PLAN FOR THE CLOSURE OF A STATE MENTAL HOSPITAL IN THE STATE OF CONNECTICUT

FINAL REPORT

Submitted in partial fulfillment of the requirements of a Contract with the Connecticut Department of Mental Health

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The contents of this report do not necessarily reflect the views of the Conneticut Department of Mental Health.

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I. INTRODUCTION

This report has been prepared under contract to the Connecticut Department of Mental Health, and in response to Legislative Act 80-80. This Act requires the Commissioner of Mental Health to develop a plan to terminate the operation of either the Connecticut Valley, Norwich, or Fairfield Hills Hospital. The ensuing material was developed in three phases. Phase I (September 1980) involved the preparation, [in collaboration with the Department of Mental Health officials and staff] of a detailed plan and technical approach for the conduct of this work.

Phase II (October and November 1980) entailed a preliminary analysis of the feasibility and impacts of closing each of the three hospitals in terms of patient dispositions, staff dispositions, recurring and non-recurring costs, and non-hospital support service arrangements. At the close of Phase II, the central and regional mental health offices distributed copies of the analyses to interested individuals and organizations, and half-day meetings were held in each region to receive comments prior to preparing the final plan. The Commissioner and Deputy Commissioners also reviewed the preliminary analysis, and provided the project director with suggestions for the final analysis.

During Phase III (December 1980-January 1981), the project director and staff reviewed the substantive comments received from the regional meetings and Commissioners, and integrated them into the final analysis and plan for the closure of one of the three mental hospitals.

The final analysis presented in Section II of this report includes the patient population size projections prerequisite to the definition of the three hospital closure options analyzed in Section II, and the hospital "non-closure" and two hospital "closure" strategies pictured in Section III. It also includes an inventory of community alternatives considered in defining the

hospital/community strategy analyzed in Section III. Finally, it addresses those factors considered by the Institute staff in identifying one of the hospitals for closure.

Section III contains a strategic plan for the closure of the Norwich Hospital. It projects the impacts of closing the Norwich Hospital on the disposition of patients and staff, on the non-recurring costs of implementation and hospital renovation, on hospital and community program operating costs, and on the non-hospital agencies dependent on the hospital for support services.

This report is largely comprised of tables designed to present the final options in as clear and concise a manner as possible. The tables are identified by title and are labeled according to the section and subsection of the report to which they pertain. Many of the tables are in sequence projecting information for a number of years. If the table is unique to a particular year, the final digit in the label includes a small case letter denoting the fiscal year to which the table applies. The letter "a" corresponds to 1981-82, "b" to 1982-83, ... "e" to 1985-86. The basic assumptions, sources of data, methodological information and qualifications necessary to assure a reasonably accurate interpretation of the analytic findings and plan are included in narrative form at the beginning of each subsection.

In order to make the hospital staff and operating cost analyses as meaningful and intelligible as possible, HSRI has structured them according to the functional areas used by the Department and hospitals for planning and budgeting purposes. There are five functional areas of concern:

- Administration--includes all business and service activities of the hospital in the areas of budgeting, financing, purchasing, personnel, stores and maintenance.
- General Services--this function provides services necessary for the physical operation of the facilities including the operation of the power, sewage, incinerator, and water system plants, and security and fire protection. Included also are repairs and maintenance of

buildings, equipment, and grounds; housekeeping services; laundry, linen, and clothing services; and transportation services.

- Care of Patients--this function provides for professional and technical services and supplies necessary in the care, treatment, and rehabilitation or patients. In addition to psychiatric, psychological and nursing care, this function also provides the following services: barbers and hairdressers; medical records units; social service departments; pharmacy; biological laboratory; radiology department; physiotherapy service; occupational therapy; recreation and religious services. It primarily covers inpatient services, but small outpatient programs exist the Connecticut Valley and Norwich Hospitals.

- Education and Training--this function includes psychiatric residency training as approved by the American Medical Association. Formal courses of instruction are conducted for nurses, occupational therapy students, psychiatric aides, social service students and psychology interns.

- Food Service--this function involves the planning, preparing, and serving of food to patients and employees, and for the sanitary condition of related equipment and facilities.

In order to make the analyses as sensitive to different patient needs as possible, HSRI has structured the bulk of the analysis by program (patient category). Changes in the patient populations, staff complements, costs, and facilities are analyzed by the following program categories:

- Drug Dependent--persons addicted to drugs;

- Alcohol Dependent--alcohol abusers;

- Mentally Retarded--persons with sub-average intellectual functioning and characterized by inadequacy in adaptive behavior;

- Psychiatric--mentally or emotionally disordered;

- Geriatric--mentally ill-aged.

In four short months, HSRI has had to obtain and digest an enormous amount of information on Connecticut's mental health delivery sysem. For the most part, we relied on existing data, adapting it for our purposes as necessary. Where adaptations and

assumptions have been made, they have been noted in the text. In spite of these limitations, we believe the report is the culmination of a well-reasoned process of analysis, and should allow the legislature to make an informed decision on whether to proceed further with the analysis and planning prerequisite to the closure of a mental hospital in Connecticut.

The succinct style of this report precludes the development of an executive summary. The report is comprised of a series of integrally-related projections. In order to understand the report, the reader must first understand the bases for the projections, i.e., what they represent and how they interrelate. The reader is encouraged to review the report narrative in its entirety before referring to the tables. To facilitate this review, in those places where the narrative is interrupted by tables, we have noted the page where the narrative continues.

II. FINAL ANALYSIS

A. Findings and Conclusion Regarding the Closure of One of the Three Mental Hospitals

In the preliminary and final analysis, we addressed eight factors, which could conceivably weigh in favor or against the closing of any one of the three hospitals:

(1) The size and locus of the patient population served;

(2) The availability of hospital and community alternatives;

(3) The ability to transfer patients to the remaining two hospitals;

(4) The ability to place patients in the community;

(5) The ability to attract and hold the staff required to meet the increased patient workloads attending the closure of one of the other hospitals:

(6) The relative cost of operating the remaining two hospitals should the third be closed;

(7) The cost of renovating buildings at the remaining hospitals to accommodate patients from the hospital closed;

(8) The feasibility and relative impact of closing on the non-hospital organizations supported by the hospital.

We did not examine the relative economic impact of closing the three hospitals on neighboring communities, nor did we consider the relative feasibility of alternative public or private uses. These factors are worth considering but lie outside the province of the Department of Mental Health, and the scope and time constraints of this study.

Of the eight factors considered, only two showed sufficient variance to serve as a basis for targeting a hospital for closure: (1) The relative acessibility of the hospital to the patients served; and (2) The potential cost of renovating buildings at the two hospitals left in operation to accommodate transfers from the hospital that is closed. Analyses of the remaining six factors showed a relatively even distribution of

staff, patient, and cost impacts and therefore did not yield enough of a differential to form a basis for decision. Two additional factors could also have had some bearing on this decision, but HSRI had neither the time nor the resources during the four months allocated to conduct reliable quantitative analyses of them. These two factors are: (1) differences in the ability of the remaining two hospitals to attract staff transfers and new hires; and (2) the relative costs of relocating the non-hospital functions from the hospital targeted for closure.

1. Accessibility

More than 96% of the patients admitted to the Connecticut Valley Hospital and Fairfield Hills Hospital live within 30 miles of these hospitals. Only 65% of the patients admitted to Norwich Hospital fall into this category, and of these, 39% live within 30 miles of the Connecticut Valley Hospital as well. The closure of the Norwich Hospital would increase the distance that must be traveled for far fewer patients and families than would be the case if either the Fairfield Hills or Connecticut Valley Hospitals were to be closed.

2. Renovation Costs

The estimated costs of renovating the patient living areas at the two hospitals remaining in operation to accommodate patients transferred from the hospital closed are shown below:

Estimated Renovation Costs

	With Air Conditioning	Without Air Conditioning
Connecticut Valley Hospital Closure:	$10,050,916	$ 8,315,375
Fairfield Hills Hospital Closure:	13,945,670	10,593,329
Norwich Hospital Closure:	10,522,470	7,869,010

The cost of renovating buildings under the Norwich or Connecticut Valley Hospital closing options do not differ

significantly--certainly not enough to warrant a decision in favor of closing one or the other. On the other hand, the cost of renovating buildings under the Fairfield closure option is roughly $3,000,000 higher. This difference is attributed to the fact that Fairfield Hills currently has an unused capacity of 232 beds that could be filled without any appreciable renovation costs. As the closing of any one of the hospitals would require the transfer of patients to the remaining two, the availability of this bed capacity at Fairfield Hills weighs in favor of keeping this hospital open and thus avoiding the renovation costs associated with establishing additional beds at Norwich or Connecticut Valley Hospitals.

3. Conclusion

In the judgment of the HSRI staff assigned to this project, and on the basis of these factors alone: if one of the three hospitals is to be closed, Norwich Hospital would seem to be the most logical choice. Accordingly, HSRI has prepared a strategic plan for the closure of the Norwich Hospital as directed by Act 80-80. The plan is drawn to include provision for further study (in the first year) of those factors not addressed at this stage:

- An analysis of the economic impact of closing the hospital;
- A study of alternative uses to which the Norwich facilities might be put;
- Further study of the impact of the hospital's closing on hospital staff requirements, and on existing staff under various retraining, housing assistance, and employment support options;
- A study of the feasibility of establishing alternate short term psychiatric inpatient units along the Eastern border to accommodate patients who would otherwise be referred to the Norwich Hospital.

Depending on the results of these studies, the preliminary plan for the closure of Norwich Hospital might warrant reconsideration.

B. Projections of Patient Population Size (Service Demand), and Patient Town of Record by Hospital

1. Size

The purpose of this analysis is to project the size of the hospital patient populations through 1985-86--in otherwords to project the service demand to be accommodated under each of the three hospital closing options examined in this Section (II), and under the non-closure and closure strategies included in the Plan (Section III).

The size projections are a product of three factors:

- Current hospital utilization rates;
- Projected availability of alternatives to hospital care;
- Economic conditions.

a. Hospital Utilization and General Population Projections

The future utilization of state mental hospital beds (i.e., the size of the potential state mental hospital patient population) is difficult to project since it is a function of both supply and demand. The supply of hospital services is affected by public policy and funding decisions, manpower availability, and a variety of other factors not directly related to demand. Demand for state hospital services is influenced by the interests and actions of the hospital staff in developing programs and seeking patients, the perceived quality and related draw of the hospital programs, the growth or decline in the population of the communities served, and the relative accessibility of the hospital to the communities served (economically, geographically, etc.). The latter factor is particularly significant. Though the state hospital, in some instances, may be viewed as the provider of first choice, in many instances it is the only provider available. The hospital is obliged to accept patients whose behavior is too disruptive to be comfortably or suitably accommodated in a general hospital, to accept persons who cannot afford private treatment and care, and to accept

persons in need primarily of the supervision and support services offered at the institution and who have no where else to go. This phenomena is in evidence in each of the hospitals. Fairfield Hill's population of mentally retarded persons, in some part, reflects the lack of alternative placements for severely and profoundly mentally retarded persons. The rise in the geriatric population at Connecticut Valley and other hospitals reflects recent problems in finding nursing home accommodations and the freeze on placements into some nursing homes. The decline in Norwich's short term population reflects the diversion of patients to the Cedarcrest Regional Hospital.

As in many states, the deinstitutionalization of longer term patients in Connecticut has ebbed and the hospitals are serving more patients for shorter periods of time. Many of the deinstitutionalized patients are now served on a short term basis and are referred to as the "revolving door" population since they require rehospitalization on a fairly regular basis.* For this reason, the base period employed in making our projections begins in July of 1978 and not before. And in order to better track the patient and service changes, the gross "patient day" projections are segmented by program category. The breakdown of patients into program groups: i.e., alcohol dependent, drug dependent, mentally retarded, mentally ill, and mentally ill aged, was completed using the "patient counts by diagnosis and age" Annual Inpatient Statistics, compiled by the State Department of Mental Health.

In making the patient day projections, it was assumed that the ratio of adult patient days to the general adult population in the hospital service areas in each of the next five fiscal years (1981-82 through 1985-86) will equal the average ratio during 1978-79 and 1979-80 at the Connecticut Valley Hospital and

*Schwartz, S. and Cocilovo, V. Administration in Mental Health Vol. 2, No. 4. Spring, 1977.

Fairfield Hills Hospital.* At the Norwich Hospital, fiscal year 1979-80 alone was used as the base period in order to fully reflect the diversion of short term mental patients to the Cedarcrest Regional Hospital.

b. Inpatient Alternatives

These utilization-based projections of the Connecticut Valley, Fairfield Hills, and Norwich Hospital patient populations were lowered to reflect the expected diversion of patients to new or expanded inpatient programs at Cedarcrest Hospital, at the Capital Region and Greater Bridgeport Mental Health Centers, and at the Manchester Memorial and Hartford Hospital Psychiatric Units. (Our preliminary projections failed to fully account for these alternatives.) Table II B. 2 indicates the total number of inpatient beds that have cleared the "certificate of need" process and/or for which a budget commitment has been made, and the estimated number of patients days that would otherwise have been spent at the Norwich, Fairfield Hills, or Connecticut Valley hospitals.

c. Economic Conditions

The projected number of short term psychiatric patients and patient days at the three state hospitals were adjusted upward by 20% to reflect the increase--recently apparent in Connecticut hospital admissions--accompanying economic declines.** At the same time,the estimated number of short term psychiatric patients expected to be diverted to the alternative regional and community hospitals was reduced by 20%.

*The general population projections were obtained from the Revised Preliminary Population Projections, Connecticut, 1970-2000, State Department of Health.

**Margaret Draughon, "Relationship Between Economic Decline and Mental Hospital Admissions Continues to be Significant," Psychological Reports, 1975, Vol. 36 pp. 882.

d. Comment

A common criticism of utilization-based projection techniques is that they under-estimate the true need for services; they fail to account for potential or "unmet" demand. It is admittedly a conservative method of projecting demand.

A related and specific criticism of our method, raised in the Regional Meetings was that "the current hospital populations, upon which our projections are based, do not include those individuals who are being denied admission to each of the hospitals." We do not believe that this criticism is justified as, reportedly, most of those individuals who are being excluded are denied admission because they do not meet the state's commitment criteria, not because of a lack of hospital capacity. Many of these persons are indigent and primarily in need of shelter that is unavailable through the town welfare departments. By law, the hospitals are to admit only those individuals requiring active mental health treatment and inpatient supervision. Where practical, inter-agency agreements might be reached between the hospitals and the town welfare departments under which the hospital would provide available facilities and support services to shelter such persons. However, the programs should be administered and financed by the Departments of Welfare.

2. Town of Record

In the preliminary analysis we considered only the level of demand at each of the hospitals, not the locus of that demand. Of concern, particularly at the Region IV meeting, was the fact that most of the state mental hospital inpatients from that region were residing in facilities outside the region. Regional officials cited an attendant transportation burden on patients and families. They also observed that many of these patients, the alcoholic patients in particular, take up residence in towns surrounding these hospitals thus hiding the true extent of the demand from Region IV residents. In order to gauge the extent of this problem in the state, HSRI calculated the percent of

patients being admitted to Norwich from region IV. During 1978-79, an estimated 65% were from region IV.

In order to assess the extent of the accessibility problem suggested at each of the hospitals, HSRI did a more in-depth analysis of the residence of record of those patients admitted to each of the hospitals in 1978-79. Less than 4% of the admissions to the Fairfield Hills Hospital and to the Connecticut Valley Hospital resided in towns outside a 30-mile radius of the hospital. Sixty percent of the admissions to the Norwich Hospital were from towns outside the 30-mile radius.*

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*Source: Table 12, Inpatient Statistics for the Year Ending June 30, 1979, Connecticut Department of Mental Health, Hartford, Connecticut.

TABLE II B. 1a

NUMBER OF ADULT PATIENTS AND PATIENT DAYS
BY PROGRAM AND LENGTH OF STAY
ESTIMATED 1979-80[a]

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	655	239326	160	58659	495	180667
Alcohol Dependent	26	9573	17	6318	9	3255
Drug Dependent	7	2393	4	1388	3	1005
Mentally Retarded	39	14360	1	431	38	13929
Mentally Ill	439	160348	92	33673	347	126675
Geriatric	144	52652	46	16849	98	35803
Fairfield Hills Hospital: Total	634	231172	180	65468	454	165704
Alcohol Dependent	19	6935	11	3953	8	2982
Drug Dependent	13	4623	6	2034	7	2589
Mentally Retarded	70	25430	5	1780	65	23650
Mentally Ill	405	147950	118	42906	288	105044
Geriatric	127	46234	40	14795	86	31439
Norwich Hospital: Total	626	228362	179	65014	448	163348
Alcohol Dependent	31	11418	25	9020	6	2398
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	44	15985	3	959	41	15026
Mentally Ill	363	132450	91	33112	272	99338
Geriatric	188	68509	60	21923	128	46586

a. Source: "Inpatient Statistics for the Year Ending June 30, 1980." Connecticut Department of Mental Health.

TABLE II B. 1b

SIZE OF THE HOSPITAL PATIENT POPULATION,
PROJECTED, 1985-86

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	657	240240	148	54109	509	186131
Alcohol Dependent	27	9883	18	6523	9	3360
Drug Dependent	2	646	0	000	2	646
Mentally Retarded	40	14825	1	445	39	14380
Mentally Ill	439	160527	81	29746	358	130781
Geriatric	149	54359	48	17395	101	36964
Fairfield Hills Hospital: Total	669	244364	197	71941	472	172423
Alcohol Dependent	14	5026	5	1923	9	3103
Drug Dependent	13	4811	6	2117	7	2694
Mentally Retarded	72	26460	5	1852	67	24608
Mentally Ill	438	159958	139	50654	299	109304
Geriatric	132	48109	42	15395	90	32714
Norwich Hospital: Total	646	235753	161	58678	485	177075
Alcohol Dependent	34	12378	27	9779	7	2599
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	48	17329	3	1040	45	16289
Mentally Ill	361	131780	66	24094	295	107686
Geriatric	203	74266	65	23765	138	50501

TABLE II B. 2

IMPACT OF ALTERNATE INPATIENT FACILITY EXPANSIONS ON PATIENT DAYS AT THE CONNECTICUT VALLEY, FAIRFIELD HILLS, AND NORWICH HOSPITALS PROJECTED 1981-82 THRU 1985-86

	Program	Increased Bed Capacity	85% Occupancy Adjustment	Effective Utilization Date	Utilization by "would-be" Patients from:[a] Connecticut Valley Hospital		Fairfield Hills Hospital		Norwich Hospital	
					Patients[b]	Patient Days	Patients[b]	Patient Days	Patients[b]	Patient Days
Cedarcrest Regional Hospital (Bldg. 1)	ST Psy.	40	34	7/1/81					34	12410
Cedarcrest Regional Hospital (Bldg. 2)	ST Psy.	60	51	7/1/82	26	9490			25	9125
Greater Bridgeport Mental Health Center	ST Psy.	22	19	7/1/81			10	3650		
Capital Region Mental Health Center										
Drug Dependent	ST Drug	30	26	7/1/81	5	1825				
Psychiatric Acute	ST Psy.	20	17	7/1/81	4	1460			4	1460
Greenwich Hospital	ST Alc.	15	13	7/1/81			6	2190		
Manchester Memorial Hospital	ST Psy.	20	17	7/1/81	2	730			2	730
Lawrence and Memorial Hospital	ST Psy.	24	20	7/1/80	9	3285				
TOTAL		231	197		46	16790	16	5840	65	23725

[a] See next page
[b] See next page

Footnotes
Table II B. 2

[a]It is assumed that:

- 100% of the patients occupying the Cedarcrest Regional Hospital would have otherwise gone to either the Connecticut Valley or Norwich Hospitals.
- 50% of the psychiatric patients in the Community Mental Health Centers and general hospitals would have otherwise gone to either the Connecticut Valley, Fairfield Hills, or the Norwich Hospitals.
- 25% of the Drug and Alcohol patients in the Community Mental Health Centers and General Hospitals would have otherwise gone to either the Connecticut Valley, Fairfield Hill, or Norwich Hospitals.

[b]"Patients" equivalent to the average daily census

C. Patient Transfer Potential Under Each Hospital Closure Option

The purpose of this analysis was to assess the logistical feasibility and relative capital investment required to accommodate the patients from one of the three hospitals of the other two.

The patient transfer projection provides for the transfer of all patients from the hospital targeted for closure to the remaining two hospitals. The relative number of patients returning to the community each year is not projected to increase in connection with the closing of the hospital.

In projecting the number of patients transferred to the hospitals under each closing option, three rules were applied.

(1) The number of patients transferred to a hospital when combined with the number of patients already at the hospital could not push the required bed capacity beyond that attainable in existing buildings (requiring and not requiring renovation);

(2) Short term patients would be transferred to the nearer of the two remaining hospitals. (Note: In the case of Connecticut Valley Hospital's Closure, the short term patients were distributed evenly to the Fairfield Hills and Norwich Hospitals);

(3) Patients would be transferred to that hospital having bed capacity available which is less costly to renovate.

Table II C. 1 projects the average daily patient populations and total patient days at the Norwich and Fairfield Hills Hospitals in 1985-86 following the transfer or referral of patients from the Connecticut Valley Hospital. Table II C. 2 projects the average daily patient populations and total patient days at the Connecticut Valley and Norwich Hospitals in 1985-86 following the transfer or referral of patients from the Fairfield Hills Hospital. Table II C. 3 projects the average daily patient populations and total patient days of the Connecticut Valley and Fairfield Hills Hospitals in 1985-86, following the transfer or referral of patients from the Norwich Hospital. Table II C. 4

projects the average daily patient populations by program at each of the hospitals under each alternative.

Sufficient capacity can be obtained through the renovation of existing buildings at any two of the hospitals to accommodate all of the patients at the other one. In other words, each of the closing options could be achieved without new construction, and without increasing the rate at which patients are currently being returned to the community.

NARRATIVE CONTINUES ON PAGE 23

TABLE II C. 1

INTER-HOSPITAL PATIENT TRANSFERS BY PROGRAM
ASSUMING CONNECTICUT VALLEY HOSPITAL IS CLOSED
PROJECTED 1985-86

	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Patients Assuming Status Quo	Patients Transferred Out	Patients Net of Transfer	Patients Assuming Status Quo	Patients Transferred In	Patients Net of Transfer	Patients Assuming Status Quo	Patients Transferred In	Patients Net of Transfer
Total	657	657	-	669	304	973	646	353	999
Alcohol Dependent	27	27	-	14	9	23	34	18	52
Drug Dependent	2	2	-	13	2	15	-	-	-
Mentally Retarded	40	40	-	72	10	112	48		48
Mentally Ill	439	439	-	438		528	361	249	610
Geriatric	149	149	-	132	63	195	203	86	289

TABLE II C.2

INTER-HOSPITAL PATIENT TRANSFERS BY PROGRAM
ASSUMING FAIRFIELD HILLS HOSPITAL IS CLOSED
PROJECTED 1985-86

	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Patients Assuming Status Quo	Patients Transferred In	Patients Net of Transfer	Patients Assuming Status Quo	Patients Transferred Out	Patients Net of Transfer	Patients Assuming Status Quo	Patients Transferred In	Patients Net of Transfer
Total	657	463	1120	669	669	-	646	206	852
Alcohol Dependent	27	14	41	14	14	-	34		34
Drug Dependent	2	13	15	13	13	-	-		
Mentally Retarded	40	72	112	72	72	-	48		48
Mentally Ill	439	232	671	438	438	-	361	206	567
Geriatric	149	132	281	132	132	-	203		203

TABLE II C.3

INTER-HOSPITAL PATIENT TRANSFERS BY PROGRAM
ASSUMING NORWICH HOSPITAL IS CLOSED
PROJECTED 1985-86

	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Patients Assuming Status Quo	Patients Transferred In	Patients Net of Transfer	Patients Assuming Status Quo	Patients Transferred In	Patients Net of Transfer	Patients Assuming Status Quo	Patients Transferred Out	Patients Net of Transfer
Total	657	416	1073	669	230	899	646	646	-
Alcohol Dependent	27	27	54	14	7	21	34	34	-
Drug Dependent	2	-	2	13	-	13	-	-	-
Mentally Retarded	40	5	45	72	43	115	48	48	-
Mentally Ill	439	181	620	438	180	618	361	361	-
Geriatric	149	203	352	132	-	132	203	203	-

TABLE II C. 4

PATIENT DISPOSITIONS BY PROGRAM UNDER EACH ALTERNATIVE
PROJECTED 1985-86*

DISPOSITIONS	ALTERNATIVES Continued Operation of the Three Hospitals	Connecticut Valley Hospital Closure	Fairfield Hills Hospital Closure	Norwich Hospital Closure
Connecticut Valley Hospital: Total	657		1120	1118
Alcohol Dependent	27		41	54
Drug Dependent	2		15	2
Mentally Retarded	40		112	43
Mentally III	439		671	733
Geriatric	149		281	286
Fairfield Hills Hospital: Total	669	973		854
Alcohol Dependent	14	23		21
Drug Dependent	13	15		15
Mentally Retarded	72	112		115
Mentally III	438	528		505
Geriatric	132	195		198
Norwich Hospital: Total	646	999	852	
Alcohol Dependent	34	52	34	
Drug Dependent	-	-	-	
Mentally Retarded	48	48	48	
Mentally III	361	610	567	
Geriatric	203	289	203	

* These figures represent average daily populations (i.e., number of patient days ÷ 365 days).

