commonwealth's privatization ("Pacheco") law which places unnecessary and unfair obstacles to the privatization of services.

This law[14] requires that, in order to privatize any service costing $500,000 or more that is currently delivered by state employees, the state agency must: 1) prepare a written statement of services; 2) estimate the most cost effective method of providing them with agency employees; and 3) use a competitive bidding process to select a contractor and compare the in-house estimate to a contractor's bid. The agency must demonstrate that the outside vendor's services are lower in cost and equivalent in quality to the services the state provides. The outside vendor must pay salaries that are equivalent to the lowest grade of the comparable state position or to the average private sector wage rate for the position.[15] In addition, the outside vendor must pay the same percentage of a qualified health insurance plan as the Commonwealth does, which is currently 75 percent or 80 percent, depending on the position. The State Auditor is responsible for determining whether these conditions have been met. Only two relatively small requests related to human services agencies have been made in

12 Shelley Murphy, "Judge bars the closing of Fernald, Says patients must be given chance to stay," Boston Globe, August 15, 2007. http://www.boston.com/news/local/articles/2007/08/15/judge_bars_the_closing_of_ fernald/, accessed 4/13/2010.

13 DMR Community Services Expansion and Facilities Restructuring Plan, March 9, 2009, p. 3.

14 Chapter 296 of the Acts of 1993.

15 As determined by the Executive Office of Administration and Finance from data collected by the Department of Employment and Training and the Division of Purchased Services.

the 17 years since the law has been implemented. Few, if any, human services providers can meet the standard for contribution to benefits because they would have to make the same contribution for all employees. This constraint rules out the potential for privatization of many service types. It would be beneficial to amend the law to address unfair obstacles to privatization, while maintaining requirements that new jobs created through privatization are fairly compensated.

Staff Objections

Closing of state institutions will have an even greater impact on state staff than the combining of area offices, since some positions will be cut and other staff will have to move into a community position in another location. Such changes must be made in conjunction with union rules for bumping that may take time to play out. DDS plans to create sufficient state-operated community residences to offer alternative employment for staff of four developmental centers that it intends to close. This practice not only preserves state employment, but also helps to provide continuity for residents who have become close to their state caregivers. DMH has not followed this practice, but staff may wish to take positions that will open up with community providers as services are expanded to create needed capacity. DPH medical staff are more likely to have alternative employment options in the broader medical community. Nonetheless, involuntary job changes can require considerably different commutes, hours or compensation. Therefore, employees should be involved in planning for changes, and changes must be implemented in accordance with the processes negotiated with unions. A portion of any savings realized from institutional closures should also be reserved in the first years following closing to assist state staff with finding new jobs.

Impact on Communities

Because state institutions are major employers in their host towns, especially in the rural areas where many are located, those towns and the legislators who represent them are justifiably concerned about the loss of jobs. Many state employees, however, will transition into new positions in provider-operated programs. However, these new jobs will be dispersed throughout a number of communities because the facilities are so much smaller. Thus support for these new programs will be more diffuse. Cities and towns also have legitimate concerns about alternative uses of the state property. Involving local communities in planning for the closure is necessary, but the interests of the individual community should not prevail when closing an institution would result in equal or better quality of care for clients at a lower cost to state taxpayers.

Estimated Savings

Adopting these recommendations will save the state the costs of operating obsolete campuses and will avoid the need for significant capital expenditures for repair and renovation. Eventually the properties may be sold, providing the Commonwealth with more liquid assets and turning the land to new uses and job creating enterprises. Years ago, the state dedicated resources to the care of people with developmental disabilities, serious mental health problems, and difficult medical needs through the creation of these institutions. Once these assets are sold, a portion of the proceeds should be dedicated through a trust fund or similar mechanism to meeting the needs of these populations in the community.

Table 15 summarizes the estimated $50 million reduction in expenditures that can be expected from the recommended closures. These are savings that remain after significant funds are used to create alternative services in the community. The savings are based on estimated reductions in DDS and DMH budgets only; savings in fringe benefits paid from the Group Insurance Commission budget are not estimated. In addition, complete data on institutional revenues from federal sources was not available to include in this analysis. Our specific assumptions and methods of estimation are described below.

DDS Developmental Centers

DDS is currently on track to close four of its six developmental centers by 2013, generating savings of almost $40 million, of which $20 million has already been realized. The closure recommended here of the Hogan Regional Center and the Wrentham Developmental Center over a four-year period (2014 to 2018) would save an estimated additional $30 million, based on the 46 percent average savings rate from the four closures that are already underway. The other 54 percent of expenditures would be redirected into community care.