D. Community Alternatives Available in Each Hospital Service Area

1. Introduction

The purpose of this analysis was to determine the availability of alternative community living and care arrangements and support services to accommodate patients who would otherwise require care at each of the three hospitals. For the most part, HSRI staff found that the existing community service network is not adequate to meet current demand. This is manifest in the waiting lists that currently exist for many of the community support services and residential alternatives. The Mental Health Office in Region IV was kind enough to document the waiting lists in that region by way of example. The list is presented at the end of this section. The need for additional hospital and non-hospital services is also well documented in the Mental Health Plans prepared in each region of the state.

Accordingly, HSRI assumes that any additional placements projected in tandem with the closure of a mental hospital will require the corresponding development of additional community alternatives. The projected community program requirements and costs (Section III.H.) reflect this assumption.

This subsection contains an inventory of alternative hospital and community based service providers. The primary emphasis of this inventory is on residential arrangements. It presents a summary picture of existing hospital and community residential options for deinstitutionalized state hospital patients. General assessments of community support services are included; more detailed information on support services is available from other sources. Each Regional Mental Health Office has a compilation of existing residential and support services available in that region; in addition, each Health Systems Agency (HSA) and Regional Mental Health Board prepares a plan documenting existing and projected service needs. HSRI staff did review available plans and incorporated relevant information.

The inventory that follows was prepared for each hospital and the surrounding region(s). There is some overlap between the Connecticut Valley and Norwich Hospital regions (Regions II, III, and IV). Norwich refers patients to providers in regions III and IV while Fairfield Hills refers patients to providers in Regions I and V.

Although the inventory focuses primarily on the availability of needed residential or inpatient care arrangements, this by no means implies that community support services are any less important. Without exception, the hospital social services staff and persons attending the regional meetings, indicated the need for a stronger network of community support services particularly in the areas of case management, partial hospitalization, day treatment and assistance in obtaining entitlements. Worth noting is the fact that a number of patients were in residence at each of the hospitals only because they required assistance in obtaining entitlements, or because their families opposed their relocation to less restrictive or more distant community alternatives.

2. Regional Inventories

a. Fairfield Hills Hospital Service Area

- Private mental hospitals

According to Fairfield Hills Social Services staff, private hospital care alternatives are generally not available to patients leaving Fairfield Hills. Some Fairfield Hills patients were originally referred from private psychiatric hospitals because their insurance coverage expired and they could no longer afford to stay in private hospital settings.

Hall-Brooke and Silver Hills Foundation are the two major private psychiatric facilities serving Region I. Approximately 42 beds (18 for adolescents) are available at Hall-Brooke and 31-50 beds at Silver Hills.

- General hospitals

There are nine general hospitals serving HSA Regions I and V with a current capacity of approximately 158 inpatient beds for psychiatric patients. Most of these inpatient units are reportedly at or near capacity. Additional bed capacity is also available in Norwalk Hospital (28 beds available for both alcohol and psychiatric patients) and Greenwich Hospital, which provides a number of scattered beds on an as needed basis. In general, most of these hospitals require that the patients be voluntary, able to finance their care--primarily through third party reimbursements--and be in need of short term treatment. For example, Stamford Hospital's agreement with Fairfield Hills provides that they will accept referrals only if the patients have third party or other appropriate financial resources. Typically, general hospital inpatient units serve clients from the community and refer them to Fairfield for more long term treatment.

According to the Social Services Chief, there are few Fairfield Hills patients who need a short term inpatient setting available through the general hospitals; however, some of their patients are currently on general hospital waiting lists. This statement, however, was questioned by Region I staff. Further, this same staff member noted that many acute situations could be handled in the community within a general hospital setting as opposed to relying on the state hospital for such services. The need for additional inpatient beds was cited by several attendees of the Region I and V meetings. Southwestern Connecticut's Draft Mental Health Systems Plan emphasizes the need for inpatient beds. In particular, the plan stressed the need for acute inpatient care for both voluntary and involuntary patients

- Forensic hospital

The Fairfield Hills Social Services Chief noted that there is no facility for females who need a forensic setting; however, the potential number of patients requiring such a setting was not provided.

- Skilled nursing facilities (SNF's) and intermediate care facilities (ICF's)

There are approximately 68 SNF's and 25 ICF's in Regions I and V. According to Fairfield Social Services staff, there is a waiting list at most facilities. At the time of the HSRI site visit to Fairfield Hills, Social Services staff reported that 21 patients were on waiting lists for skilled and intermediate care facilities while three nursing home patients were waiting to get into Fairfield Hills.

The major admission criteria used by long term care facilities for patients with a history of mental disorders include the following: a patient must be medicated and stabilized; mobile (though some facilities accept patients with multiple handicaps); and have no history of assaultiveness or anti-social behaviors. The patient must also not be a danger to himself or herself or to the community. As a rule, nursing facilities cannot accept involuntary patients.

Informal discrimination practices also occur favoring private-pay patients over indigent and Title XIX and XVIII (Medicaid and Medicare) patients. As noted by Fairfield Social Services staff, many nursing facilities limit the number of Title XVIII and indigent patients they will accept.

Another phenomenon cited by Fairfield Hills staff is the influx of New York patients into Northwestern and Southwestern Connecticut nursing homes. Since New York's Medicaid rates are substantially higher than Connecticut's, nursing home operators are more inclined to accept out-of-state patients than in-state patients. Although nursing home operators will not reveal how many former mental hospital patients they will accept, tacit limits may well be operating. Finally, several nursing facilities are no longer available to Fairfield patients because they already have more psychiatric patients then permitted under Medicaid regulations, and other facilities are in danger of losing their Medicaid reimbursement for this same reason.

Nursing facilities are also inappropriate for younger patients who need a highly structured residential setting. Further, many nursing facilities that do accept Fairfield patients want some assurances that the state hospital will be available as a back-up resource if problems arise. The need for intermediate care facilities which provide specialized care for the mentally ill elderly is cited in Region I's mental health systems plan.*

- Transitional living facilities and supervised apartment programs

There are nine halfway houses and one fullway house in Regions I and V; five of these facilities are in Region I. A total of 101 beds are available in these residences; however, most of them are operating at full capacity. Several Fairfield Hills patients are currently on waiting lists for halfway house programs. One supervised apartment program is also available in Region I. Fairfield's Social Services Chief indicated that the admission criteria for most halfway house programs vary with the facility; generally, halfway houses accept patients based on how they would fit into the particular home and program.

Several Region V attendees stressed the severe lack of housing in that region, especially in the Danbury and Waterbury areas. As noted by city welfare staff, approximately 400 single room occupancies (SRO's) were lost last year in Waterbury due to urban renewal and other occurrences. This type of housing is heavily used by former mental patients.

- Family care homes

Approximately 24 licensed family care homes are operating in Regions I and V, and there are 41 rest homes and homes for the aged. These community alternatives were not specifically addressed by Fairfield Hills staff; however, one social services

*Southwest Regional Mental Health Board, "Southwest Connecticut Mental Health Systems Plan (Second Draft) For Discussion Only," December 1, 1980, p. 9.

staff member noted that placements in licensed boarding homes often can stir up community resistance.

Of the 24 family care homes in these two regions, 18 are in the Greater Bridgeport area, yielding 53 beds. According to Region I Mental Health staff, there is a real potential for establishing additional family care beds in the Stamford, Bridgeport and Norwalk areas. According to regional staff, this community alternative should be given further consideration in planning community placements.

- Independent living and family

As noted by social services staff, the lack of appropriate support services often prevents placement either with the family or in an independent living situation.

- Mental retardation centers

Fairfield staff indicated that a few patients who are mentally retarded are currently on waiting lists for nursing facilities or ICF/MR's.

- Community support services for mental health patients

Several regional meeting attendees in Region I noted the inadequacy of certain community support services such as day treatment programs, follow-up care and social vocational services. For certain services, such as vocational rehabilitation, long waiting lists exist. This situation is worsening with budget cuts and increases in caseloads.

Another inadequate support service that was mentioned by numerous regional meeting attendees is transportation. Further, some attendees cited the lack of crisis information services and case management services.

- Acute care/treatment (alcohol)

Approximately seven facilities in Regions I and V provide acute care and treatment services for alcoholics. Four of these settings are general hospitals which provide approximately 61

inpatient beds; some of these bed capacity figures vary based on demand. Two private psychiatric facilities, Silver Hill Foundation and Hall-Brooke Hospital, also provide alcohol beds. Silver Hill has between 19-30 day beds and 10 admissions beds while Hall-Brooke has approximately 26 beds for substance abuse patients (including drug abuse). Finally, Greater Bridgeport Community Mental Health Center has 10 detoxification beds and 12 acute care beds.

- Intensive (alcohol)

Two facilities in Region I were identified as providing intensive settings for alcoholics. One facility, Guenster Rehabilitation Center, has approximately 35 slots.

- Intermediate (alcohol)

Four facilities in Region V provide intermediate services for alcohol patients totaling 110 available beds/slots. Another halfway house program sponsored by Greater Bridgeport Community Mental Health Center Regional Narcotics Program was included in the total for transitional facilities.

- Long term care (alcohol)

In Region I, the Salvation Army and Viewpoint House were identified as providing long term care with 36 beds and 9 beds available respectively for persons suffering from alcohol abuse.

- Shelter (alcohol)

Three providers, Morris Foundation, Goodwill Industries and Viewpoint House, provide shelter services for alcoholics, with approximately 42 slots available for persons in need. The need for additional shelter services in Region I is highlighted in Southwestern Connecticut's Draft Mental Health Systems Plan.

- Outpatient detoxification (drug abuse)

Approximately 10 beds/slots were identified in Regions I and V as available for outpatient detoxification services.

- Residential detoxification (drug abuse)

Several providers were identified in Region I as providing residential detoxification services for drug abusers; however, the total number of available beds is unknown.

- Outpatient methadone maintenance (drug abuse)

Four providers with approximately 484 slots provide outpatient maintenance services in Region I.

- Residential drug free (drug abuse)

Approximately 116 slots/beds are available for residential drug abuse services in Region I and V.

- Outpatient drug free (drug abuse)

Four providers provide approximately 349 beds/slots for outpatient drug free services in Region I and V.

b. Connecticut Valley Hospital (CVH) Service Area

- Private mental and general hospitals

Generally, these two care alternatives are not available for CVH patients. According to CVH Social Services Chief, the following constraints are often present: (1) no beds are available, (2) the hospital only admits short term patients; (3) the patients must be voluntary admissions and (4) insurance coverage is necessary. A total of 11 general hospitals with a capacity of 279 beds are located in Regions II and IV. The W.W.II hospital in Region II is considering expanding its inpatient unit from 8 to 24 beds. Two private psychiatric hospitals are also located in Region II and IV; however their availability for the population under discussion is limited. It should also be noted that Cedarcrest Regional Hospital is available for short term (<90 days) inpatient care. Moreover, Cedarcrest will be expanding its bed capacity from 110 to 170 total beds by 1982. In addition, the Connecticut Mental Health Center currently has 48 beds and is projected to increase its bed capacity to 56 in 1981.

Overall, however, the need for even more inpatient beds was cited at both the Region II and IV meetings and in a recent HSA Region II plan.

- Skilled and intermediate care facilities

The availability of SNF and ICF beds varies within this region, but overall, placements are difficult. According to the Chief of Social Services, CVH has a good working relationship with three long term care facilities--two SNF's and one ICF. One major provider, in particular, is inclined to accept CVH patients since it knows the state hospital will be a back-up resource in case a patient regresses.

Because of individual problem behaviors, most long term care facilities are not willing to accept such patients from CVH, but rather refer patients to CVH. In addition, some SNF's and ICF's are no longer available to CVH since they will lose their Medicaid reimbursement if more than 50% of their caseload is comprised of mental patients. There are over 98 SNF's in Regions II and IV; six have been placed on a "not available" list by the Department of Mental Health.* Five of these facilities are among the largest skilled nursing facilities in these regions (over 100 beds each). There are 31 ICF's operating in Regions II and IV. Generally, ICF's have higher numbers of mental patients than SNF's. Middletown Health Care Center, formerly an ICF, accepts many CVH patients.

Another major constraint cited by CVH staff focuses on the location of some of these long term care facilities. Even if beds are available, very often the facility is not conveniently located for the family. As a result, some patients are on as many as four and five waiting lists for facilities.

*Long term care facilities no longer available to CVH include: East Hartford Convalescent Home, Meadows Home, Lorraine Manor, Hillside Manor, Prospect Gardens, and Prospect Restorative Health Care Center.

- Transitional living and supervised apartments

Both halfway houses and supervised apartments in the CVH areas have long waiting lists. There are three halfway house programs currently operating in Regions II and IV with a combined capacity of 51 beds. Another three shared apartment programs with a combined capacity of 58 beds are also operating in this area. According to Social Services staff, more of these alternative residential settings are needed.

Although CVH Social Services staff emphasized the lack of and need for additional transitional alternatives in Region IV, especially for younger patients who do not require nursing home care, a Region IV meeting attendee noted that at least one halfway house in New Britain was not able to obtain referrals from CVH and thus had to fill the program with Norwich patients. This same attendee indicated that the number of transitional beds could be expanded quickly if buildings attached to general hospitals, such as former nursing quarters, were used for ex-mental patients.

Several Region II meeting attendees underscored the inadequacy of transitional living services in their service area. New Haven is the only town in Region II with any type of transitional services. A halfway house program with 11 slots and an apartment program with a capacity for 12 beds serve the entire region. A provider in Region II did receive a HUD Section 202 fund authorization to develop a transitional living apartment program together with the Meridan Housing Authority. When operational, this program will serve 12-15 residents.

- Family care homes

Placements in board and care and family care homes in this region have been successful according to CVH Social Services staff. As noted by the Chief of Social Services, there are probably more patients referred to this type of community placement than any other community care alternative. As a rule, there are no waiting lists for this care alternative. Approximately 57 rest homes and homes for the aged (boarding homes) are

available in Regions II and IV. Approximately six family care homes serving from one to six mentally ill adults are also available in Region IV.

- Community support services

Several Region II and IV attendees cited the lack of services for multiply-handicapped mentally ill persons (e.g., the deaf/blind mentally ill).

In addition, one attendee noted that the inventory should include the availability of self-help and other client support groups as community resources for discharged mental patients.

- Acute care and intensive treatment (alcohol)

Approximately 123 beds are available in Regions II and IV.

- Intensive (alcohol)

One program in Region IV provides 12 beds/slots for intensive alcohol services. It should be noted that in certain parts of Region II the lack of intensive treatment beds forces many patients to be transferred to services outside of their community.

- Intermediate (alcohol)

Seventy-six (76) beds are available in Region II and IV; however, only one such program exists in Region II.

- Long term care (alcohol)

Approximately 110 beds are available in Region IV. A new long term care facility for chronic alcoholics in New London is also a potential resource for CVH patients.

- Shelter (alcohol)

Two therapeutic shelter programs with approximately 42 beds are available in Regions II and IV.

- Outpatient detoxification (drug abuse)

Thirty (30) beds/slots are available for outpatient detoxification services in Region II and IV.

- Residential detoxification (drug abuse)

Fifteen beds (15) are available in Regions II and IV for inpatient detoxification.

- Outpatient methadone maintenance (drug abuse)

Approximately 430 beds are available in Regions II and IV for outpatient maintenance.

- Residential drug-free (drug abuse)

Approximately 168 beds/slots are available for residential detoxification services in Regions II and IV.

- Outpatient drug free (drug abuse)

Approximately 333 slots are available for drug free hospitalization programs in Regions II and IV.

c. Norwich Hospital Service Area

- Private mental hospitals and general hospitals

Like CVH and Fairfield Hills, the Norwich Social Services Chief reported that a major drawback to the use of general hospitals is the requirement that patients be voluntary. Elmcrest and Natchaug Hospitals, both private psychiatric facilities, accept primarily voluntary patients. Recently, Lawrence and Memorial Hospital in New London opened a 20 bed inpatient unit for acutely disturbed voluntary patients.

The need for short term acute psychiatric general hospital beds in the Backus General Hospital service area was noted in a recent paper prepared by the Eastern Regional Mental Health Board.*

- Skilled nursing and intermediate care facilities

Norwich Social Services staff recently completed a draft report examining the recidivism of patients placed into continuing

*Eastern Regional Mental Health Board, "Region III Mental Health Plan 1981-1986: Mental Health System Status," undated, p. 21.

care facilities (i.e., SNF's, ICF's and boarding homes).* A like study had been completed in June 1976. In the 1976 study, 49.5% of the extra-mural placements went to an SNF level of care; in the 1979-80 study, 60.8% went to SNF's. In 1976, 38.5% of placements went to ICF's whereas in the 1979-80 study only 29% were placed in ICF's.

Of the 179 patients placed from 7/1/79 through 6/30/80, 79 patients returned to the hospital. Some of these patients were actually readmitted twice during the study period. The preliminary study findings reveal that 33% of the readmissions for male placements occurred within the first month of placement. Females had a much lower failure rate. Some of the reasons for readmission focus on inappropriate patient behaviors (assaultiveness, threatening actions, agitation, drunkness etc.) that are not acceptable in nursing homes and boarding homes. Although placement rates were lower for ICF's and boarding homes (29% and 10% respectively), these two alternatives had the highest return rate or failure rate (56% and 72% respectively). The Norwich staff suggest that these failures indicate inappropriate placements.

The Norwich Social Services Chief noted that the current outplacements are relatively less successful than were those placements made during the 1976 study period. Although the Social Services Chief noted that they keep trying to place patients in a variety of continuing care alternatives, many are readmitted to the state hospital. An illustration of this can be seen in the placement rate with Middletown Haven, a former ICF facility now primarily serving mental patients. Since August of 1980, approximately nine Norwich patients were placed at Middletown Haven; five have returned. The Norwich staff is currently taking a hard look at the appropriateness of SNF and ICF alternatives for clients requiring continuing care. The difficulty in securing appropriate long term care placements for

*Robert E. Pflomm, Norwich PSW Supervisor, "Examination of Recidivism in Extra-Mural Placements (7/1/79-6/30/80 (DRAFT)," October 20, 1980.

mental patients is not just endemic to Norwich but affects all three hospitals. The problems associated with long term care placements in other regions have been noted in this inventory.

- Family care homes

According to the Norwich Social Services Chief, most boarding homes will accept their referrals. Most of these are rest homes or homes for the aged having a mixture of patients young and old. There are also four family care homes with approximately 15 beds serving former Norwich patients. However, all of the family care homes and homes for the aged in Region III are presently full, and will not be available for additional patients in the near future. Homes for the aged and rest homes are seldom appropriate placement alternatives as they are not equipped to deal with behavioral problems.

- Transitional living and supervised apartments

As noted by the Social Services Chief, there are very few transitional or supervised apartment programs in Region III. Two halfway house programs serving approximately 20 persons are at full capacity. Another provider, Reliance House in Norwich, recently received a Section 202 direct loan to build or rehabilitate housing for the mentally disabled. There are two supervised apartment programs serving approximately 37 patients in Region III. As noted by a Region IV meeting attendee, a significant percentage of Norwich patients are placed in transitional services in Region IV. The recent Region III long range mental health plan underscored the inadequacy of transitional living services in all service areas within the region.

According to Norwich Social Services Chief, there is a definite need for group homes with an array of support services for approximately 20 to 30 chronic patients.

- Community support services

The Region III meeting attendee noted the need for services for the multiply handicapped, mentally ill person. They also

explained that the area has no direct 24 hour/7day mental health intervention service.

- Acute care and intensive treatment (alcohol)

In addition to the programs available at Blue Hills, there are three facilities in Region III that provide this level of care for persons with alcohol-related problems. Forty (40) beds are available in these care settings.

- Intermediate (alcohol)

Approximately 46 beds are available for transitional living facilities in Region III.

- Long term care (alcohol)

One facility, SCADD, has approximately 50 beds available for this type of care alternative.

- Shelter (alcohol)

Based on the 1981 Connecticut Alcoholism and Drug Abuse Council plan, no therapeutic shelter programs could be identified in Region III.

- Residential drug free (drug abuse)

Approximately 33 beds/slots are available for residential drug free services in Region III.

- Outpatient methadone maintenance (drug abuse)

Approximately 194 beds are available for outpatient methadone maintenance in Region III.

Summary of Waiting Lists in Region IV*

HARTFORD HOSPITAL--	Outpatient Clinic -- books one month's appointments in first few days of month, no waiting list is kept, if person is in crisis and clinic is booked, they are referred to the emergency room. Three to Nine Weeks.
	Transitional Living -- thirty-five bed capacity. Full at this time, two people on waiting list. Time varies on waiting list. Average is between two and eight weeks before vacancy opens up.
GREATER HARTFORD SOCIAL CLUB--	Basic Program -- client is seen same day as referral. No waiting list.
	Transitional Living -- Program is full at this time. Four to eight people usually on waiting list. Two to eight weeks is average time to move someone off waiting list and into program.
MANCHESTER MEMORIAL HOSPITAL--	Outpatient Clinic -- Clinic schedules appointments three to six weeks in advance on the average. Twenty-two people, on an average, will be waiting for their appointment.
	Independent Living -- Program capacity is twenty. Program is currently full, with seventeen people on waiting list. Eight to twelve weeks is the average length of time on the waiting list.
ST. FRANCIS HOSPITAL--	Outpatient Clinic -- Client usually seen after eight to ten day wait. Clinic is usually booked two to five weeks in advance.
	Aftercare -- Client usually seen within five days.

*Source: Region IV Mental Health Office

GLASTONBURY MENTAL HEALTH GROUP--

Mobile Aftercare Clinic -- Appointment scheduled day of referral. Two weeks after day of referral client is seen. No waiting list, but program is at capacity.

CENTRAL CONNECTICUT MENTAL HEALTH AFFILIATES--

New Britain General Hospital--Day Treatment -- Client usually seen within two to three weeks. Waiting list of approximately seven now. Usually on waiting list for two to three weeks.

CENTRAL CONNECTICUT COMMUNITY MENTAL HEALTH AFFILIATES--

New Britain General Hospital--Transitional Living -- Usually two to five weeks waiting period.

Bristol Hospital--Outpatient Clinic -- Group intake every Wednesday. Client seen within one week. No waiting list.

Bristol Hospital--Follow-up -- Group intake every Wednesday. Will see client same day of referral if necessary. No waiting list.

E. Community Placement Potential Under Each Hospital Closure Option

Projections of the numbers of patients who might return to the community, and the care and support service requirements and costs attending their return, are presented as part of the Strategic Plan in Section III H. In order:

- To indicate the extent to which the patient census at the three hospitals could be further reduced through the placement of patients in alternate community settings;
- To indicate the extent to which the placement of patients in the community could reduce the investment required to expand current hospital capacity;
- To indicate the investment required in community care and support service arrangements to support the accelerated movement of patients to the community.

These projections are not included in this section as our preliminary analysis showed that the number of patients who might be returned to the community would not vary much as a function of the hospital to be closed.

F. Hospital Staff Requirements Under Each Hospital Closure Option

Historically, patient care staffing levels in state hospitals around the country have been notoriously low--the Connecticut hospitals were no exception. However, continued declines in the patient census at the hospitals over the past decade and a half have brought staffing levels to a more satisfactory level in spite of strict hiring and budget limitations. Still, shortages continue to exist. Qualified psychiatrists and nurses are particularly difficult to recruit. Though Connecticut fares better than most states in its ability to find psychiatrists-- perhaps because of the hospital residential training programs--more are needed. Many psychiatrists prefer the higher income potentials, working conditions, and types of clients found in the private sector. It is also difficult to wean nurses away from the general hospitals in which they were trained especially now that the general hospitals are offering improved wages, benefits, and flexible working arrangements. Generally speaking, shortages among the social services and other patient care staff are more the result of budget and hiring limitations than recruitment problems.

The central question in this analysis is: Would any one of the hospitals have a more difficult time than the other two in obtaining and retaining the larger patient care staff complement requiring to accommodate patients transferred from the hospital targeted for closure?

On the basis of the limited information at hand, it is not possible for HSRI to make an informed judgment on whether a particular hospital by virtue of its location, university affiliations, or programs would be at a distinct advantage or disadvantage in its ability to recruit new staff to meet increased patient workloads accompanying another hospital's closing.

In view of other state hospital closing experiences, it might be assumed that because Connecticut Valley Hospital is centrally located between Fairfield Hills and Norwich Hospitals, all other factors being equal, proportionately more staff would be willing and able to accept transfer to these hospitals than would be true in the case of transfer to the more distant Fairfield Hills or Norwich Hospitals. Studies of hospital closings in other states have indicated that the nearer the alternative hospital is to the hospital of original employment, the greater the number of staff willing to transfer.

However, unlike these other states, in Connecticut a large number of staff live on the grounds of hospitals, and would be forced by virtue of the hospital's closing to give up their residence. Thus, it could as easily be presumed that the availability of housing arrangements at the receiving hospital could have a greater bearing on the employee's willingness to transfer than would distance. A reliable estimate of the number of staff that would be prepared to transfer from one of the hospitals to each of the remaining two could not be derived without further study.

G. Hospital Operating Requirements and Costs Under Each Hospital Closure Option

Our preliminary analysis showed that the operating costs under each of the three closure options differed little, and thus are not considered in this analysis. They are considered in the strategic plan (Section III) as they do vary significantly between the hospital "Non-closure and hospital "Closure" strategies.

H. Renovation Requirements and Capital Costs Under Each Hospital Closure Option

The aim of this analysis was to estimate the relative costs of renovating buildings to accommodate patients from the hospital closed at the two hospitals remaining open under each of the three hospital closing options. The existing bed capacity of each of the hospitals was obtained from the "August, 1980 Quarterly Ward Assignment Reports," and verified with the Business Managers or Directors of Nursing at each hospital. The figures represent the physical bed capacity defined to include beds that could be occupied without appreciable renovation costs. Bed capacities in unoccupied building could not be counted as existing capacity since such buildings are subject to additional life safety code requirements prior to re-occupancy.

The required bed capacity was calculated using the following formulas to allow for expected fluctuations in patient admission/ discharge rates:

- Alcohol program bed capacity for short-term patients= 1.176 x average daily population. This corresponds to an 85% occupancy rate.
- Other program bed capacities for short-term patients= 1.111 x average daily population. This corresponds to a 90% occupancy rate.
- All program bed capacities for longer-term patients= 1.053 x average daily population. This corresponds to a 95% occupancy rate.

The added bed capacity possible through the renovation of existing building, and the estimated costs of renovation were prepared by the Environmental Design Group (EDG) following on-site reviews of each hospital building where there was a potential for rehabilitation. These estimates are conservative (low). They do not include the cost of furnishings and equipment for program activities, food preparation and service, and so forth; nor do they include design fees, or building contractor

administration costs.* The following assumptions were applied:

1. Projected Bed Capacity

   The projected bed capacity provides for at least 80 square feet per person and no more than 4 persons per sleeping room.

2. Renovation Criteria

   - Compliance with the State Building Code, including: Energy fitness (applied only to buildings currently unoccupied);

     Adequate heating and ventillating;

     Adequate electrical service;

     Handicap access.

   Note: Major portions of these criteria may be waivable by the office responsible for compliance with the State Building Code.

   - Compliance with the Life Safety Code (NFPA 101-1973), including:

     Provision for emergency egress;

     Fire protection systems.

   - Compliance with JCAH and HEW standards, including:

     Adequate lighting;

     Adequate bathrooms and plumbing;

     Upgrading interior finishes;

     Allowance for ancillary space, particularly kitchen and dining, within each presently unoccupied building, but not including any expansion of existing centralized hospital facilities.

   - Air Conditioning, identified as a separate cost item in accordance with the recommendation of the Department of Mental Health;

   - Conversion to electric heat, a long-range recommendation in the Wilson Report 1, is not included.

*The renovation cost estimates included in the plan (Section III. G.) do include these cost elements.

The costs of constructing or renovating buildings housing inpatient programs (e.g., Cedarcrest Regional Hospital Manchester Memorial, etc.) projected to have impact on the patient populations at the Connecticut Valley, Fairfield Hills, and Norwich Hospitals (See Table II B. 2) are not reflected in these tables. They are considered "sunk" (non-recoverable costs) and thus immaterial to this analysis.

The estimated renovation costs under each option are shown in Tables II H. 1 through II H. 3, and are summarized in Table II H. 4. The renovation requirements and costs are estimated assuming that all of the patients at the hospital closed will be transferred to the remaining two hospitals. Placement of some of these patients in the community would, of course, reduce the additional bed capacity required and related capital costs.

NARRATIVE CONTINUES ON PAGE 51

TABLE II H.1

ESTIMATED RENOVATION COSTS ASSUMING CONNECTICUT VALLEY HOSPITAL IS CLOSED AND ALL PATIENTS ARE TRANSFERRED, PROJECTED 1985-86

Hospital/Building	Available Bed Capacity	Existing Bed Capacity	New Bed Capacity	Estimated Renovation Costs			
				Without Air Conditioning		With Air Conditioning	
				Cost Per Bed	Building Cost	Cost Per Bed	Building Cost
Connecticut Valley Hospital Total		684					
Shepard Hall							
Woodward Hall (new)		52					
Leak Hall		32					
Dutcher Hall		144					
Battell Hall		186					
Merritt Hall		258					
Dutton		12					
Russell Hall							
Weeks Hall (new)							
Dix Hall							
Beers Hall							
Fairfield Hills Hospital Total	1071	911	160		3,951,284		4,668,000
Cochran House	225	225					
Canaan	261	261					
Kent	276	276					
Fairfield House	89	89					
Litchfield House	60	60					
Greenwich House	160		160	24,696	3,951,284	29,175	4,668,000
Norwich Hospital Total	1089	696	393		5,858,396		7,159,016
Kettle	210	210					
Lodge	286	286					
Seymour	64	64					
Ray	142		142	11,548	1,639,782	13,801	1,959,716
Outreach	40	40					
Bryan	109		109	9,950	1,084,533	13,426	1,463,484
Kirkbride	142		142	11,548	1,639,782	13,801	1,959,716
Gallup	56	56					
Pathway	40	40					
Total					[illegible]		[illegible]

TABLE II H.2

ESTIMATED RENOVATION COSTS ASSUMING FAIRFIELD HILLS HOSPITAL IS CLOSED AND ALL PATIENTS ARE TRANSFERRED, PROJECTED 1985-86

Hospital/Building	Available Bed Capacity	Existing Bed Capacity	New Bed Capacity	Estimated Renovation Costs			
				Without Air Conditioning		With Air Conditioning	
				Cost Per Bed	Building Cost	Cost Per Bed	Building Cost
Connecticut Valley Hospital Total	1,188	684	504		7,869,010		10,522,470
Shepard Hall							
Woodward Hall (new)	128	52	76	16,100	2,060,086	18,961	2,427,044
Leak Hall	32	32					
Dutcher Hall	144	144					
Battell Hall	186	186					
Merritt Hall	258	258					
Dutton	12	12					
Russell Hall							
Weeks Hall (new)	128		128	16,100	2,060,086	18,961	2,427,044
Dix Hall	200		200	12,487	2,497,476	20,454	4,090,792
Beers Hall	100		100	12,513	1,251,362	15,776	1,577,590
Fairfield Hills Hospital Total		911					
Cochran House		225					
Canaan		261					
Kent		276					
Fairfield House		89					
Litchfield House		60					
Greenwich House							
Norwich Hospital Total	947	696			4,364,097		5,382,916
Kettle	210	210					
Lodge	286	286					
Seymour	64	64					
Ray							
Outreach	40	40					
Bryan	109		109	9,950	1,084,533	13,426	1,463,484
Kirkbride	142		142	11,548	1,639,782	13,801	1,959,716
Gallup	56	56					
Pathway	40	40					
Total					10,593,329		13,945,670

TABLE II H. 3

ESTIMATED RENOVATION COSTS ASSUMING NORWICH HOSPITAL IS CLOSED AND ALL PATIENTS ARE TRANSFERRED, PROJECTED 1985-86

Hospital Building	Available Bed Capacity	Existing Bed Capacity	New Bed Capacity	Estimated Renovation Costs			
				Without Air Conditioning		With Air Conditioning	
				Cost Per Bed	Building Cost	Cost Per Bed	Building Cost
Connecticut Valley Hospital Total	1,188	684	504		7,869,010		10,522,470
Shepard Hall							
Woodward Hall (new)	128	52	76	16,100	2,060,086	18,961	2,427,044
Leak Hall	32	32					
Dutcher Hall	144	144					
Battell Hall	186	186					
Merritt Hall	258	258					
Dutton	12	12					
Russell Hall							
Weeks Hall (new)	128		128	16,100	2,060,086	18,961	2,427,044
Dix Hall	200		200	12,487	2,497,476	20,454	4,090,792
Beers Hall	100		100	12,513	1,251,362	15,776	1,577,590
Fairfield Hills Hospital Total	911	911					
Cochran House	225	225					
Canaan	261	261					
Kent	276	276					
Fairfield House	89	89					
Litchfield House	60	60					
Greenwich House							
Norwich Hospital Total		696					
Kettle		210					
Lodge		286					
Seymour		64					
Ray							
Outreach		40					
Bryan							
Kirkbride							
Gallup		56					
Pathway		40					
Total							

TABLE II H.4

ESTIMATED RENOVATION COSTS UNDER EACH ALTERNATIVE
PROJECTED 1985-86

	Connecticut Valley Hospital Closure		Fairfield Hills Hospital Closure		Norwich Hospital Closure	
Hospital/Building	With A-C	Without A-C	With A-C	Without A-C	With A-C	Without A-C
Connecticut Valley Hospital Total			10,522,470	7,869,010	10,522,470	7,869,010
Shepard Hall						
Woodward Hall (new)			2,427,044	2,060,086	2,427,044	2,060,086
Leak Hall						
Dutcher Hall						
Battell Hall						
Merritt Hall						
Dutton						
Russell Hall						
Weeks Hall (new)			2,427,044	2,060,086	2,427,044	2,060,086
Dix Hall			4,090,792	2,497,476	4,090,792	2,497,476
Beers Hall			1,577,590	1,251,362	1,577,590	1,251,362
Fairfield Hills Hospital Total	4,668,000	3,951,284				
Cochran House						
Canaan						
Kent						
Fairfield House						
Litchfield House						
Greenwich House						
Norwich Hospital Total	7,159,016	5,858,396	5,382,916	4,364,097		
Kettle						
Lodge						
Seymour						
Ray	1,959,716	1,639,782				
Outreach						
Bryan	1,463,484	1,084,533	1,463,484	1,084,533		
Kirkbride	1,959,716	1,639,782	1,959,716	1,639,782		
Gallup						
Pathway						
Total	10,050,916	8,315,375	13,945,670	10,593,329	10,522,470	7,869,010

I. Non-hospital Support Service Arrangements and Estimated Costs Under Each Hospital Closure Option

The purpose of this analysis was to examine the expected impact of each hospital's closure on the non-hospital organizations currently supported by each of the hospitals. The hospitals provide three basic types of support to non-hospital organizations.

(1) power and water;

(2) administrative, food, and general services;

(3) patient care services.

Tables II I. 1 through II I. 3 show the non-hospital support services for which formal interagency support agreements have been drafted, and the charges that were agreed upon for 1979-80 or that were actually charged in 1978-79. In some cases, the heat and electric charges have been altered slightly to agree with the estimates prepared by the Environmental Design Group in consultation with the Plant Supervisors at each hospital. HSRI has added the estimated costs of maintaining the hospital buildings used by two state administrative agencies at the Connecticut Valley Hospital: the Department of Purchasing Offices, and the Department of Mental Health's data processing unit. These estimates were derived by allocating the hospitals' maintenance, housekeeping, and security costs on the basis of the square feet of space occupied by these organizations.

1. Water and Power

The cost of providing heat, electricity, water, and sewage treatment services would markedly increase for the non-hospital facilities should they alone, continue in operation. Considering this marked increase in water and power costs, it would make sense to (1) either find alternate uses for the vacated hospital buildings in order to share the costs of water and power; or (2) relocate the non-hospital facilities.

a. Water and Sewer

The water supply equipment and sewage treatment plants at each of the hospitals are in good working order. In the Environmental Design Group's estimation, the more economic choice at each of the hospitals would be to continue to operate the water supply and sewage treatment plants rather than to make the sizable investment required to tie into the town water and sewer systems.

The operating costs (personnel and non-personnel) of the water supply and sewage treatment plants at each of the hospitals are estimated by the Environmental Design Group as follows:

Connecticut Valley Hospital*	$70,000
Fairfield Hills Hospital	213,000
Norwich Hospital	200,000

b. Heat and Electricity

Though the power plants are also reported to be in good working order, the cost of maintaining these oversize plants in support of only a few buildings would be prohibitive. Accordingly, the Environmental Design Group recommends that each remaining building install its own steam generation unit (boiler) for heat, and its own transformer to channel electricity from the local utility company.

Table II I. 5 displays the estimated current costs of heat and electricity, the projected capital costs of converting to these alternate power systems, and the projected annual fuel and electricity costs under these alternate power systems.

2. Patient Care Services

Patient care services for which there are documented inter-agency agreements and billing arrangements are shown in Tables II I. 1 to 3. They consist exclusively of medical and dental

*The lower cost at the Connecticut Valley Hospital is explained by the fact that the hospital has its own reservoir (water source) and thus no water charge is included.

services. Alternate providers of medical and dental services would be relatively easy to obtain on a contract basis with nearby private or institutional practitioners.

Not documented are the private consulting arrangements between the Housatonic Adolescent Hospital and psychiatrists of the Fairfield Hills Hospital, and between the Riverview Children's Unit and Whiting Forensic Unit and psychiatrists of the Connecticut Valley Hospital. The hospital psychiatrists provide a needed and accessible treatment and back up resource for these children, youth, and forensic programs. Like arrangements would be much more difficult and more costly to arrange if these units were no longer located adjacent to an operating mental hospital.

3. Administrative, Food, and General Services

Like the medical and dental services, some administrative, food, and general services (e.g., security, facility maintenance and repair, food, transportation, and accounting) could be purchased under contract. Alternatively, staff might be hired to perform these services in-house. The cost of these alternative arrangements should not be appreciably different than are the current costs. Needed equipment for the in-house provision of these support services might be obtained from the hospital slated for closure.

4. Hospital-by-hospital Summary

a. Fairfield Hills Hospital

If the Fairfield Hills Hospital were to be closed, the regional laundry services could be provided by the Connecticut Valley Hospital or at another facility, public or commercial, in the area. Yet even if alternative uses for the vacated hospital buildings could be found, it may make little sense for the Housatonic facility to remain on site. The primary advantage of its central location on the grounds is access to the patient care services provided by the Fairfield Hills professional staff--an

advantage that would be lost if the hospital staff were to be relocated. In the case of the Newtown Housing for the elderly, other housing units would have to be found for the elderly--a nearly impossible feat according to local Department of Welfare officials.

b. Connecticut Valley Hospital

Should the Connecticut Valley Hospital be closed, the costs of supplying water and power to the remaining non-hospital facilities would not be unreasonably high, relative to the costly and impractical relocation of the Riverview Children's Unit and Whiting Forensic Institute would be unnecessary. Located apart from the main hospital campus, their operations would be little affected by whatever alternative uses might be found for the vacated buildings. Finding alternative uses for the vacated buildings would probably be an easier task at the Connecticut Valley Hospital than at Norwich given its proximity to the Hartford metropolitan area.

c. Norwich Hospital

Should the Norwich Hospital be closed, the cost of supplying the remaining non-hospital facilities with power and water would be relatively low. However, given the nature of the Ribicoff Research Center's operation, it may make sense for this function to be relocated to a university-based location. The regional laundry services at the Connecticut Valley and Fairfield Hills Hospitals could absorb the added laundry demands of the patients transferred from Norwich. As the Regional Transit Center does not rely on the hospital for its water supply or treatment, the Center would have to bear only the cost of converting its power supply to the public utility.

Alternative uses for the vacated buildings may be more difficult to find at Norwich than would be the case at either Connecticut Valley or Fairfield Hills given the hospital's relatively rural location and poor local economic conditions.

Yet, for this very reason, finding alternative uses for the Norwich Hospital is probably more important than at the other hospitals.

NARRATIVE CONTINUES ON PAGE 61

TABLE II I. 1

NON-HOSPITAL SUPPORT SERVICE ARRANGEMENTS
AND ESTIMATED COSTS, 1979-80
CONNETICUT VALLEY HOSPITAL

Organization Supported	Services Provided	Estimated Cost
Riverview Children's Unit	Patient Care:	
	Dental Services	1,650
	Medical Services (EEG tests; X-ray)	202
	Administration:	
	Postage	617
	General Services:	
	Security	4,500
	Miscellaneous	3,248
	Heat and Elect.	103,278
	Maintenance	20,190
Regional Laundry	General Services:	
	Heat and Elect.	107,702
	Security	600
Department of Purchasing	General Services:	
	Heat and Elect.	58,715
	Maintenance	220,086

(Continued)

Organization Supported	Services Provided	Estimated Cost
CADAC & Blue Hills Hospital	Patient Care:	
	Dental Services	1,701
	General Services:	
	Miscellaneous	2,408
Whiting Forensic Institute	Patient Care:	
	Dental Services	4,245
	EEG tests; X-ray	2,297
	Medications	17,804
	Food Services:	
	Food	140,200
	General Services:	
	Heat and Elect.	113,100
	Maintenance	11,089
DMH Data Processing Unit	General Services:	
	Maintenance	60,963

TABLE II I. 2

NON-HOSPITAL SUPPORT SERVICE ARRANGEMENTS
AND ESTIMATED COSTS, 1979-80
FAIRFIELD HILLS HOSPITAL

Organization Supported	Services Provided	Estimated Cost
Housatonic Adolescent Hospital	Patient Care: Dental, Radiology EEG, EKG, etc.	31,553
	Food Services: Food	35,434
	General Services: Transportation	4,680
	Maintenance and Repair	24,532
	Security	12,000
	Heat and Electricity	94,671
	Administration: Postage and Switchboard	868
Newton Housing for the Elderly (Nunnuwalk Meadows East and West)	General Services: Heat and Elect.	28,938
	Water	5,623
Fairfield Hills Laundry	General Services: Heat and Elect.	66,426
Meals-on-Wheels	Food Services: Meals	3,240

TABLE II I. 3

NON-HOSPITAL SUPPORT SERVICE ARRANGEMENTS
AND ESTIMATED COSTS, 1979-80
NORWICH HOSPITAL

Organization Supported	Services Provided	Estimated Cost
Regional Laundry	General Services: Heat and Elect.	80,600
Montville Correction Center	Patient Care: Dental Services	1,705
Ribicoff Research Center	Administrative Services: General	30,000
	Maintenance	55,348
	Heat and Elect.	41,498

TABLE II I. 4

ESTIMATED COST OF CURRENT AND ALTERNATE
POWER SYSTEMS FOR SELECTED HOSPITAL BUILDINGS

	Current Operating Costs		Capital Conversion Costs		Alternate Power System Operating Costs	
Hospital/Building	Heat	Elect.	Heat	Elect.	Heat	Elect.
Connecticut Valley Hospital						
Regional Laundry	48,052	59,650	25,000	10,000	62,000	50,000
Riverview Children's Center	46,635	56,633	22,000	10,000	76,765	46,058
Whiting Forensic Institute	50, 460	62,640	32,000	10,000	82,000	50,000
Sewage Treatment Plant	--	70,000	--	40,000	--	90,000
Fairfield Hills Hospital						
Regional Laundry	29,636	36,790	25,000	10,000	38,400	30,600
Housatonic Adolescent Hospital	42,241	52,430	22,000	10,000	74,108	44.466
Newtown Housing for the Elderly	25,822	32,054	58,000	10,000	42,000	21,000
Sewage Treatment Plant	--	70,000	--	40,000	--	90,000
Norwich Hospital						
Regional Laundry	35,960	44,640	25,000	10,000	50,000	34,000
Regional Transit Center	--	--	--	7,000	--	30,000
Ribicoff Research Center	18,512	22,980	20,000	10,000	36,000	12,000
Sewage Treatment Plant	--	70,000	--	40,000	--	90,000

III. STRATEGIC PLAN

A. Overview

A primary purpose of this strategic plan is to present, in a clear and succinct fashion, the configurational (mental health patients, staff and services), and fiscal implications of closing the Norwich Hospital. On the surface, the structural and monetary focus of this plan may seem cold and narrow. The objective would appear to dismiss the emotional and physical trauma experienced by patients subject to involuntary relocation, to ignores the burden of the hospital's closing may have on families of patients, to eschew the question of whether patients will benefit from such a move, and to neglect the economic and personal burdens on the hospital staff and local business persons whose livelihoods are threatened.*

However, considered further, the impetus for the plan is understandable. The cost of care in Connecticut's mental hospitals has risen dramatically over the past decade in the face of a marked decline in the patient census. The cost can be expected to rise even further with inflation and as the level and quality of hospital staff continues to improve. At the same time, the cost of the community mental health system continues to grow though not nearly fast enough to meet the inexorable increase in demand.

As has been done in many other states, the Connecticut Legislature is seeking to determine whether the ever-escalating cost of delivering mental health treatment and support services in the state can be stemmed or at least slowed through the consolidation of the state hospital configuration.

The Human Services Research Institute presents this strategic plan as the "first" word not the "last," acknowledging the validity and importance of these broader concerns, and

*A list of references examining these important issues is presented in Appendix D.

trusting that, should the Legislature decide to proceed with the plan, these issues will be addressed in a thorough going and responsible planning and implementation process of the sort capsuled below.

The planning process undertaken by the Department should be open to participation by all concerned. It should be tied to the ongoing Mental Health and Health Systems Planning processes in the state.

The plan should contain a clear and comprehensive definition of the goals (aims) of the hospital consolidation including expected savings and delivery system improvements, future role of the state hospitals with respect to alcohol detoxification services and other short-term services, and safeguards attending the hospital's closure (i.e., insuring well-being of the patients, protecting the patients' rights, providing staff employment alternatives, etc.). Worth pointing out is the fact that at this stage the plan is devoid of goals. It is programmatically sterile. Neither the Department nor the Legislature dictated a picture of the "new" system they would like to see. Given the nature of the task, HSRI was reticent to impose its own picture, not wanting to assert a particular bias, nor to distract from the central purpose of this plan: to analyze objectively the fiscal implications of closing a mental hospital in Connecticut, specifically the Norwich State Hospital.

The resulting plan should have at least the tacit endorsement of those key individuals and organizations whose support is required to carry it through. In other words, it should be politically feasible. Sufficient funds must be committed to effect the plan. Other state experiences have shown that when such a commitment is lacking, the quality of care at the receiving hospitals suffers, and patients are effectively abandoned in the community.

Finally, a management team should be assigned full-time to implement the plan. The process of bringing about such a dramatic change in the mental health service system is a turbulent one demanding constant management attention. It is

also a far-reaching process requiring the coordination of a myriad of providers, administrative agencies, client advocates, case managers, and others.

The management team should be the focal point for all activities outlined in the plan. This concentration of responsibility will promote the integration of the many activities involved and should result in a more cohesive effort. The project team should be involved in all major decisions concerning costs, timing, plan refinement and modification, and the consummation of interdepartmental agreements. The team should be organized at the very beginning of the planning process, and should continue to oversee the implementation through the five-year transition period. By establishing an implementation management team state officials can be assured that someone is accountable for the accomplishment of the plan.

This strategic plan presents three contrasting pictures of how Norwich patients might be served in the future: (1) patients continue to be served at Norwich; (2) patients are transferred to the Connecticut Valley or Fairfield Hills Hospitals; (3) some patients are placed in the community and others are transferred.

Section B projects the hospital staff requirements, surpluses, and deficits; and operating costs by program, function, and funding source should patients continue to be served at the Norwich Hospital. Comparing this "Non-closure" strategy with the two closure strategies presented in the following subsections indicates the relative impacts of a decision to close the Norwich Hospital.

The two "closure strategies" described in subsections C-K are at opposite poles. Under the "Inter-hospital Strategy", all patients who would otherwise be cared for at Norwich would be transferred to the Fairfield Hills and Connecticut Valley Hospitals; no patients would be accommodated in the community.

Strict adherence to this strategy would lead to the marked expansion of the two remaining hospitals. It would fly-in-the-face of current treatment philosophies which favor smaller, less-restrictive inpatient treatment facilities, and would do relatively little to curb the growth of the state hospital operating budgets. However, it would result in fewer surplus staff and thus in less staff opposition.