TABLE 15

Cost Savings from Present and Future Institutional Closures after Investment in Community Care
(in Millions)

	Annual savings already taken	Annual Future Savings	Total Past and Future Savings
DDS Closure of Fernald	$20M		
DMH Closure of Westborough and Quincy	$14M		
DDS Planned Closure of 3 additional ICFs		$19M	
Recommended closure of Hogan @ average savings of 46%		$11.3M	
Recommended closure of Wrentham @ average savings of 46%		$21.5M	
Recommended closure of Pocasset and Corrigan		$4M	
Total	**$34M**	**$55.8M**	**$89.8M**

Source: DMR Community Services Expansion and Facilities Restructuring Plan, Revised March 9, 2009. Conversations with DMH Financial Staff.

DMH Acute Units

DMH recently closed a 16-bed acute facility in Quincy, saving approximately $4 million in operating costs. Similar savings can be generated by closing DMH's two remaining 16-bed acute psychiatric units, the Pocasset and Corrigan Mental Health Centers, for a total of $8 million. However, because these facilities serve parts of the state that have relatively few acute psychiatric beds, DMH should redirect half of the savings to community services to prevent acute hospitalization.

DMH Long Term Units

DMH's near complete closure of Westborough State Hospital has redirected $15 million to create and expand community services for individuals being discharged, and saved approximately $10 million annually. DMH also estimates that $100 million in capital costs will be avoided, net of demolition and remediation costs for vacating Westborough. DMH is building a new 320-bed facility on the grounds of Worcester State Hospital to be opened in 2012. At that time, DMH should close the 60-bed Lindemann Center. DMH should then determine how best to reduce capacity at its remaining facilities to reach approximately 625 beds, which would maintain DMH's current bed capacity and allow the transfer of operating funds to the new facility. There would be minimal savings.

Public Health Hospital Services

We have not made specific recommendations or estimated potential savings regarding the closure or consolidation of DPH hospitals. DPH has a number of options for delivering its essential safety net services at lower costs, including transferring Massachusetts Hospital School students to special education facilities, consolidating services in the least costly facilities, leasing alternate space, and contracting for certain services.

Conclusion

The Commonwealth has debated agency restructuring and closure of institutions for almost 40 years. The state's economy and our budget crisis require action now. This paper offers a framework for building a public consensus around two critical changes – rationalizing the human services structure and closing state institutions.

Restructuring is essential not just to streamline administration but more importantly to improve access to and coordination of services for clients, and to support them in the least restrictive setting. While numerous barriers have held back the many previous efforts to make these changes, the state's budget crisis is now forcing action. We strongly urge that savings realized as a result of these changes be used to address unmet needs and strengthen community systems.

The recommendations made in this paper are based on a detailed understanding of the existing system and extensive research. Implementing them will achieve numerous advantages for our residents: enhanced accessibility and responsiveness to clients; better coordination of care; greater consistency across the state; and increased cost effectiveness. These two significant improvements in care are also estimated to generate cost savings of at least $65 million annually. These savings should be reinvested to meet the needs of those on service waiting lists, to improve quality of care, and to strengthen the provider system of care.

Appendix I:
Area and Regional Offices

Area and Regional Offices of the Largest EOHHS Agencies*

	DMH	DPH	DYS	DTA	DCF	DDS	MRC	Total
Current Local Offices	29 sites* in 25 locations 13 leased 16 in state facilities	None	20 sites co-located in provider spaces	24 leased area offices 3 satellites and 11 SNAP outreach sites hosted by community organizations	29 leased area offices in 28 sites	23 leased offices 1 leased satellite	25 leased area offices; 2 leased satellites	149 offices 3 leased satellites; 14 hosted satellites/ outreach sites
Current Local Office FTE	398	0	122	1233	2797	693	351	5594
Regional Offices	6 areas being reduced to 3	6 offices in 5 locations	5 in secure state facilities	0 offices 5 regional managers are sited in central office	6	4	3 regional managers in area offices	26 offices being reduced to 23

Source: EHS_HR Data Request to DMA 3.3.10 and DYS email, 6/17/2010.
*DMH uses different terminology for areas and regions. DMH "sites" correspond to other agency "areas" and DMH areas correspond to other agency "regions." DYS refers to "district" rather than "area" offices. For the sake of convenience this paper uses the term "area" to refer to all local offices.

Appendix II:
Analysis of Disabled Persons Protection Commission Data

About the Disabled Persons Protection Commission (DPPC). DPPC is responsible for receiving and investigating abuse or neglect of disabled adults by a caretaker as specified by Massachusetts General Law, Chapter 19C. It can delegate these investigations to other agencies that serve adults with disabilities, such as DDS, DMH or MRC, but monitors the investigations and has the right to reinvestigate.