Under the "Hospital/Community Strategy" most of the shorter term patients who would otherwise be treated at Norwich would be referred to newly developed or expanded short term inpatient facilities in Region III. The longer term patients who are able to function in the community, given adequate care and support service arrangements would be placed in community settings. Shorter term patients who could not be accommodated in less restrictive treatment settings, and longer term patients who require psychiatric attention and twenty-four hour supervision would be transferred to Connecticut Valley or Fairfield Hills. Pushed too far or too fast, this strategy could result in the "dumping" of patients into poor quality nursing homes, substandard living arrangements, and unprepared and unaccepting communities.

By projecting those two divergent strategies, we are effectively presenting the range of impacts possible with the closing of the Norwich Hospital. Where along the spectrum the actual impacts will eventually fall will depend on a variety of factors such as: patient and family needs and preferences, the extent to which the Department of Mental Health is interested in developing the hospital versus community alternatives to meet these needs, the extent to which the legislature is willing to commit funds to support these alternative strategies, the extent to which community providers are willing to care for these patients, and the degree to which the towns are willing to accept community-based programs and patients.

Before presenting these two strategies, a word of caution is in order. Viewed apart from the prospect of a hospital's

closing, the placement of hospital patients in community-based alternatives and the development of mechanisms to divert all but the more seriously disabled from mental hospitals, is a positive step. However, our experience has shown that linking the deinstitutionalization of patients too closely with the closing of hospitals can be a self-defeating proposition. The prospect of the hospital closure overshadows deinstitutionalization and impedes its progress. The strength of the patient-caseworker relationship can be undermined, the attitude of cooperation between the hospital and community programs can be poisoned, the prospect of needed community and political support can be dimmed, and administrative pressures (real or imagined) to discharge patients prematurely can hamper a conscientious deinstitutionalization effort.*

For these reasons, accelerated efforts to develop community alternatives should be statewide and not tied to the closing of a particular hospital. In other words, these efforts should not be concentrated in the Norwich Hospital Service Area.

Finally, both strategies require time in order to mount a comprehensive and participatory implementation planning process; to prepare longer term patients for relocation; to develop essential community treatment, care, and support services; to renovate and refurbish hospital buildings; and to provide for orderly and equitable staff arrangements. A realistic transition period for both strategies is four to five years.

*Ashbaugh, John and Valerie Bradley, "Linking Deinstitutionalization of Patients with Hospital Phase-down: The Difference Between Success and Failure," Hospital and Community Psychiatry, Volume 30, No. 2, February, 1979.

B. Continued Operation of Three Hospitals ("Non-closure" Strategy)

This section includes projections from 1981-82 through 1985-86 of:

- The size of the patient populations by program at each of the three hospitals. (Sub-section B 1)
- The staffing surpluses and deficits at each of the hospitals by program and function; and (Sub-section B 2)
- The operating costs at each of the hospitals by program, function, and funding source. (Sub-sections B 3 and 4)

assuming that none of the hospitals is closed, and that each of the hospitals continues its current pattern of operation.

1. Patient Dispositions

The technique and assumptions used to project the size of the patient populations at each of the hospitals are explained in Section II B.

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TABLE III B. 1a

DISPOSITION OF HOSPITAL PATIENTS BY PROGRAM:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1981-82

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	647	236034	160	58631	487	177862
Alcohol Dependent	26	9424	17	6220	9	3204
Drug Dependent	2	531	0	000	2	531
Mentally Retarded	39	14137	1	424	38	13713
Mentally Ill	439	160108	97	35400	342	124708
Geriatric	142	51834	45	16587	97	35247
Fairfield Hills Hospital: Total	652	238125	193	70315	459	167810
Alcohol Dependent	13	4833	5	1813	8	3020
Drug Dependent	13	4682	6	2060	7	2622
Mentally Retarded	71	25752	5	1803	66	23949
Mentally Ill	427	156036	136	49656	291	106380
Geriatric	128	46822	41	14983	87	31839
Norwich Hospital: Total	612	223250	150	54866	462	168384
Alcohol Dependent	32	11770	25	9298	7	2472
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	45	16478	3	989	42	15489
Mentally Ill	341	124381	60	21980	281	102401
Geriatric	194	70621	62	22599	132	48022

TABLE III B. 1b

DISPOSITION OF HOSPITAL PATIENTS BY PROGRAM:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1982-83

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	634	231527	142	51842	492	179685
Alcohol Dependent	26	9544	17	6299	9	3245
Drug Dependent	2	561	0	000	2	561
Mentally Retarded	39	14317	1	430	38	13887
Mentally Ill	424	154611	78	28315	346	126296
Geriatric	144	52494	46	16798	98	35696
Fairfield Hills Hospital: Total	655	239163	193	70336	462	168827
Alcohol Dependent	13	4876	5	1838	8	3038
Drug Dependent	13	4711	6	2073	7	2638
Mentally Retarded	71	25908	5	1814	66	24094
Mentally Ill	429	156562	136	49537	293	107025
Geriatric	129	47106	41	15074	88	32032
Norwich Hospital: Total	621	226494	154	55855	467	170639
Alcohol Dependent	33	11928	26	9423	7	2505
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	46	16699	3	1002	43	15697
Mentally Ill	346	126300	62	22529	284	103771
Geriatric	196	71567	63	22901	133	48666

TABLE III B. 1c

DISPOSITION OF HOSPITAL PATIENTS BY PROGRAM:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1983-84

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	643	234611	144	52643	499	181968
Alcohol Dependent	26	9664	17	6378	9	3286
Drug Dependent	2	591	0	000	2	591
Mentally Retarded	40	14497	1	435	39	14062
Mentally Ill	429	156705	79	28821	350	127884
Geriatric	146	53154	47	17009	99	36145
Fairfield Hills Hospital: Total	659	240638	194	70791	465	169847
Alcohol Dependent	13	4919	5	1862	8	3057
Drug Dependent	13	4739	6	2085	7	2654
Mentally Retarded	72	26065	5	1825	67	24240
Mentally Ill	431	157525	136	49854	295	107671
Geriatric	130	47390	42	15165	88	32225
Norwich Hospital: Total	629	229737	156	56843	473	172894
Alcohol Dependent	33	12085	26	9547	7	2538
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	46	16920	3	1015	43	15905
Mentally Ill	351	128220	63	23077	288	105143
Geriatric	199	72512	64	23204	135	49308

TABLE III B. 1d

DISPOSITION OF HOSPITAL PATIENTS BY PROGRAM:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1984-85

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	651	237695	146	53444	505	184251
Alcohol Dependent	27	9784	18	6457	9	3327
Drug Dependent	2	621	0	000	2	621
Mentally Retarded	40	14677	1	440	39	14237
Mentally Ill	435	158799	80	29327	355	129472
Geriatric	147	53814	47	17220	100	36594
Fairfield Hills Hospital: Total	663	242110	195	71245	468	170865
Alcohol Dependent	13	4961	5	1886	8	3075
Drug Dependent	13	4768	6	2098	7	2670
Mentally Retarded	72	26221	5	1835	67	24386
Mentally Ill	434	158486	137	50170	297	108316
Geriatric	131	47674	42	15256	89	32418
Norwich Hospital: Total	638	232981	158	57833	480	175148
Alcohol Dependent	33	12243	26	9672	7	2571
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	47	17140	3	1028	44	16112
Mentally Ill	357	130140	65	23626	292	106514
Geriatric	201	73458	64	23507	137	49951

TABLE III B. 1e

DISPOSITION OF HOSPITAL PATIENTS BY PROGRAM:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1985-86

	All Patients:		Shorter Term Patients:		Longer Term Patients:	
	Average Daily Census	Patient Days	Average Daily Census	Patient Days	Average Daily Census	Patient Days
Connecticut Valley Hospital: Total	657	240240	148	54109	509	186131
Alcohol Dependent	27	9883	18	6523	9	3360
Drug Dependent	2	646	0	000	2	646
Mentally Retarded	40	14825	1	445	39	14380
Mentally Ill	439	160527	81	29746	358	130781
Geriatric	149	54359	48	17395	101	36964
Fairfield Hills Hospital: Total	669	244364	197	71941	472	172423
Alcohol Dependent	14	5026	5	1923	9	3103
Drug Dependent	13	4811	6	2117	7	2694
Mentally Retarded	72	26460	5	1852	67	24608
Mentally Ill	438	159958	139	50654	299	109304
Geriatric	132	48109	42	15395	90	32714
Norwich Hospital: Total	646	235753	161	58678	485	177075
Alcohol Dependent	34	12378	27	9779	7	2599
Drug Dependent	-	-	-	-	-	-
Mentally Retarded	48	17329	3	1040	45	16289
Mentally Ill	361	131780	66	24094	295	107686
Geriatric	203	74266	65	23765	138	50501

2. Staff Dispositions

Tables III B. 2a-e compare existing staffing levels to projected staffing requirements in 1981-82 through 1985-86.

a. Baseline Estimates

The existing staffing levels were obtained from Monthly Status Reports in July of 1980. The complement of patient care staff associated with each program was determined by first identifying the amount of time spent on each ward by the patient care staff, and then determining types of the patients (drug, geriatric ...) residing on each ward. The department heads of six major patient care services--medical/psychiatric, nursing, psychological, social services and rehabilitation therapies--were asked to estimate the average percent of time spent by their staff on each ward using "time allocation" forms designed by HSRI. A copy of this form is shown in Appendix A.

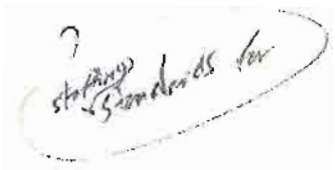
The break-out of the patients on each ward by program category was approximated using:

- descriptive ward reports;
- discussions with patient care staff; and
- for mixed wards, especially the psychiatric wards, an analysis of the MSIS patient data.

The required staffing levels were derived as follows:

- "Patient Care" and "Education and Training" staff

  To determine the number of staff required in these positions, we applied registered nurses, psychiatrists, psychiatric residents, psychologists, psychiatric aides, social workers and rehabilitation workers. The staffing standards prepared for the Department of Mental Health by



Marjorie Bayes, Ph.D. and Karen Kmetzo, R.N. in February, 1979.* These standards were defined by Bayes and Kmetzo at each of the three hospitals using an established workload analysis method. The patient care staff workloads associated with different patient groups are known to vary significantly. This phenomenon is well explained in Bayes' and Kmetzo's report and is reflected in their staffing standards.

-Other "patient care" and "education and training" staff positions to which the standards did not apply were assumed to be appropriately staffed. The total number of patient care staff required for each patient care program and for the "education and training" function were then computed by adding (1) and (2).

- "Food Services" Staff

  Wilson's standard of "one food service worker for every eight inpatients" was applied in projecting the number of food service workers required.**

- "Administrative" and "General Services" Staff

  The number of staff required in these areas can vary significantly from hospital to hospital depending on the organizational structure, and facility configurations; accordingly, no standards could reliably be applied in these areas. It had to be assumed that these positions were appropriately staffed.

- "Outpatient" Services Staff

  It was assumed that this program was adequately staffed.

- "Research" Staff

  These staff positions were not included in the analysis.

*Staffing Needs and Standards for Psychiatric Inpatient Facilities in the State of Connecticut, February, 1979.

**Wilson, Richard H., Staffing Standards and Needs for the New Jersey State Psychiatric Hospitals, Joint Study Group on Hospital Staffing, November, 1978. This standard may be high in more centralized and modern food service operations.

b. Projected Estimates

The required staffing levels were projected to change according to the following assumptions.

- the size of the required "patient care" and "food services" complements were projected to change at the same rate of change projected in the number of patient days;
- the size of the required "administrative services" staff complements were projected change at one-third the rate of change projected in the number of patient days;
- the size of the required "education and training" staff complements were projected to change at two-thirds the rate of change projected in the number of patient days;
- the size of the required "general services" staff complements were projected to change at a rate of 3 staff per 10,000 square feet of space occupied in patient wards. This assumption was formulated based on the Wilson report (cited earlier).

NARRATIVE CONTINUES ON PAGE 80

TABLE III B. 2a

STAFF REQUIREMENTS, SURPLUSES, AND DEFICITS BY PROGRAM AND FUNCTION:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1981-82

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	52	-	56	57	1	55	55	-
Food Services	79	81	2	69	82	13	71	76	5
General Services	179	179	-	181	182	1	141	140	(1)
Patient Care	663	698	35	745	728	(17)	711	742	31
. Medical/Psychiatric Services	23	30	7	35	34	(1)	32	37	5
- Alcohol/Drug	8	8	-	6	5	(1)	3	4	1
- MI/MR	11	16	5	23	23	-	22	25	3
- Geriatric	4	6	2	6	6	-	7	8	1
. Nursing Services	489	513	24	515	494	(21)	528	507	(21)
- Alcohol/Drug	93	81	(12)	77	66	(11)	53	51	(2)
- MI/MR	313	342	29	345	333	(12)	327	312	(15)
- Geriatric	83	90	7	93	95	2	148	144	(4)
. Psychology Services	19	21	2	21	29	8	12	25	13
- Alcohol/Drug	3	3	-	7	8	1	2	3	1
- MI/MR	15	17	2	12	18	6	8	17	9
- Geriatric	1	1	-	2	3	1	2	5	3
. Social Services	33	53	20	28	50	22	26	55	29
- Alcohol/Drug	11	15	4	5	8	3	4	9	5
- MI/MR	16	29	13	17	31	14	18	37	19
- Geriatric	6	9	3	6	11	5	4	9	5
. Rehabilitation Services	45	36	(9)	43	22	(21)	39	43	4
- Alcohol/Drug	5	3	(2)	6	2	(4)	2	3	1
- MI/MR	34	28	(6)	31	17	(14)	31	33	2
- Geriatric	6	5	(1)	6	3	(3)	6	7	1
. Personal Care Services	7	6	(1)	10	10	-	8	8	-
. Miscellaneous Services	47	39	(8)	93	89	(4)	66	67	1
Training & Education	29	29	-	25	22	(3)	36	31	(5)

STAFF REQUIREMENTS, SURPLUSES, AND DEFICITS BY PROGRAM AND FUNCTION:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1982-83

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	52	-	56	57	1	55	56	1
Food Services	79	79	-	69	82	13	71	78	7
General Services	179	178	(1)	181	182	1	141	140	(1)
Patient Care	663	684	21	745	731	(14)	711	751	40
. Medical/Psychiatric Services	23	30	7	35	34	(1)	32	37	5
- Alcohol/Drug	8	8	-	6	5	(1)	3	4	1
- MI/MR	11	16	5	23	23	-	22	25	3
- Geriatric	4	6	2	6	6	-	7	8	1
. Nursing Services	489	502	13	515	496	(19)	528	515	(13)
- Alcohol/Drug	93	80	(13)	77	66	(11)	53	52	(1)
- MI/MR	313	331	18	345	334	(11)	327	317	(10)
- Geriatric	83	91	8	93	96	3	148	146	(2)
. Psychology Services	19	20	1	21	29	8	12	25	13
- Alcohol/Drug	3	3	-	7	8	1	2	3	1
- MI/MR	15	16	1	12	18	6	8	17	9
- Geriatric	1	1	-	2	3	1	2	5	3
. Social Services	33	52	19	28	50	22	76	55	29
- Alcohol/Drug	11	15	4	5	8	3	4	9	5
- MI/MR	16	28	12	17	31	14	18	37	19
- Geriatric	6	9	3	6	11	5	4	9	5
. Rehabilitation Services	45	35	(10)	43	22	(21)	39	43	4
- Alcohol/Drug	5	3	(2)	6	2	(4)	2	3	1
- MI/MR	34	27	(7)	31	17	(14)	31	33	2
- Geriatric	6	5	(1)	6	3	(3)	6	7	1
. Personal Care Services	7	6	(1)	10	10	-	8	8	-
. Miscellaneous Services	47	39	(8)	93	90	(3)	66	68	2
Training & Education	29	29	-	25	23	(2)	36	32	(4)

STAFF REQUIREMENTS, SURPLUSES, AND DEFICITS BY PROGRAM AND FUNCTION:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1983-84

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	52	-	56	57	1	55	56	1
Food Services	79	80	1	69	82	13	71	79	8
General Services	179	178	(1)	181	183	2	141	141	-
Patient Care	663	693	30	745	736	(9)	711	763	52
. Medical/Psychiatric Services	23	30	7	35	34	(1)	32	38	6
- Alcohol/Drug	8	8	-	6	5	(1)	3	4	1
- MI/MR	11	16	5	23	23	-	22	26	4
- Geriatric	4	6	2	6	6	-	7	8	1
. Nursing Services	489	510	21	515	500	(15)	528	523	(5)
- Alcohol/Drug	93	82	(11)	77	67	(10)	53	53	-
- MI/MR	313	336	23	345	336	(9)	327	322	(5)
- Geriatric	83	92	9	93	97	4	148	148	-
. Psychology Services	19	20	1	21	29	8	12	25	13
- Alcohol/Drug	3	3	-	7	8	1	2	3	1
- MI/MR	15	16	1	12	18	6	8	17	9
- Geriatric	1	1	-	2	3	1	2	5	3
. Social Services	33	52	19	28	50	22	26	56	30
- Alcohol/Drug	11	15	4	5	8	3	4	9	5
- MI/MR	16	28	12	17	31	14	18	38	20
- Geriatric	6	9	3	6	11	5	4	9	5
. Rehabilitation Services	45	35	(10)	43	22	(21)	39	44	5
- Alcohol/Drug	5	3	(2)	6	2	(4)	2	3	1
- MI/MR	34	27	(7)	31	17	(14)	31	34	3
- Geriatric	6	5	(1)	6	3	(3)	6	7	1
. Personal Care Services	7	6	(1)	10	10	-	8	8	-
. Miscellaneous Services	47	40	(7)	93	91	(2)	66	69	3
Training & Education	29	29	-	25	23	(2)	36	32	(4)

TABLE II. B. 2d

STAFF REQUIREMENTS, SURPLUSES, AND DEFICITS BY PROGRAM AND FUNCTION:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1984-85

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	53	1	56	57	1	55	56	1
Food Services	79	81	2	69	83	14	71	80	9
General Services	179	178	(1)	181	183	2	141	141	-
Patient Care	663	700	37	745	741	(4)	711	773	62
. Medical/Psychiatric Services	23	30	7	35	34	(1)	32	38	6
- Alcohol/Drug	8	8	-	6	5	(1)	3	4	1
- MI/MR	11	16	5	23	23	-	22	26	4
- Geriatric	4	6	2	6	6	-	7	8	1
. Nursing Services	489	514	25	515	504	(11)	528	531	3
- Alcohol/Drug	93	83	(10)	77	68	(9)	53	54	1
- MI/MR	313	338	25	345	338	(7)	327	327	-
- Geriatric	83	93	10	93	98	5	148	150	2
. Psychology Services	19	20	1	21	29	8	12	26	14
- Alcohol/Drug	3	3	-	7	8	1	2	3	1
- MI/MR	15	16	1	12	18	6	8	18	10
- Geriatric	1	1	-	2	3	1	2	5	3
. Social Services	33	53	20	28	50	22	26	56	30
- Alcohol/Drug	11	15	4	5	8	3	4	9	5
- MI/MR	16	29	13	17	31	14	18	38	20
- Geriatric	6	9	3	6	11	5	4	9	5
. Rehabilitation Services	45	36	(9)	43	22	(21)	39	44	5
- Alcohol/Drug	5	3	(2)	6	2	(4)	2	3	1
- MI/MR	34	28	(6)	31	17	(14)	31	34	3
- Geriatric	6	5	(1)	6	3	(3)	6	7	1
. Personal Care Services	7	6	(1)	10	10	-	8	8	-
. Miscellaneous Services	47	41	(6)	93	92	(1)	66	70	4
Training & Education	29	30	1	25	23	(2)	36	32	(4)

STAFF REQUIREMENTS, SURPLUSES, AND DEFICITS BY PROGRAM AND FUNCTION:
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1985-86

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	53	1	56	57	1	55	56	1
Food Services	79	82	3	69	84	15	71	81	10
General Services	179	179	-	181	183	2	141	141	-
Patient Care	663	710	47	745	750	5	711	783	72
. Medical/Psychiatric Services	23	30	7	35	35	-	32	38	6
- Alcohol/Drug	8	8	-	6	5	(1)	3	4	1
- MI/MR	11	16	5	23	24	(1)	22	26	4
- Geriatric	4	6	2	6	6	-	7	8	1
. Nursing Services	489	522	33	515	510	(5)	528	538	10
- Alcohol/Drug	93	85	(8)	77	69	(8)	53	55	2
- MI/MR	313	343	30	345	342	(3)	327	331	4
- Geriatric	83	94	11	93	99	6	148	152	4
. Psychology Services	19	20	1	21	29	8	12	26	14
- Alcohol/Drug	3	3	-	7	8	1	2	3	1
- MI/MR	15	16	1	12	18	6	8	18	10
- Geriatric	1	1	-	2	3	1	2	5	3
. Social Services	33	54	21	28	51	23	26	57	31
- Alcohol/Drug	11	16	5	5	8	3	4	9	5
- MI/MR	16	29	13	17	32	15	18	39	21
- Geriatric	6	9	3	6	11	5	4	9	5
. Rehabilitation Services	45	36	(9)	43	22	(21)	39	45	6
- Alcohol/Drug	5	3	(2)	6	2	(4)	2	3	1
- MI/MR	34	28	(6)	31	17	(14)	31	35	4
- Geriatric	6	5	(1)	6	3	(3)	6	7	1
. Personal Care Services	7	6	(1)	10	10	-	8	8	-
. Miscellaneous Services	47	42	(5)	93	93	-	66	71	5
Training & Education	29	30	1	25	23	(2)	36	33	(3)

3. Hospital Operating Costs

a. Baseline Costs

Our baseline estimates of the cost of operating each hospital were derived primarily from the estimated 1979-80 expenditures shown in the Department of Mental Health's budget request for 1980-81. From these costs, we subtracted the estimated costs of providing support services to outside organizations (shown in Tables II I. 1-3). Then we added the "off the books" costs obtained from the Comptroller's Office. These costs include such items as fringe benefits (at 28.5% of salaries), insurance, telephone, automated data processing services, and payments to towns in lieu of taxes. We also added the cost of ambulance services at each of the hospitals.

We did not add the costs incurred by the Bureau of Collection services at each hospital. We did not include an allowance for asset depreciation, nor did we add an interest cost for recent capital improvement investments. We did not estimate the value ("paper cost") of the services donated by the many volunteers at the hospitals. At Norwich Hospital we excluded the operating cost of the Ribicoff Research Center as these activities are not viewed as an integral part of the hospital's delivery of services to patients.

The Connecticut Valley Hospital, Fairfield Hills Hospital, and Norwich Hospital record costs in such object classes as salaries, supplies, postage, food, ... according to a standard chart of accounts. They also estimate the distribution of these costs by the following functional areas:

- Patient Care
- Administrative Services
- Food Services
- General Services
- Education and Training

HSRI allocated the "patient care" costs still further according to the program categories listed below:*

- Alcohol Dependent
- Drug Dependent
- Mentally Retarded
- Mentally Ill
- Geriatric

These costs were allocated in proportion to the salaries of the full-time equivalent staff associated with each program. This section marks the beginning of the analysis of the two "closure" strategies. Most of the implementation tasks presented in this subsection pertain to both the "Inter-Hospital" strategy and the "Hospital/Community" Strategy. In those cases where a task is applicable to one or the other, the relevant strategy is shown in parentheses. Sub-section D through I project the impacts of implementing each of these "closure" strategies. As indicated previously, the actual impacts are likely to fall somewhere in between those projected under these two strategies.

The salaries were obtained from computer listings of actual staff salaries in July, 1980. The method used to estimate the number of full-time-equivalent staff devoted to each program is described in the previous subsection.

b. Projected Costs

In projecting the operating costs of each of the hospitals, we did not venture to guess what the inflation rate will be in future years. The projected costs are in "1979-80 dollars."

The projected costs include the salaries and fringe benefits of existing staff plus the estimated salaries of additional staff required to meet the staffing standards or minus the salaries of existing staff in excess of the staffing standards described in

*These categories are defined on pages 2 and 3.

the previous subsection. This adjustment was made under the premise that the strategic plan ought to reflect what "should be" rather than "what is" in the interest of positive change.

The operating costs by program and function are projected to change directly with the change in staff costs (salaries and fringe benefits). This is a reasonable assumption as staff costs account for about 85% of the total operating cost.

c. Sources of Funding

HSRI calculated the portion of the operating costs at the three hospitals funded under private and third-party arrangements in 1978-79 from the Bureau of Collections' Annual Report.

The Hospitals' operating budgets for the same year showed that only 0.7% of their costs were covered under federal grants--principally CETA and NIDA funds. The balance of the hospitals operating costs were program-funded by the state. HSRI applied these same percentages to the projected hospital budgets assuming that the relative funding shares would not change in future years.

NARRATIVE CONTINUES ON PAGE 93

TABLE III B. 3a

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION,
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1981-82

	Consolidated	Admin. Services	Food Services	General Services	Patient ~~Census~~ Service	Education & Training
Connecticut Valley Hospital: Total	21122135	1392594	1585267	3948535	13643047	552692
Alcohol Dependent					2056800	
Drug Dependent					504381	
Mentally Retarded					275618	
Mentally Ill					8268545	
Geriatric					2331040	
Outpatient	206663				206663	
Fairfield Hills Hospital: Total	22564403	1537361	1902616	5183864	13479783	460779
Alcohol Dependent					1896526	
Drug Dependent					981929	
Mentally Retarded					549880	
Mentally Ill					7795816	
Geriatric					2255632	
Outpatient						
Norwich Hospital: Total	18618255	1362213	1889124	1816115	13133684	417119
Alcohol Dependent					1302131	
Drug Dependent					-	
Mentally Retarded					404520	
Mentally Ill					7822039	
Geriatric					3385541	
Outpatient	219453				219453	
Total	62304793	4292168	5377007	10948514	40256514	1430590

TABLE III B. 3b

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION,
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1982-83

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	20654963	1392594	1585267	3948535	13175875	552692
Alcohol Dependent					2036129	
Drug Dependent					181908	
Mentally Retarded					275618	
Mentally Ill					8144517	
Geriatric					2331040	
Outpatient	206663				206663	
Fairfield Hills Hospital: Total	22203100	1552583	2067683	5209655	12932008	441171
Alcohol Dependent					1548643	
Drug Dependent					981929	
Mentally Retarded					538658	
Mentally Ill					7595924	
Geriatric					2266854	
Outpatient						
Norwich Hospital: Total	18458662	1375835	1980386	1806989	12903001	392451
Alcohol Dependent					1295521	
Drug Dependent					-	
Mentally Retarded					416417	
Mentally Ill					7620440	
Geriatric					3351170	
Outpatient	219453				219453	
Total	61316725	4321012	5633336	10965179	39010884	1386314

TABLE III B. 3c

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION,
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1983-84

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	20592488	1392594	1569648	3948535	13129019	552692
Alcohol Dependent					2036129	
Drug Dependent					190176	
Mentally Retarded					279752	
Mentally Ill					8061831	
Geriatric					2354468	
Outpatient	206663				206663	
Fairfield Hills Hospital: Total	22323560	1552583	2067683	5235445	13016874	450975
Alcohol Dependent					1571087	
Drug Dependent					981929	
Mentally Retarded					538658	
Mentally Ill					7635902	
Geriatric					2289298	
Outpatient						
Norwich Hospital: Total	18705090	1389457	2016891	1816115	13083449	399178
Alcohol Dependent					1295521	
Drug Dependent					-	
Mentally Retarded					424349	
Mentally Ill					7741400	
Geriatric					3402726	
Outpatient	219453				219453	
Total	61621138	4334634	5654222	11000095	39229342	1402845

TABLE III B. 3d

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION,
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1984-85

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	20777320	1406520	1593076	3948535	13268207	560982
Alcohol Dependent					2056800	
Drug Dependent					198445	
Mentally Retarded					283887	
Mentally Ill					8144517	
Geriatric					2377895	
Outpatient					206663	
Fairfield Hills Hospital: Total	22452774	1552583	2076371	5261235	13111610	450975
Alcohol Dependent					1593531	
Drug Dependent					991748	
Mentally Retarded					538658	
Mentally Ill					7675881	
Geriatric					2311742	
Outpatient						
Norwich Hospital: Total	21000068	1389457	2044270	3907233	13259930	399178
Alcohol Dependent					1308740	
Drug Dependent					-	
Mentally Retarded					432281	
Mentally Ill					7862359	
Geriatric					3437097	
Outpatient					219453	
Total	64230162	4348560	5713717	13117003	39639747	1411135

TABLE III B. 3e

HOSPITAL OPERATING COSTS BY PROGRAM ANF FUNCTION,
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1985-86

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	20976621	1420446	1616503	3948535	13421864	569273
Alcohol Dependent					2087807	
Drug Dependent					210848	
Mentally Retarded					288021	
Mentally Ill					8227202	
Geriatric					2401323	
Outpatient					206663	
Fairfield Hills Hospital: Total	22584695	1552583	2102434	5261235	13217468	450975
Alcohol Dependent					1615975	
Drug Dependent					1001568	
Mentally Retarded					561102	
Mentally Ill					7715859	
Geriatric					2322964	
Outpatient						
Norwich Hospital: Total	21169015	1389457	2071649	3907233	13394770	405906
Alcohol Dependent					1341789	
Drug Dependent					-	
Mentally Retarded					436247	
Mentally Ill					7942999	
Geriatric					3454282	
Outpatient	219453				219453	
Total	64730331	4362486	5790586	13117003	40034102	1426154

TABLE III B. 4a

HOSPITAL OPERATING COSTS BY SOURCE
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1981-82
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	21121	15694	908	908	760	148	1415	1288
Fairfield Hills Hospital	22564	16765	970	970	812	158	1512	1377
Norwich Hospital	18618	13833	801	801	670	130	1247	1136
Total	62303	46292	2679	2679	2242	436	4174	3801

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

TABLE III B. 4b

HOSPITAL OPERATING COSTS BY SOURCE
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1982-83
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	20655	15347	888	888	744	194	1384	1260
Fairfield Hills Hospital	22203	16497	955	955	799	155	1488	1354
Norwich Hospital	18459	13715	794	794	664	129	1237	1126
Total	61317	45559	2637	2637	2207	428	4109	3740

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

TABLE III B. 4c

HOSPITAL OPERATING COSTS BY SOURCE
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1983-84
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	20592	15301	885	885	741	144	1380	1256
Fairfield Hills Hospital	22324	16586	960	960	804	156	1496	1362
Norwich Hospital	18705	13896	804	804	673	131	1253	1141
Total	61621	45186	2649	2649	2218	431	4129	3759

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

TABLE III B. 4d

HOSPITAL OPERATING COSTS BY SOURCE
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1984-85
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	20776	15438	893	893	748	145	1392	1267
Fairfield Hills Hospital	22453	16682	966	966	803	157	1504	1370
Norwich Hospital	21000	15603	903	903	756	147	1407	1281
Total	64229	47723	2762	2762	2312	449	4303	3918

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

TABLE III B. 4e

HOSPITAL OPERATING COSTS BY SOURCE
ASSUMING CONTINUED OPERATION OF ALL THREE HOSPITALS
PROJECTED 1985-86
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	20977	15586	902	902	755	147	1405	1280
Fairfield Hills Hospital	22584	16780	971	971	813	158	1513	1378
Norwich Hospital	21168	15729	910	910	762	148	1418	1291
Total	64729	48095	2783	2783	2330	453	4336	3949

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

4. Hospital Renovation Costs

The existing bed capacity at each of the hospitals is sufficient to accommodate the projected patient demand. Accordingly, no significant renovation costs are projected under the "Non-closure" strategy.

C. Implementation Timetable: "Inter-Hospital" and "Hospital/Community" Strategies for Closing the Norwich Hospital

This section marks the beginning of the analysis of the two "closure" strategies. Most of the implementation tasks presented in this subsection pertain to both the "Inter-Hospital" strategy and the "Hospital/Community" strategy. In those cases where a task is applicable to one or the other, the relevant strategy is shown in parentheses. Sub-sections D through I project the impacts of implementing each of these "closure" strategies. As indicated previously, the actual impacts are likely to fall somewhere in between those projected under these two strategies.

1. Overview

The Implementation Timetable presents the major milestones to be reached in effecting the "Inter-Hospital" or "Hospital/Community" strategies described in Sub-sections III D though I. The timetable spans a five-year transition period from July 1981 through June 1986. The milestones are listed below in chronological order within each of six areas of activity:

Project Management--involves the planning, budgeting, monitoring and coordination of the wide ranging tasks attending the hospital's closure.

Client Management--involves the individual case management activities of evaluation, planning (treatment, relocation, pre-discharge) monitoring, and coordination.

Community Program Development--involves the planning, budgeting, design, and implementation of programs (treatment, care rehabilitation) in community settings to serve patient needs.

Hospital Program Development--involves the planning, budgeting, design, and implementation of programs (treatment, care rehabilitation) at the hospitals to serve the needs of the transferring patients.

Personnel Management--entails personnel planning, counseling training, placement, and transfer support activities consistent with patient, staff and program requirements.

Hospital Facility and Equipment Planning--entails facility planning, financing, design, and construction activities at the Connecticut Valley and Fairfield Hills Hospitals responsive to life safety code and programmatic requirements. It further entails the orderly disposition of land, facilities, and equipment at the Norwich Hospital.

Table III C. 1 outlines these milestones in table form.

List of Milestones

Project Management

9/81	Organize and staff a Project Office to plan and coordinate the activities connected with the hospitals' closing
10/81	Organize and regularly convene a steering committee to oversee the project, comprised of key decision-makers and actors concerned
11/81	Complete Project Management Plan for 1981-82
12/81	Complete a Public Relations Plan
12/81	Complete Strategic Plan for the relocation of the Ribicoff Research Center
12/81	Complete Strategic Plan for the alternate provision of Regional Laundry Services
1/82	Complete study of the economic impact of the Norwich Hospital's closure, and of the alternative uses to which the Facility might be put
7/82	Complete Five-Year Implementation Plan and Budget with Annual Updates
8/82	Design and Implement a formalized monitoring and evaluation procedure
7/82 thru 6/86	Carry out the Implementation Plan and update quarterly

Client Management

3/82	Complete systematic patient care/support service needs assessment
12/82	Design and agree-upon ad hoc patient preparation, assessment, movement, and follow-up procedures to be employed
6/82	Complete Individual Patient Placement Plans ("Hospital/Community" Strategy)
6/83	Complete Individual Patient Transfer Plans (Fairfield Hills Hospital)

6/84 Complete Individual Patient Transfer Plans (Connecticut Valley Hospital)

1983-84 thru 1984-85 Implement the Aggregate Patient Placement Plans ("Hospital/Community" Strategy)

1983-84 thru 1984-85 Implement the Aggregate Patient Transfer Plans

Community Program Development ("Hospital/Community" Strategy)

4/82 Complete an "accessibility" survey of community care and support service providers

6/82 Complete community program development/utilization plan and associated budget/grant requests (part of Implementation Plan and Budget)

8/82 Implement the approved Community Program Development and Utilization Plan

Hospital Program Development

8/82 Complete hospital "Patient Care" and "Education and Training" program plans and budget requests to accommodate Norwich patient transfers at the Fairfield Hills Hospital and at the Connecticut Valley Hospital

7/83 thru 6/84 Implement the hospital program plans approved at the Fairfield Hills Hospital

7/84 thru 6/86 Implement the hospital program plans approved at the Connecticut Valley Hospital

Personnel Management

10/81 Organize and regularly convene a committee, of decision-makers and actors concerned, to oversee the personnel activities

2/82 Complete profiles and survey of career preferences of staff at the Norwich Hospital

6/82	Complete an inventory of state and other jobs available for employees guided by employee preferences, qualifications, and projected surpluses
6/82	Complete projected staffing needs survey (manning tables) at the Connecticut Valley and Fairfield Hills Hospitals
3/83	Prepare overall and individual employee transfer, placement and training plans and procedures
6/83	Establish a pool of temporary staff to fill in where needed at Norwich during the transition period
7/83 thru 6/86	Implement the plans and procedures

Hospital Facility and Equipment Planning

10/81	Prepare plan and budget request to secure A&E fees for renovation work
2/82	Inventory salvageable furnishings and equipment at Norwich and prepare a plan for redistributing these to the Fairfield Hills and Connecticut Valley Hospitals
4/82	Decide on the buildings to be renovated at the Connecticut Valley Hospital consistent with the patient needs assessment
6/82	Prepare Renovation Design Specifications and Award Architectual and Engineering (A&E) Contract
10/82	Prepare the Facilities Plan and Budget Request
12/82	Approve A&E Designs
4/83	Award the Construction Contract
4/84	Complete Construction and Final Inspections
1984-85 thru 1985-86	Complete Demolition/Salvage Operations
1983-84 thru 1984-85	Furnish and Equip the renovated buildings

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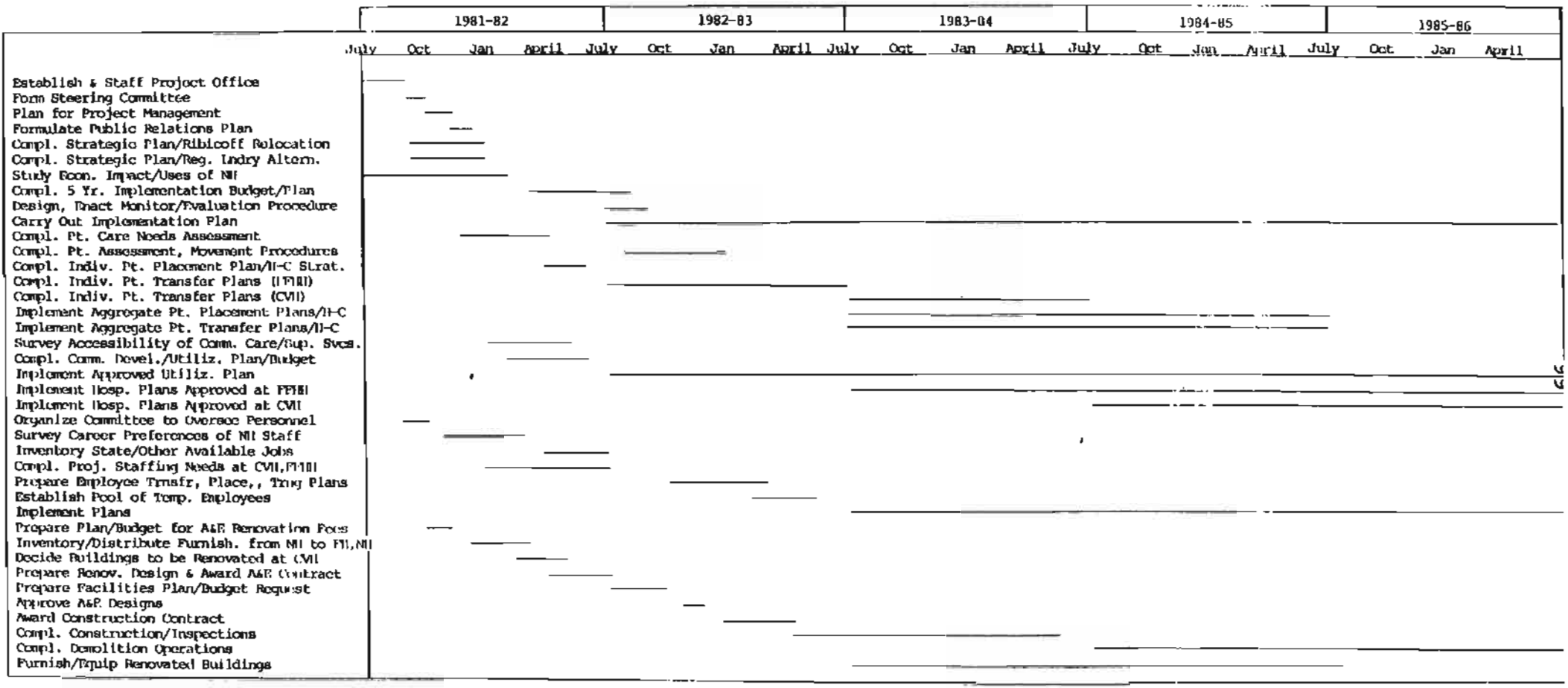
TABLE III C. 1

IMPLEMENTATION TIMETABLE:
"INTER-HOSPITAL" AND "HOSPITAL/COMMUNITY" STRATEGIES
FOR CLOSING NORWICH HOSPITAL, PROJECTED 1981-82 THROUGH 1985-86



D. Patient Dispositions

As explained in Section III A, there are two hospital closure strategies. (1) The "inter-hospital strategy" calling for the future transfer or diversion of all patients from the Norwich Hospital to the Connecticut Valley and Fairfield Hills Hospitals, and (2) the "hospital community strategy" calling for the accelerated placement or diversion of patients from the Norwich Hospital to community settings as well as for the transfer of Norwich patients to the Connecticut Valley and Fairfield Hills Hospitals. This section projects the movement of patients under each of these "closure" strategies.

1. Inter-hospital Strategy

Under this strategy, 230 longer term Norwich patients would be transferred or diverted to Fairfield Hills occupying the bed capacity available. The bulk of these transfers would occur in 1983-84. The balance of the patients, 156 shorter term and 243 longer term, would be transferred or diverted from Norwich to the Connecticut Valley Hospital in 1984-85.

2. Hospital/Community Strategy

This series of patient projections is intended to depict the situation if the development of Community Care and Support Service arrangements were to be accelerated:

- to permit the outplacement of longer term patients capable of residing in the Community from all three hospitals, given an adequate care and support service network; and

- to permit the diversion of those shorter term patients living within 30 miles of the Norwich Hospital and not within 30 miles of the Connecticut Valley Hospital who might otherwise require admission or readmission to the Norwich Hospital. The balance of the Norwich patients would be transferred to the Connecticut Valley and Fairfield Hills Hospitals.

In projecting the number of longer term patients who could return to the community given adequate community supports, we relied primarily on the judgments of treatment staff as to the

appropriate care alternative for each patient. These judgments were documented in a "patient assessment" form of HSRI's design. A copy of this form is shown in Appendix B. The hospital staff's assessments of the patients problems were verified through random checks against the MSIS patient records.

It could be that the hospital staff underestimated the number of patients able to return to the community, as their judgments were reportedly tempered by the current, limited availability of community alternatives. Their estimates might also have been colored to some extent by the staff's strong belief in the value of their own programs, opportunity to view the client only in an institutional setting, and uncertainty concerning the quality of other community programs. However, it has been HSRI's experience that such bias is minimal, and that it is outweighed by the staff's intimate knowledge of the patients.

Under this strategy a total of 535 longer term patients would be placed in the community:

- 198 would be placed in community settings from the Connecticut Valley Hospital,
- 155 would be placed in community settings from the Fairfield Hills Hospital, and
- 182 placed in community settings from the Norwich Hospital.

The balance would be transferred to the Connecticut Valley and Fairfield Hills Hospitals.

In addition, 66 full-time equivalent shorter term Norwich patients or about 35% of Norwich's projected shorter-term population would be referred to alternate short-term treatment alternatives in the community. The balance would be transferred to Connecticut Valley--most because their disruptive and destructive behaviors require more supervision then could be obtained in the community settings, and some because they live in towns within a 30-mile radius of the Connecticut Valley Hospital. Note: This is not to say that general hospitals and other short-term treatment providers could not adequately care

for "problem" patients given additional staff, facility safeguards, and the willingness to do so. In fact, a number of general hospital psychiatrists speaking at the regional meetings made clear their feelings that the general hospitals not only could but should do more to accommodate such patients. However, for the reasons presented in Section III A, we were hesitant to make such a difficult change even more difficult by introducing it in connection with the closing of a mental hospital.

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TABLE III D. 1c

PATIENT DISPOSITION BY PROGRAM:
INTER-HOSPITAL STRATEGY
PROJECTED 1983-84

Patient Population	Average Daily Census: As of 7/1			Community Placement		Net of Community Placement		Transferred In(Out)		Net of Transfer and Community Placement		
	Shorter Term	Longer Term	Total	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Total
Connecticut Valley Hospital: Total	144	499	643							144	499	643
Alcohol Dependent	17	9	26							17	9	26
Drug Dependent	0	2	2							0	2	2
Mentally Retarded	1	39	40							1	39	40
Mentally Ill	79	350	429							79	350	429
Geriatric	47	99	146							47	99	146
Fairfield Hills Hospital: Total	194	465	659					(0)	(230)	194	695	889
Alcohol Dependent	5	8	13					(0)	(7)	5	15	20
Drug Dependent	6	7	13							6	7	13
Mentally Retarded	5	67	72					(0)	(43)	5	110	115
Mentally Ill	136	295	431					(0)	(180)	136	475	611
Geriatric	42	88	130							42	88	130
Norwich Hospital: Total	156	473	629					(0)	(230)	156	243	399
Alcohol Dependent	26	7	33					(0)	(7)	26	0	26
Drug Dependent												
Mentally Retarded	3	43	46					(0)	(43)	3	0	3
Mentally Ill	63	288	351					(0)	(180)	63	108	171
Geriatric	64	135	199					(0)	(0)	64	135	199

TABLE III D. 1d

PATIENT DISPOSITION BY PROGRAM:
INTER-HOSPITAL STRATEGY
PROJECTED 1984-85

Patient Population	Average Daily Census: As of 7/1			Community Placement		Net of Community Placement		Transferred In(Out)		Net of Transfer and Community Placement		
	Shorter Term	Longer Term	Total	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Total
Connecticut Valley Hospital: Total	146	505	651					(156)	(243)	302	748	1050
Alcohol Dependent	18	9	27					(26)	(0)	44	9	53
Drug Dependent	0	2	2							0	2	2
Mentally Retarded	1	39	40					(3)	(0)	4	39	43
Mentally Ill	80	355	435					(63)	(108)	143	463	606
Geriatric	47	100	147					(64)	(135)	111	235	346
Fairfield Hills Hospital: Total	195	698	893							195	698	893
Alcohol Dependent	5	15	20							5	15	20
Drug Dependent	6	7	13							6	7	13
Mentally Retarded	5	110	115							5	110	115
Mentally Ill	137	477	614							137	477	614
Geriatric	42	89	131							42	89	131
Norwich Hospital: Total	156	243	399					(156)	(243)	0	0	0
Alcohol Dependent	26	0	26					(26)	(0)	0	0	0
Drug Dependent												
Mentally Retarded	3	0	3					(3)	(0)	0	0	0
Mentally Ill	63	108	171					(63)	(108)	0	0	0
Geriatric	64	135	199					(64)	(135)	0	0	0

TABLE III D., 1e

PATIENT DISPOSITION BY PROGRAM:
INTER-HOSPITAL STRATEGY
PROJECTED 1985-86

Patient Population	Average Daily Census: As of 7/1			Community Placement		Net of Community Placement		Transferred In(Out)		Net of Transfer and Community Placement		
	Shorter Term	Longer Term	Total	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Total
Connecticut Valley Hospital: Total	304	752	1056					(5)	(12)	309	764	1073
Alcohol Dependent	44	9	53					(1)	(0)	45	9	54
Drug Dependent	0	2	2					(0)	(0)	0	2	2
Mentally Retarded	4	39	43					(0)	(2)	4	41	45
Mentally Ill	144	466	610					(3)	(7)	147	473	620
Geriatric	112	236	348					(1)	(3)	113	239	352
Fairfield Hills Hospital: Total	197	702	899							197	702	899
Alcohol Dependent	5	16	21							5	16	21
Drug Dependent	6	7	13							6	7	13
Mentally Retarded	5	110	115							5	110	115
Mentally Ill	139	479	618							139	479	618
Geriatric	42	90	132							42	90	132
Norwich Hospital: Total												
Alcohol Dependent												
Drug Dependent												
Mentally Retarded												
Mentally Ill												
Geriatric												

TABLE III D. 2c

PATIENT DISPOSITION BY PROGRAM:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1983-84

Patient Population	Average Daily Census:											
	As of 7/1			Community Placement		Net of Community Placement		Transferred In(Out)		Net of Transfer and Community Placement		
	Shorter Term	Longer Term	Total	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Total
Connecticut Valley Hospital: Total	144	499	643	0	194	144	305	0	0	144	305	449
Alcohol Dependent	17	9	26	0	3	17	6	0	0	17	6	23
Drug Dependent	0	2	2	0	2	0	0	0	0	0	0	0
Mentally Retarded	1	39	40	0	9	1	30	0	0	1	30	31
Mentally Ill	79	350	429	0	152	79	198	0	0	79	198	277
Geriatric	47	99	146	0	28	47	71	0	0	47	71	118
Fairfield Hills Hospital: Total	194	465	659	0	150	194	315	0	216	194	532	726
Alcohol Dependent	5	8	13	0	4	5	4	0	4	5	8	13
Drug Dependent	6	7	13	0	4	6	3	0	0	6	3	9
Mentally Retarded	5	67	72	0	5	5	62	0	33	5	95	100
Mentally Ill	136	295	431	0	118	136	177	0	171	136	348	484
Geriatric	42	88	130	0	19	42	69	0	8	42	78	120
Norwich Hospital: Total	156	473	629	0	177	156	296	0	216	156	80	236
Alcohol Dependent	26	7	33	0	3	26	4	(0)	(4)	26	0	26
Drug Dependent												
Mentally Retarded	3	43	46	0	10	3	33	(0)	(33)	3	0	3
Mentally Ill	63	288	351	0	117	63	171	(0)	(171)	63	0	63
Geriatric	64	135	199	0	47	64	88	(0)	(8)	64	80	144