About the Data. DPPC provided DMA with three years of data on the number of reports received about DDS and DMH clients. The data included the total number of reports received, those determined as meeting the criteria for investigation, the number of investigations and their disposition. The tables below show the number of investigations undertaken and the number sustained. Sustained instances are investigations for which there was clear evidence that abuse or neglect had occurred; some of the unsubstantiated investigations determined that abuse or neglect had not occurred, but other reports could not be resolved one way or the other. The data also indicate the types of abuse or neglect investigated and sustained. Instances are categorized by type of injury: physical, emotional or sexual. They are also categorized as an act (an action taken that causes an injury) or an omission (failure to perform necessary care). One investigation of a single incident may include multiple types of abuse or neglect. Therefore, the total types of problems investigated exceed the total number of investigations. Incidents range from relatively minor, such as missing or not correctly performing a scheduled administration of medication, to incidents of abuse that cause major injury.

The DPPC data for clients of DDS and DMH indicated whether the reported incidents occurred in state-operated institutions (DDS Developmental Centers or DMH State Hospitals) or other community-based residential or 24-hour care programs. These included both state-operated and provider-operated community residences.

DMA also received data from DMH and DDS on the number of their clients served in the different settings in each year. Combining these data, DMA calculated the number of sustained investigations per thousand clients served in each type of setting.

Findings. This analysis found that both DDS and DMH community residential programs had a much lower rate of substantiated instances than did state-operated institutions in all three years. The rate of substantiated instances in community residences fell over the three years. DDS performed a similar analysis of DPPC investigations of its clients several years ago, with similar results. It found a slightly higher rate of substantiated instances in DDS institutional settings than in community residences in three of five years between FY2002 and FY2006.[16]

Limitations. DMA's review is a preliminary analysis that did not account for differences in the caseload of clients served or the reporting practices in different settings. Therefore, we do not conclude that one setting is more dangerous than another. However, we concur with DDS that there is no evidence that community residences are more dangerous for clients than care in state institutions.

16 Affidavit of Gail Grossman, US District Court, District of Massachusetts, Case: 1:72-cv-00469-JLT, Document 198-7, Filed 5/31/2007.

TABLE II–1

Disabled Persons Protection Commission

Sustained Investigations of DMH Services per Thousand Clients Served

Department of Mental Health	2007			2008			2009		
Institutions	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000
Clients served in a year	2,198			2,094			2,184		
Total 19C Investigated	40		18.2	43		20.5	68		31.1
Physical Injury	28	3	1.4	32	5	2.4	39	6	2.7
Emotional Injury	4	0	-	8	0	-	10	2	0.9
Sexual	9	0	-	9	0	-	22	1	0.5
Act	24	1	0.5	27	3	1.4	48	3	1.4
Omission	22	2	0.9	23	4	1.9	32	6	2.7
Community Residental Program	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000
Clients served in a year	8,213			8,187			8,232		
Total 19C Investigated	63		7.7	62		7.6	94		11.4
Physical Injury	21	3	0.4	23	6	0.7	32	2	0.2
Emotional Injury	16	2	0.2	30	2	0.2	44	7	0.9
Sexual	34	6	0.7	23	0	-	36	6	0.7
Act	46	8	1.0	39	2	0.2	72	11	1.3
Omission	27	1	0.1	32	3	0.4	40	4	0.5

Sources: DPPC Special Report 4/2010 and DMH Special Report 5/2010

TABLE II–2

Disabled Persons Protection Commission

Sustained Investigations of DDS Services per Thousand Clients Served

Department of Mental Health	2007			2008			2009		
Institutions	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000
Clients served in a year	967			903			866		
Total 19C Investigated	78		80.7	63		69.8	63		72.7
Physical Injury	65	14	14.5	48	12	13.3	39	7	8.1
Emotional Injury	6	3	3.1	9	1	1.1	9	2	2.3
Sexual	4	1	1.0	2	0	0.0	2	0	
Act	62	15	15.5	47	9	10.0	58	10	11.5
Omission	67	14	14.5	45	12	13.3	35	5	5.8
Community Residental Program	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000	Number Investigated	Number Sustained	Sustained per 1,000
Clients served in a year	10,792			11,494			11,601		
Total 19C Investigated	556		51.5	572		49.8	558		48.1
Physical Injury	422	93	8.6	398	77	6.7	391	69	5.9
Emotional Injury	131	25	2.3	160	38	3.3	108	17	1.5
Sexual	42	5	0.5	54	7	0.6	47	7	0.6
Act	386	84	7.8	438	86	7.5	404	69	5.9
Omission	360	67	6.2	335	62	5.4	338	50	4.3

Sources: DPPC Special Report 4/2010 and DMH Special Report 5/2010