TABLE III D. 2d

PATIENT DISPOSITION BY PROGRAM:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1984-85

Patient Population	Average Daily Census: As of 7/1			Community Placement		Net of Community Placement		Transferred In(Out)		Net of Transfer and Community Placement		
	Shorter Term	Longer Term	Total	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Total
Connecticut Valley Hospital: Total	146	311	457	0	2	146	309	95	74	241	383	624
Alcohol Dependent	18	6	24	0	0	18	6	16	0	34	6	40
Drug Dependent												
Mentally Retarded	1	30	31	0	0	1	30	2	0	3	30	33
Mentally Ill	80	203	283	0	2	80	201	39	0	119	201	320
Geriatric	47	72	119	0	0	47	72	38	74	85	146	231
Fairfield Hills Hospital: Total	195	535	730	0	2	195	537	0	13	195	350	745
Alcohol Dependent	5	8	13	0	0	5	8	0	0	5	8	13
Drug Dependent	6	3	9	0	0	6	3	0	0	6	3	9
Mentally Retarded	5	95	100	0	0	5	95	0	1	5	96	101
Mentally Ill	137	350	487	0	1	137	351	0	4	137	355	492
Geriatric	42	79	121	0	1	42	80	0	8	42	88	130
Norwich Hospital: Total	158	87	245	63	0	95	74	(96)	(74)	0	0	0
Alcohol Dependent	26	0	26	10	0	16	0	(17)	(0)	0	0	0
Drug Dependent												
Mentally Retarded	3	1	4	1	0	2	0	(2)	(0)	0	0	0
Mentally Ill	65	4	69	26	0	39	0	(39)	(0)	0	0	0
Geriatric	64	82	146	26	0	38	74	(38)	(74)	0	0	0

TABLE III D. 2e

PATIENT DISPOSITION BY PROGRAM:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1985-86

Patient Population	Average Daily Census:											
	As of 7/1			Community Placement		Net of Community Placement		Transferred In(Out)		Net of Transfer and Community Placement		
	Shorter Term	Longer Term	Total	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Shorter Term	Longer Term	Total
Connecticut Valley Hospital: Total	243	387	630	0	2	243	389	2	5	245	394	639
Alcohol Dependent	34	6	40	0	0	34	6	0	0	34	6	40
Drug Dependent												
Mentally Retarded	3	30	33	0	0	3	30	0	1	3	31	34
Mentally Ill	120	204	324	0	2	120	206	1	3	121	209	330
Geriatric	86	147	233	0	0	86	147	1	1	87	148	235
Fairfield Hills Hospital: Total	197	554	751	0	3	197	557	1	0	198	557	755
Alcohol Dependent	5	9	14	0	1	5	10	0	0	5	10	15
Drug Dependent	6	3	9	0	0	6	3	1	0	7	3	10
Mentally Retarded	5	96	101	0	0	5	96	0	0	5	96	101
Mentally Ill	139	357	496	0	1	139	358	0	0	139	358	497
Geriatric	42	89	131	0	1	42	90	0	0	42	90	132
Norwich Hospital: Total	3	5	8	3	5	0	0			0	0	0
Alcohol Dependent	1	0	1	1	0	0	0			0	0	0
Drug Dependent												
Mentally Retarded	0	1	1	0	1	0	0			0	0	0
Mentally Ill	1	3	4	1	3	0	0			0	0	0
Geriatric	1	1	2	1	1	0	0			0	0	0

E. Staff Dispositions

The methods and assumptions used in projecting the numbers of staff required in years 1983-84 and 1984-85 are the same as these described in Subsection B. 2. In 1985-86, the following provisions apply at the Norwich Hospital under these two "closure strategies:

- an "administrative services" staff complement of 18 will be required for the first six-months to close-out the books, prepare the patient records for transfer, handle remaining personnel matters, etc.
- a "general services" staff complement of 46 will be required to maintain the grounds and facilities, power, water and sewage treatment plants; provide security and fire protection, salvage furnishings and equipment, and perform other support activities. These staff would remain on board until a decision is reached to abandon the facility or until an alternative use is found.

Tables III E. 1c-e show the projected number of staff required from 1983-84 through 1985-86, existing staff as of July, 1980, and the net staff surplus or deficit by functional area and patient care program at each of the hospitals under the Inter-hospital strategy. Tables III E. 2c-e provide like information under the "Hospital/Community" strategy.

The number of surplus staff are the greatest under the "Hospital/Community Strategy." In fact, staff are surplus at the Connecticut Valley and Fairfield Hills Hospitals as well as at the Norwich Hospital. Under the "Inter-Hospital" strategy with the exception of some "rehabilitation workers", staff surpluses appear at Norwich only.

Tables III E. 3c-e show the number of surplus staff projected at the Norwich Hospital from 1983-84 through 1985-86 under the "Inter-Hospital" strategy. They further show the number of Norwich Hospital staff projected to voluntarily or involuntarily resign (furlough), retire, or accept transfer to the Connecticut Valley Hospital, Fairfield Hills Hospital, or other state employ-ment. Tables III E. 4c-e present like projections under the Hospital/Community Strategy.

The numbert of hospital employees projected to resign, transfer, or retire is based on similar hospital closing experiences in Ohio, California, and Pennsylvania.* It is assumed that of:

- Those staff who have less than ten years tenure,

  -50% will accept transfer
  -35% will voluntarily resign
  -15% will accept furlough

- Those staff who have 11-20 years tenure,

  -65% will accept transfer
  -10% will voluntarily resign
  -20% will accept furlough
  - 5% will retire

- Those staff who have more than 20 years tenure,

  -60% will accept transfer
  - 5% will accept furlough
  -35% will retire

Of those willing to transfer it is assumed that they would first accept available positions at the Connecticut Hospital. It is assumed that one half of the remaining employees would transfer to available positions at the Fairfield Hills Hospital and that the balance would transfer to other state positions available.

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*John Ashbaugh et. al., An Evaluation of the Mental Health Pilot Project in the Northeast Region of Pennsylvania January 31, 1978; Douglas Schultz, et al., The Effects of the Closing of Cleveland State Hospital on its Patients and Staff, November 1975; Samuel Weiner, et. al., Process and Impacts of the Closing of DeWitt State Hospital, May 1973.

TABLE III E. 1c

STAFF REQUIREMENTS, SURPLUSES & DEFICITS BY PROGRAM & FUNCTION:
UNDER THE INTER-HOSPITAL STRATEGY
PROJECTED 1983-84

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	52	-	56	64	8	55	49	(6)
Food Services	79	80	1	69	111	42	71	50	(21)
General Services	179	178	(1)	181	200	19	141	123	(18)
Patient Care	663	694	31	745	974	229	711	465	(246)
. Medical/Psychiatric Services	23	30	7	35	46	11	32	22	(10)
- Alcohol/Drug	8	8	-	6	7	1	3	3	-
- MI/MR	11	16	5	23	33	10	22	11	(11)
- Geriatric	4	6	2	6	6	-	7	8	1
. Nursing Services	489	509	20	515	658	143	528	329	(199)
- Alcohol/Drug	93	81	(12)	77	81	4	53	41	(12)
- MI/MR	313	336	23	345	480	135	327	140	(187)
- Geriatric	83	92	9	93	97	4	148	148	-
. Psychology Services	19	20	1	21	39	18	12	14	2
- Alcohol/Drug	3	3	-	7	10	3	2	2	-
- MI/MR	15	16	1	12	26	14	8	7	(1)
- Geriatric	1	1	-	2	3	1	2	5	3
. Social Services	33	52	19	28	65	37	26	32	6
- Alcohol/Drug	11	15	4	5	10	5	4	7	3
- MI/MR	16	28	12	17	44	27	18	16	(2)
- Geriatric	6	9	3	6	11	5	4	9	5
. Rehabilitation Services	45	35	(10)	43	30	(13)	39	23	(16)
- Alcohol/Drug	5	3	(2)	6	2	(14)	2	2	-
- MI/MR	34	27	(7)	31	25	(6)	31	14	(17)
- Geriatric	6	5	(1)	6	3	(3)	6	7	1
. Personal Care Services	7	6	(1)	10	18	8	8	5	(3)
. Miscellaneous Services	47	42	(5)	93	118	25	66	40	(26)
Training & Education	29	29	-	25	28	3	36	24	(12)

TABLE III E. 1d

STAFF REQUIREMENTS, SURPLUSES & DEFICITS BY PROGRAM & FUNCTION:
UNDER THE INTER-HOSPITAL STRATEGY
PROJECTED 1984-85

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	63	11	56	64	8	55	-	(55)
Food Services	79	131	52	69	112	43	71	-	(71)
General Services	179	210	31	181	200	19	141	-	(141)
Patient Care	663	1149	486	745	972	227	711	-	(711)
. Medical/Psychiatric Services	23	51	28	35	46	11	32	-	(32)
- Alcohol/Drug	8	15	7	6	7	1	3	-	
- MI/MR	11	22	11	23	33	10	22	-	
- Geriatric	4	14	10	6	6	-	7	-	
. Nursing Services	489	841	352	515	661	146	528	-	(528)
- Alcohol/Drug	93	158	65	77	81	4	53	-	
- MI/MR	313	465	152	345	482	137	327	-	
- Geriatric	83	218	135	93	98	5	148	-	
. Psychology Services	19	30	11	21	39	18	12	-	(12)
- Alcohol/Drug	3	6	3	7	10	3	2	-	
- MI/MR	15	22	7	12	26	14	8	-	
- Geriatric	1	2	1	2	3	1	2	-	
. Social Services	33	90	57	28	65	37	26	-	(26)
- Alcohol/Drug	11	30	19	5	10	5	4	-	
- MI/MR	16	39	23	17	44	27	18	-	
- Geriatric	6	21	15	6	11	5	4	-	
. Rehabilitation Services	45	55	10	43	30	(13)	39	-	(39)
- Alcohol/Drug	5	6	1	6	2	(4)	2	-	
- MI/MR	34	37	3	31	25	(6)	31	-	
- Geriatric	6	12	6	6	3	(3)	6	-	
. Personal Care Services	7	10	3	10	13	3	8	-	(8)
. Miscellaneous Services	47	72	25	93	118	25	66	-	(66)
Training & Education	29	41	12	25	28	3	36	-	(36)

TABLE III E. 1e

STAFF REQUIREMENTS, SURPLUSES & DEFICITS BY PROGRAM & FUNCTION
UNDER THE INTER-HOSPITAL STRATEGY
PROJECTED 1985-86

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	63	11	56	65	9	55	18	(37)
Food Services	79	134	55	69	112	43	71	—	(71)
General Services	179	212	33	181	200	19	141	46	(95)
Patient Care	663	1171	508	745	980	235	711	—	(711)
. Medical/Psychiatric Services	23	51	28	35	46	11	32	—	(32)
- Alcohol/Drug	8	15	7	6	7	1	3	—	—
- MI/MR	11	22	11	23	33	10	22	—	—
- Geriatric	4	14	10	6	6	-	7	—	—
. Nursing Services	489	858	369	515	667	152	528	—	-528
- Alcohol/Drug	93	160	67	77	83	6	53	—	—
- MI/MR	313	476	163	345	485	140	327	—	—
- Geriatric	83	222	139	93	99	6	148	—	—
. Psychology Services	19	30	11	21	39	18	12	—	-12
- Alcohol/Drug	3	6	3	7	10	3	2	—	—
- MI/MR	15	22	7	12	26	14	8	—	—
- Geriatric	1	2	1	2	3	1	2	—	—
. Social Services	33	92	59	28	65	37	26	—	-26
- Alcohol/Drug	11	31	20	5	10	5	4	—	—
- MI/MR	16	40	24	17	44	27	18	—	—
- Geriatric	6	21	15	6	11	5	4	—	—
. Rehabilitation Services	45	56	11	43	30	-13	39	—	-39
- Alcohol/Drug	5	6	1	6	2	-4	2	—	—
- MI/MR	34	38	4	31	25	-6	31	—	—
- Geriatric	6	12	6	6	3	-3	6	—	—
. Personal Care Services	7	10	3	10	13	3	8	—	-8
. Miscellaneous Services	47	74	27	93	120	27	66	—	-66
Training & Education	29	42	13	25	28	3	36	—	-36

TABLE III E. 2c

STAFF REQUIREMENTS, SURPLUSES & DEFICITS BY HOSPITAL, PROGRAM & FUNCTION
UNDER THE HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1983-84

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	47	(5)	56	59	3	55	44	(11)
Food Services	79	56	(23)	69	91	22	71	30	(41)
General Services	179	164	(15)	181	182	1	141	110	(31)
Patient Care	663	489	(174)	745	697	(48)	711	294	(417)
. Medical/Psychiatric Services	23	22	(1)	35	36	1	32	13	(19)
- Alcohol/Drug	8	6	(2)	6	4	(2)	3	3	-
- MI/MR	11	11	-	23	26	3	22	4	(18)
- Geriatric	4	5	1	6	6	-	7	6	(1)
. Nursing Services	489	360	(129)	515	428	(87)	528	202	(326)
- Alcohol/Drug	93	65	(28)	77	54	(23)	53	41	(12)
- MI/MR	313	220	(93)	345	279	(66)	327	54	(273)
- Geriatric	83	75	(8)	93	95	2	148	107	(41)
. Psychology Services	19	15	(4)	21	31	10	12	9	(3)
- Alcohol/Drug	3	3	-	7	7	-	2	2	-
- MI/MR	15	11	(4)	12	21	9	8	3	(5)
- Geriatric	1	1	-	2	3	1	2	4	2
. Social Services	33	38	5	28	54	26	26	20	(6)
- Alcohol/Drug	11	12	1	5	7	2	4	7	3
- MI/MR	16	19	3	17	36	19	18	6	(12)
- Geriatric	6	7	1	6	11	5	4	7	3
. Rehabilitation Services	45	25	(20)	43	24	(19)	39	16	(23)
- Alcohol/Drug	5	3	(2)	6	2	(4)	2	2	-
- MI/MR	34	18	(16)	31	19	(12)	31	9	(22)
- Geriatric	6	4	(2)	6	3	(3)	6	5	(1)
. Personal Care Services	7	4	(3)	10	12	2	8	4	(4)
. Miscellaneous Services	47	25	(22)	93	112	19	66	30	(36)
Training & Education	29	23	(6)	25	25	-	36	19	(17)

TABLE III E. 2d

STAFF REQUIREMENTS, SURPLUSES & DEFICITS BY HOSPITAL, PROGRAM & FUNCTION
UNDER THE HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1984-85

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	53	1	56	59	3	55	–	(55)
Food Services	79	78	(1)	69	93	24	71		(71)
General Services	179	177	(2)	181	183	2	141		(141)
Patient Care	663	695	32	745	714	(31)	711		(711)
. Medical/Psychiatric Services	23	32	9	35	37	2	32	0	(32)
- Alcohol/Drug	8	10	2	6	4	(2)	3	0	
- MI/MR	11	12	1	23	26	3	22	0	
- Geriatric	4	10	6	6	7	1	7	0	
. Nursing Services	489	512	23	515	440	(75)	528	0	(528)
- Alcohol/Drug	93	113	20	77	54	(23)	53	0	
- MI/MR	313	252	(61)	345	283	(62)	327	0	
- Geriatric	83	147	64	93	103	10	148	0	
. Psychology Services	19	20	1	21	31	10	12	0	(12)
- Alcohol/Drug	3	5	2	7	7	–	2	0	
- MI/MR	15	13	(2)	12	21	9	8	0	
- Geriatric	1	2	1	2	3	1	2	0	
. Social Services	33	57	24	28	56	28	26	0	(26)
- Alcohol/Drug	11	21	10	5	7	2	4	0	
- MI/MR	16	22	6	17	37	20	18	0	
- Geriatric	6	14	8	6	12	6	4	0	
. Rehabilitation Services	45	33	(12)	43	24	(19)	39	0	(39)
- Alcohol/Drug	5	5	–	6	2	(4)	2	0	
- MI/MR	34	20	(14)	31	19	(12)	31	0	
- Geriatric	6	8	2	6	3	(3)	6	0	
. Personal Care Services	7	6	(1)	10	12	2	8	0	(8)
. Miscellaneous Services	47	35	(12)	93	114	21	66		(66)
Training & Education	29	29	–	25	125	100	36		(36)

TABLE III E. 2a

STAFF REQUIREMENTS, SURPLUSES & DEFICITS BY HOSPITAL, PROGRAM & FUNCTION
UNDER THE HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1985-86

Function/Position \ Hospital	Connecticut Valley Hospital			Fairfield Hills Hospital			Norwich Hospital		
	Existing	Required	Net	Existing	Required	Net	Existing	Required	Net
Administration	52	53	1	56	59	3	55	18	(37)
Food Services	79	80	1	69	94	25	71		
General Services	179	178	(1)	181	184	3	141	46	(95)
Patient Care	663	710	47	745	728	(17)	711		(711)
. Medical/Psychiatric Services	23	32	9	35	37	2	32		(32)
- Alcohol/Drug	8	10	2	6	4	(2)	3	-	(3)
- MI/MR	11	12	1	23	26	3	22	-	(22)
- Geriatric	4	10	6	6	7	1	7	-	(7)
. Nursing Services	489	523	34	515	447	(68)	528		(528)
- Alcohol/Drug	93	113	20	77	58	(19)	53	-	(53)
- MI/MR	313	260	(53)	345	286	(59)	327	-	(327)
- Geriatric	83	150	67	93	103	10	148	-	(148)
. Psychology Services	19	21	2	21	32	11	12	-	(12)
- Alcohol/Drug	3	5	2	7	8	1	2	-	(2)
- MI/MR	15	13	(2)	12	21	9	8	-	(8)
- Geriatric	1	3	2	2	3	1	2	-	(2)
. Social Services	33	58	25	28	57	29	26	-	(26)
- Alcohol/Drug	11	21	10	5	8	3	4	-	(4)
- MI/MR	16	23	7	17	37	20	18	-	(18)
- Geriatric	6	14	8	6	12	6	4	-	(4)
. Rehabilitation Services	45	34	(11)	43	24	(19)	39	-	(39)
- Alcohol/Drug	5	5	-	6	2	(4)	2	-	(2)
- MI/MR	34	21	(13)	31	19	(12)	31	-	(31)
- Geriatric	6	8	2	6	3	(3)	6	-	(6)
. Personal Care Services	7	6	(1)	10	13	3	8	-	(8)
. Miscellaneous Services	47	36	(11)	93	118	25	66	-	(66)
Training & Education	29	29	-	25	25	-	36	-	(36)

TABLE III E. 3c

DISPOSITION OF SURPLUS STAFF AT NORWICH HOSPITAL
BY FUNCTION UNDER THE INTER-HOSPITAL STRATEGY
PROJECTED 1983-84

Positions	Number Transferring							Number Resigning	Number Furloughing	Number Retiring
	Number of Surplus Staff	Total Transferred	To CVH	Positions Available CVH	To FHH	Positions Available FHH	Other State Empl.			
Administration	6	-	-	8.	1.6	1.7	3.3	1.4	1.	.3
Food Services	21	1.	1.	42.	5.3	5.3	11.6	5.	3.2	1.2
General Services	18	1.	-	19.	5.	5.	10.	4.3	2.7	.2
Patient Care	246	31.	31.	229.	52.5	52.5	13.6	59.	37.2	13.8
. Medical and Psychiatric Services	10	7.	5.5	11.	-	-	5.5	2.4	1.5	.6
. Nursing Services	199	20.	20.	143.	45.	45.	110.	47.8	30.1	11.1
. Psychological Services		4.		18.						
. Social Services		19.		37.						
. Rehabilitative Services	16	10.	-	13.	-	8.9		3.8	2.4	.9
. Personal Care Services	3	1.	-	8.	.8	.8	1.6	.7	.5	.2
. Miscellaneous Services	26	5.	-	25.	7.2	7.2	14.4	6.2	3.9	1.5
Education and Training	12	-	-	3.	3.	3.6	6.6	2.9	1.8	.7

TABLE III E. 3d

DISPOSITION OF SURPLUS STAFF AT NORWICH HOSPITAL
BY FUNCTION UNDER THE INTER-HOSPITAL STRATEGY
PROJECTED 1984-85

Positions	Number Transferring							Number Resigning	Number Furloughing	Number Retiring
	Number of Surplus Staff *	Total Transferred	To CVH	Positions Available CVH	To FHH	Positions Available FHH	Other State Empl.			
Administration	49	27.1	11.	11.	6.4	6.4	9.7	11.8	7.4	2.7
Food Services	50	27.7	27.7	59.	-	37.7	-	12.	7.5	2.8
General Services	123	68.	31.	31.	14.	14.	23.	29.5	18.6	6.9
Patient Care	465	257.2	257.2	455.	-	174.5	-	111.6	70.2	26.
. Medical and Psychiatric Services	22	12.2	12.2	22.5	-	11.	-	5.3	3.3	1.2
. Nursing Services	329	181.9	181.9	332.	-	101.	-	79.	49.7	18.4
. Psychological Services	12	6.6	6.6	11.	-	18.	-	2.9	1.8	.7
. Social Services	26	14.4	14.4	57.	-	37.	-	6.2	3.9	1.5
. Rehabilitative Services	23	12.7	10.	10.	-	13.	2.7	5.5	3.5	1.3
. Personal Care Services	5	2.8	2.8	3.	-	2.2	-	1.2	.7	.3
. Miscellaneous Services	66	36.5	2.5	25.	5.7	17.8	5.8	15.8	10.	3.7
Education and Training	10	5.5	5.5	12.	-	-	-	2.4	1.5	.6

TABLE III E. 3e

DISPOSITION OF SURPLUS STAFF AT NORWICH HOSPITAL
BY FUNCTION UNDER THE INTER-HOSPITAL STRATEGY
PROJECTED 1985-86

Positions	Number Transferring							Number Resigning	Number Furloughing	Number Retiring
	Number of Surplus Staff	Total Transferred	To CVH	Positions Available CVH	To FHH	Positions Available FHH	Other State Empl.			
Administration	32							7.7	4.8	1.8
Food Services										
General Services	33							7.9	5.	1.9
Patient Care										
. Medical and Psychiatric Services										
. Nursing Services										
. Psychological Services										
. Social Services										
. Rehabilitative Services										
. Personal Care Services										
. Miscellaneous Services										
Education and Training										

TABLE III E. 4c

DISPOSITION OF SURPLUS STAFF AT NORWICH HOSPITAL
BY FUNCTION UNDER THE HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1983-84

Positions	Number Transferring							Number Resigning	Number Furloughing	Number Retiring
	Number of Surplus Staff	Total Transferred	To CVH	Positions Available CVH	To FHH	Positions Available FHH	Other State Empl.			
Administration	11	6.1	-	-	3.	3.	3.1	2.6	1.7	.6
Food Services	41	22.7	-	-	11.4	22.	11.3	9.8	6.2	2.3
General Services	31	17.1	-	-	1.	1.	16.1	7.4	4.7	1.8
Patient Care	417	230.6	-	-	-	48.	230.6	100.	63.	23.4
. Medical and Psychiatric Services	19	10.5	-	1.	1.	1.	9.5	4.5	2.9	1.1
. Nursing Services	326	180.3	-	-	-	87.	180.3	78.2	49.2	18.3
. Psychological Services	3	1.6	-	-	.8	10.	.8	.7	.5	.2
. Social Services	6	3.3	3.3	5.	-	26.	-	1.4	.9	.3
. Rehabilitative Services	23	12.7	-	-	-	19.	12.7	5.5	3.5	1.3
. Personal Care Services	4	2.2	-	-	1.	2.	1.2	1.	.6	.2
. Miscellaneous Services	36	19.9	*	22.	19.	19.	.9	8.6	5.4	2.
Education and Training	17	9.4	-	-	-	-	9.4	4.1	2.6	.9

* Surplus of 12 by next year could place some temp.

TABLE III E. 4d

DISPOSITION OF SURPLUS STAFF AT NORWICH HOSPITAL
BY FUNCTION UNDER THE HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1984-85

Positions	Number Transferring							Number Resigning	Number Furloughing	Number Retiring
	Number of Surplus Staff	Total Transferred	To CVH	Positions Available CVH	To FHH	Positions Available FHH	Other State Empl.			
Administration	12	6.6	1.	1.	-	-	5.6	2.9	1.8	.7
Food Services	30	16.6	-	-	8.3	12.6	8.3	7.2	4.5	1.7
General Services	77	42.6	-	-	2.	2.	40.6	18.5	11.6	4.3
Patient Care	294	162.5	32.	-	-	31.	130.5	70.6	44.4	16.5
. Medical and Psychiatric Services	13	7.2	7.2	9.	-	1.	-	3.1	2.	.7
. Nursing Services	202	111.7	23.	23.	-	75.	88.7	48.5	30.5	11.3
. Psychological Services	9	5.	1.	1.	2.	9.2	2.	2.1	1.4	.5
. Social Services	20	11.1	11.1	20.7	-	28.	-	4.8	3.	1.1
. Rehabilitative Services	16	8.8	-	-	-	19.	8.8	3.8	2.4	1.
. Personal Care Services	4	2.2	-	-	1.	1.	1.2	1.	.6	.2
. Miscellaneous Services	30	16.6	-	-	2.	2.	14.6	7.2	4.5	1.7
Education and Training	19	10.5	-	-	5.	100.	5.5	4.6	28.	1.1

TABLE III E. 4e

DISPOSITION OF SURPLUS STAFF AT NORWICH HOSPITAL
BY FUNCTION UNDER THE HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1985-86

Positions	Number Transferring							Number Resigning	Number Furloughing	Number Retiring
	Number of Surplus Staff	Total Transferred	To CVH	Positions Available CVH	To FHH	Positions Available FHH	Other State Empl.			
Administration	32							7.7	4.8	1.8
Food Services										
General Services	33							7.9	5.	1.9
Patient Care										
. Medical and Psychiatric Services										
. Nursing Services										
. Psychological Services										
. Social Services										
. Rehabilitative Services										
. Personal Care Services										
. Miscellaneous Services										
Education and Training										

F. Hospital Operating Costs

This section includes the hospital operating costs and related sources of funding projected from 1983-84 through 1985-86 under the "Inter-Hospital" strategy and under the "Hospital/ Community" strategy. The operating costs in 1981-82 and 1982-83 are identical to those projected under the "Non-closure" strategy, (Tables III B. 3 a and b). The methods and assumptions applied in estimating these costs are the same as those applied in estimating the hospital operating costs under the "Non-closure" Strategy, and are described in Subsection III B. 3.

Worth emphasizing here is that the costs are based only on the number of hospital staff required, and do not cover the costs of surplus staff. Thus it is assumed that staff will resign, retire, transfer or accept furlough as they become surplus. This is rarely the case. The reduction in hospital staff size characteristically lags behind--in some cases far behind--the time at which staff become surplus. Simply put, the potential savings in hospital operating costs may not be realized for some time, depending on the rate at which surplus staff relocate.

Tables III F. 1 c-e project the operating costs at each of the hospitals by functional area and by patient care program under the "Inter-Hospital" strategy. Tables III F. 2 c-e project the operating costs at each hospital by functional area and patient care program under the "Inter-Hospital" strategy.

Tables III F. 3 c-e estimate the portion of the projected hospital operating costs supported under the funding "Inter-Hospital" strategy according to the categories listed below:

- State
  - Program
  - Medicaid
- Federal
  - Medicaid
  - Medicare
  - Program

- Private Insurance
- Private and Other Third Party

Tables III F. 4 c-e provide like estimates of the hospital operating costs under the "Hospital/Community" strategy. The operative method and assumptions are the same as those described for the "Non-closure" strategy in Sub-section III B 3. with one exception: Under the "Hospital/Community" strategy, for every "geriatric" patient projected to move to the community, $80 per patient day is substracted from the Medicaid, Medicare, private insurance, other third party and private psychiatric funding streams, and added to the state program funding stream. This adjustment is made to reflect the fact that, unlike the other patient groups, the geriatric patients are almost totally supported by third party and private pay funds.

NARRATIVE CONTINUES ON PAGE 137

TABLE III F. 1c

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION:
INTER-HOSPITAL STRATEGY
PROJECTED 1983-84

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	20582152	1392594	1569648	3948535	13118683	552692
Alcohol Dependent					2025793	
Drug Dependent					190176	
Mentally Retarded					279752	
Mentally Ill					8061831	
Geriatric					2354468	
Outpatient					206663	
Fairfield Hills Hospital: Total	25161595	1643911	2432569	5441768	15143453	499994
Alcohol Dependent					1930193	
Drug Dependent					981929	
Mentally Retarded					706989	
Mentally Ill					9235044	
Geriatric					2289298	
Outpatient						
Norwich Hospital: Total	17434139	1300913	1642717	3633727	10506940	349842
Alcohol Dependent					1156715	
Drug Dependent					-	
Mentally Retarded					222089	
Mentally Ill					5725410	
Geriatric					3402726	
Outpatient						
Total	63177886	4337418	5644934	13024030	38769076	1402528

TABLE III F. 1d

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION:
INTER-HOSPITAL STRATEGY
PROJECTED 1984-85

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	26098915	1538816	2085055	4303903	17505147	665994
Alcohol Dependent					3080033	
Drug Dependent					198445	
Mentally Retarded					292155	
Mentally Ill					9756883	
Geriatric					3970968	
Outpatient					206663	
Fairfield Hills Hospital: Total	28119172	1735240	2806142	5673881	17354896	549013
Alcohol Dependent					2311742	
Drug Dependent					981929	
Mentally Retarded					875319	
Mentally Ill					10874164	
Geriatric					2311742	
Outpatient						
Norwich Hospital: Total	7890026	824139	638834	2148978	4127822	150253
Alcohol Dependent					502345	
Drug Dependent					-	
Mentally Retarded					11898	
Mentally Ill					1895030	
Geriatric					1718549	
Outpatient						
Total	62108113	4098195	5530031	12126762	38987865	1365260

TABLE III F. 1e

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION:
INTER-HOSPITAL STRATEGY
PROJECTED 1985-86

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	31474244	1685039	2592653	4659271	21757985	779296
Alcohol Dependent					4154943	
Drug Dependent					198445	
Mentally Retarded					300424	
Mentally Ill					11493277	
Geriatric					5610896	
Outpatient						
Fairfield Hills Hospital: Total	28201503	1735240	2814829	5673881	17428540	549013
Alcohol Dependent					2334186	
Drug Dependent					981929	
Mentally Retarded					875319	
Mentally Ill					10914142	
Geriatric					2322964	
Outpatient						
Norwich Hospital: Total	862647	217954		644693		
Alcohol Dependent						
Drug Dependent						
Mentally Retarded						
Mentally Ill						
Geriatric						
Outpatient						
Total	60538394	3638233	5407482	10977845	39186525	1328309

TABLE III F. 2c

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1983-84

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	18144660	1322964	1335372	3790594	11201071	494659
Alcohol Dependent					1901765	
Drug Dependent					90954	
Mentally Retarded					254947	
Mentally Ill					6614836	
Geriatric					2131906	
Outpatient	206663				206663	
Fairfield Hills Hospital: Total	21800168	1575415	2180624	5209655	12363892	470582
Alcohol Dependent					1537421	
Drug Dependent					834640	
Mentally Retarded					448882	
Mentally Ill					7276095	
Geriatric					2266854	
Outpatient						
Norwich Hospital: Total	15235160	1239614	1387183	3457901	8832016	318446
Alcohol Dependent					1156715	
Drug Dependent					-	
Mentally Retarded					237953	
Mentally Ill					4515816	
Geriatric					2921532	
Outpatient						
Total	55179988	4137993	4903179	12458150	32396979	1283687

TABLE III F. 2d

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1984-85

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	18295027	1336890	1327563	3770851	11365064	494659
Alcohol Dependent					2439220	
Drug Dependent					-	
Mentally Retarded					238410	
Mentally Ill					5622611	
Geriatric					2858160	
Outpatient					206663	
Fairfield Hills Hospital: Total	21560352	1598247	2310940	5235445	11925530	490190
Alcohol Dependent					1526199	
Drug Dependent					687350	
Mentally Retarded					359105	
Mentally Ill					6996245	
Geriatric					2356631	
Outpatient						
Norwich Hospital: Total	5850407	726839	383301	2168514	2452897	118856
Alcohol Dependent					502345	
Drug Dependent					-	
Mentally Retarded					27761	
Mentally Ill					685436	
Geriatric					1237355	
Outpatient						
Total	45705786	3661976	4021804	11174810	25743491	1103705

TABLE III F. 2e

HOSPITAL OPERATING COSTS BY PROGRAM AND FUNCTION:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1985-86

	Consolidated	Admin. Services	Food Services	General Services	Patient Census	Education & Training
Connecticut Valley Hospital: Total	20873012	1420446	1546221	3909050	13444603	552692
Alcohol Dependent					3111040	
Drug Dependent					-	
Mentally Retarded					242544	
Mentally Ill					6077381	
Geriatric					3806975	
Outpatient					206663	
Fairfield Hills Hospital: Total	21767370	1598247	2337003	5235445	12106485	490190
Alcohol Dependent					1526199	
Drug Dependent					687350	
Mentally Retarded					359105	
Mentally Ill					7076202	
Geriatric					2457629	
Outpatient						
Norwich Hospital: Total	862647	217954	-	644693		
Alcohol Dependent					-	
Drug Dependent					-	
Mentally Retarded					-	
Mentally Ill					-	
Geriatric					-	
Outpatient					-	
Total	43503029	3236647	3883224	9789188	25551088	1042882

Table III F. 3c

HOSPITAL OPERATING COSTS BY SOURCE:
INTER-HOSPITAL STRATEGY
PROJECTED 1983-84
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	20583	15293	885	885	741	144	1379	1256
Fairfield Hills Hospital	25162	18695	1082	1082	906	176	1686	1535
Norwich Hospital	17435	12954	750	750	628	122	1168	1063
Total	63178	46941	2717	2717	2274	442	4233	3854

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

Table III F. 3d

HOSPITAL OPERATING COSTS BY SOURCE:
INTER-HOSPITAL STRATEGY
PROJECTED 1984-85
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	26099	19391	1122	1122	940	183	1749	1592
Fairfield Hills Hospital	28117	20893	1209	1209	1012	197	1884	1715
Norwich Hospital	7889	5862	339	339	284	55	529	481
Total	62108	46146	2671	2671	2236	435	4161	3789

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

Table III F. 3e

HOSPITAL OPERATING COSTS BY SOURCE:
INTER-HOSPITAL STRATEGY
PROJECTED 1985-86
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	31473	23385	1353	1353	1133	220	2109	1920
Fairfield Hills Hospital	28202	20954	1213	1213	1015	197	1890	1720
Norwich Hospital	863	641	37	37	31	6	58	53
Total	60538	44980	2603	2603	2179	424	4056	3693

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

Table III F. 4c

HOSPITAL OPERATING COSTS BY SOURCE:
HOSPITAL COMMUNITY STRATEGY
PROJECTED 1983-84
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	18145	14299	648	648	519	127	1006	898
Fairfield Hills Hospital	21801	16752	875	875	687	153	1295	1164
Norwich Hospital	15236	12692	332	331	396	107	749	628
Total	55180	43744	1855	1854	1602	386	3050	2689

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

Table III F. 4d

HOSPITAL OPERATING COSTS BY SOURCE:
HOSPITAL/COMMUNITY STRATEGY
PROJECTED 1984-85
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	18296	13593	787	787	659	128	1226	1116
Fairfield Hills Hospital	21562	16049	924	924	771	151	1436	1307
Norwich Hospital	5851	5106	73	73	126	41	242	190
Total	45706	34748	1783	1783	1556	320	2903	2613

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

Table III F. 4e

HOSPITAL OPERATING COSTS BY SOURCE:
HOSPITAL COMMUNITY STRATEGY
PROJECTED 1985-86
(figures in thousands of dollars)

Hospital	Total Cost	Source: State Program	State Medicaid	Federal Medicaid	Federal Medicare	Federal Program	Private Insurance	Other Third Party
Connecticut Valley Hospital	20874	15509	898	898	751	146	1399	1273
Fairfield Hills Hospital	21767	16202	933	933	778	152	1450	1319
Norwich Hospital	862	699	23	23	25	6	46	40
Total	43503	32410	1854	1854	1554	305	2894	2632

a. Source: these estimates are based on the "Schedule of Receipts: Inpatient Services," 1978-79 Annual Report, Bureau of Collections

Note: All patients except geriatric patients are assumed to partake equally of these funds and thus the projected placement of these patients in the community will not alter the hospital funding patterns. However, as virtually all geriatric patients are eligible for some form of third party reimbursement, for every geriatric patient day spent in the community as opposed to the hospital, the third party shares' are projected to decrease proportionately by $80/day.

G. Renovation Requirements and Costs

Tables III G. 1 b-e include estimates of the costs of renovating buildings to accommodate patients from the Norwich hospital at the Connecticut Valley Hospital under the "Inter-Hospital" strategy. The bed capacity existing at the Fairfield Hills Hospital should be sufficient to accommodate 230 of the longer-term patients transferring from Norwich; no building renovations would be required at Fairfield Hills.

As explained in Section II H, the existing bed capacity at each of the hospitals was obtained from the "August, 1980 Quarterly Ward Assignment Reports," and verified with the Business Managers or Directors of Nursing at each hospital. The figures represent those beds which are currently occupied or which could be occupied without appreciable renovation costs. Bed capacities in unoccupied buildings could not be counted as existing capacity since such buildings are subject to additional life safety code requirements prior to re-occupancy.

The required bed capacity was calculated using the following formulas to allow for expected fluctuations in patient admission/discharge rates:

- Alcohol program bed capacity for short-term patients= 1.176 x average daily population. This corresponds to an 85% occupancy rate.
- Other program bed capacities for short-term patients= 1.111 x average daily population. This corresponds to a 90% occupancy rate.
- All program bed capacities for longer-term patients= 1.053 x average daily population. This corresponds to a 95% occupancy rate.

The added bed capacity possible through the renovation of existing buildings at Connecticut Valley Hospital, and the estimated costs of renovation were prepared by the Environmental Design Group (EDG) following on-site reviews of each hospital building. These estimates include the cost of furnishings and equipment, ancillary space for program activities, food preparation and service, and so forth; they also include design

fees and building contractor administration costs. The following assumptions were applied:

1. Projected Bed Capacity

   The projected bed capacity provides for at least 80 square feet per person and no more than 4 persons per sleeping room.

   Note: The actual bed capacity of the buildings following renovation might vary from the estimated bed capacity depending on the final design. Indicative of this is the fact that the EDG's final estimate of the bed capacities of certain buildings at the Connecticut Valley Hospital (Tables III G. 1b-d) differ from the preliminary estimates (Tables II H. 1-3). The final estimates were based on model layouts (See Appendix C); the preliminary estimates were not.

2. Renovation Criteria

   - Compliance with the State Building Code, including:

     Energy fitness (applied only to buildings currently unoccupied);

     Adequate heating and ventillating;

     Adequate electrical service;

     Handicap access.

   Note: Major portions of these criteria may be waivable by the office responsible for compliance with the State Building Code.

   - Compliance with the Life Safety Code (NFPA 101-1973), including:

     Provision for emergency egress;

     Fire protection systems.

   - Compliance with JCAH and HEW standards, including:

     Adequate lighting;

     Adequate bathrooms and plumbing;

     Upgrading interior finishes;

Allowance for ancillary space, for program activities, and kitchen and dining within each presently unoccupied building, but not including any expansion of existing centralized hospital facilities.

- Air Conditioning is identified as a separate cost item in accordance with the recommendation of the Department of Mental Health;

NARRATIVE CONTINUES ON PAGE 143

TABLE III G. 1b

HOSPITAL RENOVATION COSTS:
INTER-HOSPITAL STRATEGY
PROJECTED 1982-83

Hospital Building	Capacity			Architect and Engineering Fees[a]	Construction Costs[b]		Furnishings and Equipment[c]	Total Cost (a+b+c)
	Total Available Bed Capacity	Existing Bed Capacity	Additional Bed Capacity Required		Total	Cost per Bed		
Connecticut Valley Hospital: Total	1,186	684	502	951,615	9,516,144	22,748	951,615	11,419,372
Shepard Hall	75		75	163,643	1,636,429	21,819	163,643	1,963,715
Woodward Hall (new)	52	52						
Leak Hall	32	32						
Dutcher Hall	144	144						
Battell Hall	186	186						
Merritt Hall	258	258						
Dutton	12	12						
Russell Hall	136		136	220,865	2,208,646	16,240	220,865	2,650,376
Weeks Hall (new)								
Dix Hall	180		180	385,512	3,855,116	21,417	385,512	4,626,140
Beers Hall	111		111	181,595	1,815,953	16,360	181,595	2,179,143
		Funds Expended		951,615				

[a] Estimated at 10% of Construction Costs.
[b] Includes cost of remodelling with air conditicning and includes contractor overhead and profit allowance. Remodelling layouts and cost details are presented in Appendix C.
[c] Estimated at 10% at Construction Costs.

TABLE III G. 1c

HOSPITAL RENOVATION COSTS:
INTER-HOSPITAL STRATEGY
PROJECTED 1983-84

Hospital Building	Capacity			Architect and Engineering Fees[a]	Construction Costs[b]		Furnishings and Equipment[c]	Total Cost (a+b+c)
	Total Available Bed Capacity	Existing Bed Capacity	Additional Bed Capacity Required		Total	Cost per Bed		
Connecticut Valley Hospital: Total	1,186	684	502	951,615	9,516,144	22,748	951,615	11,419,372
Shepard Hall	75		75	163,643	1,636,429	21,819	163,643	1,963,715
Woodward Hall (new)	52	52						
Leak Hall	32	32						
Dutcher Hall	144	144						
Battell Hall	186	186						
Merritt Hall	258	258						
Dutton	12	12						
Russell Hall	136		136	220,865	2,208,646	16,240	220,865	2,650,376
Weeks Hall (new)								
Dix Hall	180		180	385,512	3,855,116	21,417	385,512	4,626,140
Beers Hall	111		111	181,595	1,815,953	16,360	181,595	2,179,143
		Funds Expended			9,516,144			

[a] Estimated at 10% of Construction Costs.
[b] Includes cost of remodelling with air conditicning and includes contractor overhead and profit allowance. Remodelling layouts and cost details are presented in Appendix C.
[c] Estimated at 10% at Construction Costs.

TABLE III G. 1d

HOSPITAL RENOVATION COSTS:
INTER-HOSPITAL STRATEGY
PROJECTED 1984-85

Hospital Building	Capacity			Architect and Engineering Fees[a]	Construction Costs[b]		Furnishings and Equipment[c]	Total Cost (a+b+c)
	Total Available Bed Capacity	Existing Bed Capacity	Additional Bed Capacity Required		Total	Cost per Bed		
Connecticut Valley Hospital: Total	1,186	684	502	951,615	9,516,144	22,748	951,615	11,419,372
Shepard Hall	75		75	163,643	1,636,429	21,819	163,643	1,963,715
Woodward Hall (new)	52	52						
Leak Hall	32	32						
Dutcher Hall	144	144						
Battell Hall	186	186						
Merritt Hall	258	258						
Dutton	12	12						
Russell Hall	136		136	220,865	2,208,646	16,240	220,865	2,650,376
Weeks Hall (new)								
Dix Hall	180		180	385,512	3,855,116	21,417	385,512	4,626,140
Beers Hall	111		111	181,595	1,815,953	16,360	181,595	2,179,143
		Funds Expended					951,615	

[a] Estimated at 10% of Construction Costs.
[b] Includes cost of remodelling with air conditioning and includes contractor overhead and profit allowance. Remodelling layouts and cost details are presented in Appendix C.
[c] Estimated at 10% at Construction Costs.

H. Community Alternative Requirements and Costs

By definition, the community alternatives would be developed as part of the "Hospital/Community" strategy only. Tables III H. 1 c-e project the costs of providing a continuum of permanent and temporary living environments ranging from more restrictive to less restrictive (less supervised) settings; Tables III H. 3 c-e project the types and amounts of state, federal, and other funds that would be used to cover these costs. Tables III H. 2 c-e project the costs of providing a comprehensive array of community support services for patients during the same three years; tables III H 4 c-e project the types and amounts of state, federal, and other funds that would be used to cover these costs.

1. Requirements and Costs

The total cost of each of the community alternatives is a function of its unit cost and utilization.

The unit cost figures employed are intended to be reasonably representative of service costs in Connecticut. Still, it is important to note that unit costs vary widely as a function of staffing patterns, facility type and location, the types of patients served, and other factors idiosyncratic to a given service situation. Thus, the unit costs at best represent an average cost; the actual range of unit costs can vary widely.

The actual development and utilization of the community alternatives may also vary from that projected even if funds are available. The development of nursing homes can and reportedly has been stymied by the inability to obtain the required certificates-of-need. Similarly, the commission on Hospitals and Health Care has reportedly been slow to approve some hospital program expansions.

The allowable fees for some care and support services are not high enough to stimulate the development of new programs, and hardly enough for many providers to continue in operation. In the case of nursing home services, the average per diem

reimbursements of approximately $24.50 for Intermediate Care Facilities and $38.00 for Skilled Nursing Facilities under Connecticut's Medicaid plan is not sufficient to induce many providers to accept former mental patients let alone expand their programs in order to accommodate former mental patients. Special staffing and support services are required to properly manage and care for these individuals. The per diem rate of at the state-administered Middletown Health Care Center, specially designed to provide nursing care to former mental patients, is approximately $48.00 per day--an indication of the higher cost of caring for these persons. Special rates for "Intermediate Care Facilities for the Mentally Ill (ICF-MI)" would likely be required to encourage the entrepreneurial development of needed nursing home beds. This is a critical area of concern as so many of the hospital patients are projected to need nursing home care (see Tables III H. 1c-e). Zoning restrictions and community resistance can also slow the development of the less restrictive residential alternatives; a special state zoning statute covering living arrangements for mentally ill persons in Connecticut may well be required in order to develop less restrictive living arrangements in residential neighborhoods like that covering living arrangements for the mentally retarded. In the case of community support services, available services may well be under-utilized unless the advocacy and care management network is active and strong.

The basis for our utilization and cost projections are presented below.

a. Care Arrangements

As explained in Section III D our estimates of the number longer term patients in each program who could be placed in nursing homes, family care homes; supervised, unsupervised, or transitional living arrangements were based on the judgments of those patient care staff familiar with the patients. HSRI obtained staff judgments using the Preliminary Patient Assessment Forms shown in Appendix B. In making its projections, HSRI

assumed that the same proportion of patients currently judged able to relocate to these different types of arrangements, would be able to relocate in future years. As indicated in Tables III H. 1c-e, in the judgment of the hospital patient care staff, of the longer term patients who could be placed in the community most could go to SNF's and ICF's or could live independently; relatively few would need family care, supervised apartments, or transitional living arrangements. According to their judgments, the need for less restrictive community care alternatives in the future should be relatively low.

In the case of the shorter term patients, HSRI projected that 35% of the shorter term patient population served at Norwich could be accommodated at general hospital psychiatric inpatient and detoxification units, free-standing detoxification units, Intensive Treatment (drug and alcohol dependents) facilities, shelter care (drug and alcohol dependents) facilities in the area. The other 65% would be accommodated at the Connecticut Valley Hospital.

The number of additional beds required by type of care arrangement projected through 1985-86 are estimated on the next page.*

*These estimates were derived by (1) dividing the number of patient days projected under each type of care arrangement shown in Table III H. 1e by 365 to determine the average daily census, and (2) multiplying the following factors to allow for normal fluctuations in client admissions and discharges:

- 1.053 for the permanent, more restrictive care arrangements; this corresponds to a 95% occupancy rate.
- 1.111 for the permanent, less restrictive care arrangements; this corresponds to a 90% occupancy rate.
- 1.176 for the temporary care arrangements; this corresponds to an 85% occupancy rate.

Care Arrangement	Beds Required
Permanent, More Restrictive Arrangements:	
Total	363
Skilled Nursing Facilities (SNF's)	176
Intermediate Care Facilities (ICF's)	152
Intermediate Care Facilities for the Mentally Retarded (ICF-MR's)	35
Permanent, Less Restrictive Arrangements:	
Total	167
Family Care	38
Supervised Apartments	23
Independent Living	106
Temporary Arrangements: Total	128
D&A Intermediate Care	3
MI/MR Transitional Living	43
D&A Intensive Treatment	3
D&A Shelter	1
Detoxification	9
Short-term Psychiatric Inpatient	69

The footnotes to Tables III H. 1 c-e list the references upon which the per diem costs were based.

b. Support Services

Our estimates of the costs of community support services are premised upon what "should be," rather than "what is." Whenever possible, we derived service utilization and unit cost figures from successful programs in Connecticut. When not possible, we used figures derived from model experiences in other states. Two sets of utilization rates were applied--one set for those patients in more restrictive settings, and another for those patients in less restrictive settings.

These utilization rates and estimated costs per client are presented in Tables III H. 2 f and g. The sources of information, upon which the utilization rates and costs are based, are identified in footnotes to these tables.

2. Sources of Funding

a. Scope

HSRI considered the following funding arrangements:

- Federal
  - Medicaid
  - Medicare
  - Supplemental Security Income (SSI)
  - Vocational Rehabilitation (VR)
  - Community Mental Health Center (CMHC) Grants
  - National Institute on Alcoholism and Alcohol Abuse (NIAAA)
- State
  - Medicaid
  - Supplemental Security Income (SSI)
  - Vocational Rehabilitation (VR)
  - Community Mental Health Center (CMHC) Grants
  - Connecticut Alcohol and Drug Abuse Council (CADAC)
  - Other Grants
- Individual
  - Private Insurance
  - Medicare
  - Private Pay

Since Connecticut is currently at its Title XX ceiling, HSRI did not count Title XX Funds as a potential resource.

Nor did HSRI consider some other existing programs such as the $25 per month federal supplement paid to nursing home (SNF, ICF, and ICF-MR) patients or Food Stamps. For example, eligible clients residing in a transitional living in facility could receive approximately $10-20 per month in Food Stamps. Neither did HSRI consider Section 8 rental subsidies, and Section 202 construction loans available to indigent patients in the community. Note: the Connecticut Department of Mental Health staff have already helped secure Section 202 funding for several local providers.

Finally, HSRI did not consider some of the new or prospective federal funding programs such as:

- Independent Living Funds available under the Rehabilitation Services Act and administered by the Department of Education.

- Additional Community Support Services Funds which are authorized but not appropriated under the Mental Health Systems Act, administered by the National Institute of Mental Health. This Act incorporates existing mental health funding programs, such as the Community Mental Health Centers Act and the Community Support Program as well as funding authorizations for new grant programs to special populations such as the chronically mentally ill.

- Medicaid Funds: Intermediate Care Facilities for the Mentally Retarded Based on the 1978 amendments to the Developmental Disabilities Act, the definition of "developmental disability" was changed to reflect a functional orientation as opposed to a categorical orientation. As a result of that change, it is likely that many chronically mentally ill persons whose disability originated before age 22 and who can meet certain self-care requirements can fall under the rubric of developmental disability. Accordingly, if the Connecticut Developmental Disability program has adopted the new definition, it is conceivable that many chronically mentally ill persons could qualify for ICF/DD services under the existing Medicaid Program.

The amount of each type of funds employed is a function of (1) client eligibility, (2) funding provisions, and (3) service qualifications. HSRI used the following simplifying assumptions in order to apply the multiplicity of different eligibility and funding provisions associated with the use of these funds. These assumptions were drawn from the following printed materials and from conversations with knowledgeable federal and state officials.

- Connecticut Department of Income Maintenance, "State Plan under Title XIX " May 22, 1980

- Connecticut Department of Income Maintenance, Public Assistance Manual, Volume 1. Chaper 3, 1971

- Connecticut Department of Income Maintenance, Department Bulletins, Nos. 3261, 3262, May 22, 1980, May 23, 1980

- Connecticut Department of Income Maintenance, Schedule of Rates

- State of Connecticut, "Relative Value Scale of Physicians Services and Procedures and Diagnosis Codes." Revised Edition, January 1, 1976

- Guinn, Waymon and Normadie Kamar, "A Working Manual of Third Party funding sources for Community Mental Health Centers," U. S. Department of HHS, NIMH, Publication #ADM.80-826 printed in 1978 and reprinted in 1980

b. Client Eligibility Assumptions

Two basic assumptions were applied:

- Those patients who are currently "indigent"--i.e., the state is paying for their hospital care or they are receiving Title XIX in the hospital--would be eligible to receive a variety of public assistance programs: e.g., Title XIX, SSI, Food Stamps, etc. in the community.

- Those "private-pay" patients who are currently eligible for private insurance or receive income either from relatives, an estate or other source would be primarily responsible for payment; the State would cover the remaining costs.

Note: In order to apply these assumptions, HSRI first had to estimate the percent of "indigent" patients, and the percent of "private-pay" patients in each of the program categories. (i.e., alcohol dependent, drug dependent, mentally retarded and mentally ill, and geriatric). This was done by matching coded MSIS patient records with coded accounts receivable data for a 48% sample of patients at the three hospitals in August of 1980.

- All patients groups, including alcohol and drug abusers, would be eligible for SSI--i.e., they are presumed to be chronically disabled and work impaired.

c. Funding Provisions

The following assumptions were applied:

- For those public assistance programs which do not fully cover the costs of a reimbursable service, the state would be obligated to pickup the balance.

- SSI (Supplemental Security Income)--Unless otherwise noted, eligible clients would be able to receive the full monthly Federal allotment of $238.00.

- SSI State Supplement--If a disabled client is eligible for Federal SSI, he/she would also be able to receive a maximum state supplement of $80.40/month for food, clothing, etc., and an average of $100/month in rent allowance. If a disabled client is living in a family care (board and care) arrangement, he/she is eligible for the maximum state supplement of $195.00/month.

- Title XIX (Medicaid)--The Medicaid program would reimburse eligible seniors at a 50% Federal; 50% State matching ratio. As indicated earlier, where the Medicaid approved rates or fees for do not cover the full service costs, the State would be responsible for assuming the unreimbursed cost. The Medicaid approved rates apply to the full cost of all qualifying care arrangements.

- Title XVIII (Medicare)

  -Deductibles and premiums associated both with Part A and Part B would be covered.

  -For both Parts, A and B, eligible patients would be within designated time limits in order to receive coverage.

  -Inpatient psychiatric care is limited to 190 days of lifetime coverage. For other hospital settings, an eligible patient has up to 90 days for each spell of illness; after 90 days, he/she gets an extra 60 days of lifetime coverage. These days are re-calculated for every new benefit period.

  -Part A covers inpatient care, including psychiatric hospitals and SNF's;

  -Part B covers a variety of medical services and outpatient psychiatric services.

  -For both Parts A and B, the Federal government will cover 80% of the service costs; the individual must cover the remaining 20%.

  -Reimbursement for outpatient psychiatric services is limited to $250.000 annually.

- Community Mental Health Center (CMHC) Funds--If available, all third party payments would be recovered before the following CMHC funding formula is applied: Federal funds would cover 50% of the costs of a CMHC services; State funds would cover the remaining 50%.

- Vocational Rehabilitation--since the Federal/State Vocational Rehabilitation program for the chronically disabled is limited, only 1/3 of those clients who need vocational services would be able to receive Federal funding; other funding sources, including State DMH funds, would be used to cover the remaining 2/3 of the clients who would require such services. Eligible services would be reimbursed on an "80%-Federal and 20%-State" basis.

- Drug Abuse (PL 92-255) as amended--Federal drug funds would cover 60% and state funds 40% of the costs of eligible services.

- Alcoholism (PL 91-616) as amended--After all third party payments have been recovered, Federal alcohol funds would reimburse 20% of the costs and State funds, 80% of the costs of eligible services.

- Private Insurance--Deductibles and premiums have been covered; private insurance programs for certain eligible services would cover 80% of the costs; the individual client would pick up the remaining 20% of the costs.

d. Service Qualifications

The following assumptions were applied:

- Advocacy/Case Management, Emergency Housing, House Finding, Life Skills Training--CMHC funds for mentally ill, mentally retarded and geriatric clients would apply to 20% of the costs of these services; the State and Individuals themselves would cover the remaining 80%. NIDA, NIAAA, and CADAC funds would cover eligible alcohol-dependent and drug-dependent clients.

- Transportation--Medicaid would apply to the full cost of public or private transportation for eligible clients; CMHC funds would apply to 20% of the costs'; the State and Individuals would assuming the remaining 80%

- Physician Services--Medicaid funding would apply to 44% of the service costs

- Dental Services--Medicaid would apply to 40% of the service costs

- Medication Monitoring--Medicaid would apply to 33% of the service costs

- Drugs--Medicaid would apply to 50% of the service costs

- Emergency Services--CMHC funds would apply to 50% of the service costs

- Day Treatment--Medicaid would apply to 85% of the costs; CMHC funds would apply to 85% of the costs
- Partial Hospitalization--CMHC funds would apply to 85% of the service costs
- Social-Rec Services--CMHC funds would apply to 20% of the service costs
- Diag. and Eval.--Medicaid funds would apply to 87% of the service costs; CMHC funds would apply to 87% of the service costs.
- Outpatient Counseling Therapy--Medicaid would apply to 44% of the service costs

NARRATIVE CONTINUES ON PAGE 169

TABLE III H. 1c

COMMUNITY PROGRAM ALTERNATIVES:
CARE ARRANGEMENT REQUIREMENTS AND OPERATING COSTS
PROJECTED 1983-84

Hospital Service Areas	Average Daily Census SF	Average Daily Census LT	Alternate Care Arrangements: Permanent: More Restrictive SNF	ICF	ICF-MR	Less Restrictive Family Care	Supervised Apts.	Indep. Living	Temporary: D&A[i] Interm. MI/MR Trnstnl. Living	D&A[h] Intensive Treatment	D&A[h] Shelter	Detoxification: Free[h] Standing	Detoxification: General[h] Hospital	Psy.[j] Inpatient General Hospital
Connecticut Valley Hospital														
Alcohol Dependent	0	1095	365	730										
Drug Dependent	0	730						730						
Mentally Retarded	0	3285			2628			657						
Mentally Ill	0	55480	9986	23024		2081	2081	18308						
Geriatric	0	10220	8524	848				848						
Fairfield Hills Hospital														
Alcohol Dependent	0	1460		730					730					
Drug Dependent	0	1460						1460						
Mentally Retarded	0	1825	365		1095				365					
Mentally Ill	0	43070	5944	15591	2240	2929	2240	5944	8183					
Geriatric	0	6935	6068	867										
Norwich Hospital														
Alcohol Dependent	0	1095	821			137		137						
Drug Dependent	0	0	-			-		-						
Mentally Retarded	0	3650	2084		1044				522					
Mentally Ill	0	42705	9609	8456	4954	6961	2989	5979	3972					
Geriatric	0	17155	16194	961										
Total Days			59960	51207	11961	12108	7310	34063	13772					
Cost Per Day			38.[a]	24.50[a]	59.[c]	6.50[c]	[b,d,e] 25	6.50[b]	28.[f,i]					
Total Cost			2278480	1254572	705699	78702	182750	221410	385616					

Grand Total: 5,107,229

TABLE III H. 1d

COMMUNITY PROGRAM ALTERNATIVES:
CARE ARRANGEMENT REQUIREMENTS AND OPERATING COSTS
PROJECTED 1984-85

Hospital Service Areas	Average Daily Census SF	Average Daily Census LT	Alternate Care Arrangements: Permanent: More Restrictive SNF	ICF	ICF-MR	Less Restrictive Family Care	Supervised Apts.	Indep. Living	Temporary: D&A I Interm. MI/MR Trnstnl. Living	D&A[h] Intensive Treatment	D&A[h] Shelter	Detoxification: Free[h] Standing	Detoxification: General[h] Hospital	Psy.[j] Inpatient General Hospital
Connecticut Valley Hospital														
Alcohol Dependent	0	1095		730										
Drug Dependent	0	730						730						
Mentally Retarded	0	3285			2628			657						
Mentally Ill	0	56210	10118	23327		2108	2108	18549						
Geriatric	0	10220	8524	848				848						
Fairfield Hills Hospital														
Alcohol Dependent	0	1460		730					730					
Drug Dependent	0	1460						1460						
Mentally Retarded	0	1825	365		1095				365					
Mentally Ill	0	43435	5994	15722	2259	2954	2259	5994	8253					
Geriatric	0	7300	6387	913										
Norwich Hospital														
Alcohol Dependent	3650[h]	1095	821			137		137		730	365	1277	1278	
Drug Dependent	0	0												
Mentally Retarded	365	3650	2084		1044				522					365
Mentally Ill	10090	42705	9609	8456	4954	6961	2989	5979	3972					10090
Geriatric	10090	17155	16194	961										10090
Total Days			60096	51687	11980	12160	7356	34354	13842	730	365	1277	1278	20545
Cost Per Day			38.[a]	24.50[a]	59.[a]	6.50[c]	25.[b,d,e]	6.50[b]	28.[f,i]	45.[g]	16.50[g]	72.[g]	226.[a]	226.[a]
Total Cost			2283648	1266332	706820	79040	183900	223301	387576	32850	6023	91944	288828	4643170

Grand Total: 10,193,432

TABLE III H. 1e

COMMUNITY PROGRAM ALTERNATIVES:
CARE ARRANGEMENT REQUIREMENTS AND OPERATING COSTS
PROJECTED 1985-86

Hospital Service Areas	Average Daily Census SF	Average Daily Census LT	Alternate Care Arrangements: Permanent: More Restrictive SNF	ICF	ICF-MR	Less Restrictive Family Care	Supervised Apts.	Indep. Living	Temporary: D&A I Interm. MI/MR Trnstnl. Living	D&A[h] Intensive Treatment	D&A[h] Shelter	Detoxification: Free[h] Standing	General[h] Hospital	Pay.[j] Inpatient General Hospital
Connecticut Valley Hospital														
Alcohol Dependent	0	1095	365	730										
Drug Dependent	0	730						730						
Mentally Retarded	0	3285			2628			657						
Mentally Ill	0	56940	10249	23631		2135	2135	18790						
Geriatric	0	10220	8524	848				848						
Fairfield Hills Hospital														
Alcohol Dependent	0	1825		913					912					
Drug Dependent	0	1460						1460						
Mentally Retarded	0	1825			1095				365					
Mentally Ill	0	43800	6044	15856	2278	2978	2278	6044	8322					
Geriatric	0	7665	6707	958										
Norwich Hospital														
Alcohol Dependent	4015	1095	821			137		137		803	402	1405	1405	
Drug Dependent	0	0												
Mentally Retarded	365	4015	2293		1148				574					365
Mentally Ill	10455	43800	9637	8672	5081	7139	3066	6132	4073					10455
Geriatric	10455	17520	16539	981										10455
Total Days			61179	52589	12230	12389	7479	34798	14246	803	402	1405	1405	21275
Cost Per Day			38.[a]	24.50[a]	59.[a]	6.50[c]	25.[b,d,e]	6.50[b]	28.[f,i]	45.[g]	16.50[g]	72.[g]	226.[a]	226.[a]
Total Cost			2324802	1288431	721570	80529	186975	226187	398888	36135	6633	101160	317530	4808150

Grand Total: 10,486,990

FOOTNOTES TO TABLES III H. 1 c-e

a. "Schedule of Rates," Connecticut Department of Income Maintenance

b. Supplemental Security Income Allowance $80.40/month for food, clothing, and personal needs + rental allowance for furnished two-person apartment in Hartford, Waterbury, and Norwich

c. Supplemental Security Income Allowance-Licensed Board and Care Homes

d. Porter, Robert C., "Cost Analysis of a Mental Health Delivery System," prepared for the Health Care Financing Admin.-based on a study Former Mental Hospital Patients served by the Brockton Multi-Service Center in Massachusetts in 79/80

e. Greater Hartford Social Club, Grant Application, 8/6/79

f. United Social and Mental Health Services, Inc., Grant Application, 7/16/79

g. Based on a letter from McConnell, Donald J., Executive Commissioner Alcohol and Drug Abuse Counsel (CADAC) Letter to Ralph J. Coruso, Office of Fiscal Analysis, Subject: Department of Mental Health Alcoholism and Drug Abuse Services, March 13, 1980; and follow-up discussions with Bob Cole, CADAC.

h. Projected days spent in temporary D&A Intensive Treatment, Shelter, and Detoxification facilities are based on discussions with Roger Howard, Director Blue Hills Hospital; and Bill Cole, and Al Duran, Planners, CADAC.

i. No downward cost adjustment is made for patient's subsequent movement to supervised apartments

j. Number of patient days projected to be the same as they would have been at the state hospital

TABLE III H. 2c

COMMUNITY PROGRAM ALTERNATIVES:
SUPPORT SERVICE REQUIREMENTS AND OPERATING COSTS
PROJECTED 1983-84

	Patients in:[a]		Number Using Community Support Services:							
	Permanent Less Restrictive Arrangements	Permanent More Restrictive Arrangements	Medication Monitoring	Drugs	Emergency Services	Day Treatment	Partial Hospitalization	Social-Recreational Services	Diagnosis & Evaluation	Outpatient Counseling & Therapy
Hospital/Program of Origin										
Connecticut Valley Hospital										
Alcohol Dependent		21		18.90	1.05				2.10	2.10
Drug Dependent	14	-	12.60	12.60	2.10	1.68	2.10	4.62	12.88	8.48
Mentally Retarded	1	5	.90	5.40	.40	.12	.15	.33	1.42	1.10
Mentally Ill	94	138	84.60	208.80	21.	11.28	14.10	31.02	100.28	70.20
Geriatric		28	25.20	1.40					2.80	2.80
Fairfield Hills Hospital										
Alcohol Dependent		14		12.60	.70				1.40	1.40
Drug Dependent	28		25.20	25.20	4.20	3.36	4.20	9.24	25.76	16.80
Mentally Retarded		3	2.70	.15					.30	.30
Mentally Ill	46	99	41.40	130.50	11.85	5.52	6.90	15.18	52.22	37.50
Geriatric		19		17.10	.95				1.90	1.90
Norwich Hospital										
Alcohol Dependent	5	15	4.50	18.	1.50	.60	.75	1.65	6.10	4.50
Drug Dependent	-	-	-	-	-	-	-	-	-	-
Mentally Retarded		6		5.40	.30				.60	.60
Mentally Ill	66	96	59.40	145.80	14.70	7.92	9.90	21.78	70.32	49.20
Geriatric		47		42.30	2.35				4.70	4.70
Total Patients			228.6	670.5	62.65	30.48	38.1	83.82	282.78	201.5
Cost Per Patient			2944.	245.	198.	987.	734.	794.	234.	340.
Total Cost			672,998	164,273	12,375	30,084	27,965	66,553	66,171	68,510

[a]Estimated by first dividing the number of patient days (as shown in Tables III H 1c through e) by the median length of stay for the shorter and longer term patients in each program, and then dividing again by the average number of admissions per patient (by program) to arrive at an unduplicated count. The median length of stay and readmission figures for 1978-79 were used (Source: "Admissions Per Patient," Table VI. Inpatient Statistics for Year Ending June 30, 1979, Connecticut Department of Mental Health).

TABLE III H. 2d

COMMUNITY PROGRAM ALTERNATIVES:
SUPPORT SERVICE REREQUIREMENTS AND OPERATING COSTS
PROJECTED 1984-85

	Patients in:[a]		Number Using Community Support Services:							
	Permanent Less Restrictive Arrangements	Permanent More Restrictive Arrangements	Medication Monitoring	Drugs	Emergency Services	Day Treatment	Partial Hospitalization	Social-Recreational Services	Diagnosis & Evaluation	Outpatient Counseling & Therapy
Hospital/Program of Origin										
Connecticut Valley Hospital										
Alcohol Dependent	-	21	-	18.90	1.05				2.10	2.10
Drug Dependent	14	-	12.60	12.60	2.10	1.68	2.10	4.62	12.88	8.40
Mentally Retarded	1	5	.90	5.40	.40	.12	.15	.33	1.42	1.10
Mentally Ill	95	139	85.50	210.60	21.60	11.40	14.25	31.35	101.30	70.90
Geriatric	-	28		25.20	1.40				2.80	2.80
Fairfield Hills Hospital										
Alcohol Dependent	-	14	-	12.60	.70	-	-	-	1.40	1.40
Drug Dependent	28	-	25.20	25.20	4.20	3.36	4.20	9.24	25.76	16.80
Mentally Retarded	-	3		2.70	.15				.30	.30
Mentally Ill	47	100	42.30	132.30	12.05	5.64	7.05	15.51	53.24	38.20
Geriatric	-	20		18.	1.				2.	2.
Norwich Hospital										
Alcohol Dependent	5	15	4.50	18.	1.50	.60	.75	1.65	6.10	4.50
Drug Dependent	-	-							-	-
Mentally Retarded	-	6		5.40	.30				.60	.60
Mentally Ill	66	96	59.40	145.80	14.70	7.92	9.90	21.78	70.32	49.20
Geriatric	-	47		42.30	2.35				4.70	4.70
Total Patients			230.4	675.	63.1	30.72	38.40	84.48	284.92	203.
Cost Per Patient			2944.	245.	198.	987.	734.	794.	234.	340.
Total Cost			678,298	165,375	12,494	30,321	28,186	67,077	66,671	69,020

[a]Estimated by first dividing the number of patient days (as shown in Tables III H 1c through e) by the median length of stay for the shorter and longer term patients in each program, and then dividing again by the average number of admissions per patient (by program) to arrive at an unduplicated count. The median length of stay and readmission figures for 1978-79 were used (Source: "Admissions Per Patient," Table VI. Inpatient Statistics for Year Ending June 30, 1979, Connecticut Department of Mental Health).

TABLE III H. 2e

COMMUNITY PROGRAM ALTERNATIVES:
SUPPORT SERVICE REQUIREMENTS AND OPERATING COSTS
PROJECTED 1985-86

	Patients in:[a]		Number Using Community Support Services:							
	Permanent Less Restrictive Arrangements	Permanent More Restrictive Arrangements	Medication Monitoring	Drugs	Emergency Services	Day Treatment	Partial Hospitalization	Social-Recreational Services	Diagnosis & Evaluation	Outpatient Counseling & Therapy
Hospital/Program of Origin										
Connecticut Valley Hospital										
Alcohol Dependent	-	21		18.90	1.05				2.10	2.10
Drug Dependent	14	-	12.60	12.60	2.10	1.68	2.10	4.62	12.88	8.40
Mentally Retarded	1	5	.90	5.40	.40	.12	.12	.33	1.42	1.10
Mentally Ill	96	141	86.40	213.30	21.45	11.52	14.40	31.68	102.42	71.70
Geriatric	-	28		25.20	1.40				2.80	2.80
Fairfield Hills Hospital										
Alcohol Dependent	-	17		15.30	.85				1.70	1.70
Drug Dependent	28	-	25.20	25.20	4.20	3.36	4.20	9.24	25.76	16.80
Mentally Retarded	-	3		2.70	.15				.30	.30
Mentally Ill	47	101	42.30	133.20	12.10	5.64	7.05	15.51	53.34	38.30
Geriatric	-	21		18.90	1.05				2.10	2.10
Norwich Hospital										
Alcohol Dependent	5	15	4.50	18.	1.50	.60	.75	1.65	6.10	4.50
Drug Dependent	-	-								
Mentally Retarded	-	7		5.40	.30				.60	.60
Mentally Ill	68	97	61.20	148.50	15.05	8.16	10.20	22.44	72.26	50.50
Geriatric	-	47		42.30	2.35				4.70	4.70
Total Patients			233.10	684.90	63.95	31.08	38.82	85.47	288.48	205.60
Cost Per Patient			2944.	245.	198.	987.	734.	794.	234.	340.
Total Cost			686,246	167,800	12,662	30,676	28,494	67,863	67,504	69,904

[a] Estimated by first dividing the number of patient days (as shown in Tables III H 1c through e) by the median length of stay for the shorter and longer term patients in each program, and then dividing again by the average number of admissions per patient (by program) to arrive at an unduplicated count. The median length of stay and readmission figures for 1978-79 were used (Source: "Admissions Per Patient," Table VI. Inpatient Statistics for Year Ending June 30, 1979, Connecticut Department of Mental Health).

TABLE III. H. 2f
COMMUNITY SUPPORT SERVICES
COSTS AND UTILIZATION RATES FOR
CLIENTS IN MORE RESTRICTIVE CARE FACILITIES

	Percent Utilizing Services and Level of Use (Hrs.)			
Services	Percent	Units Per Patient	Unit Cost	Cost Per Client
Advocacy/Case Mgmt.	25	14/hrs.[a]	32.50/hr.[a]	455.
Emergency Housing Svc.	NA	NA	37.50/day[d]	NA
House Finding Svcs.	NA	NA	32.58/day[d]	NA
Life Skills Training	1.2	450/hrs.	4.75/hr.[a]	2138.
Vocational Svc.	0.9	43/days	21.50/day[a]	925.
Transportation	20	150/trips	2.00/trip[b]	300.
Physician Svc.	75	4/visits	20.40/visit[f]	82.
Dental Svcs.	50.0	4/visits	27.25/visit[f]	109.
Medication Monitoring	Part of Care Arrangement Cost		46.00/hr.[a]	
Drugs	90	365/days	0.67/day[d]	245.
Emergency Svc.	5	3/hrs.[a]	66.00/hr.[a]	198.
Day Treatment	NA	NA	23.50/day[c]	NA
Partial Hospitalization	NA	NA	45.89/day[a]	734.
Social-Recreational Svcs.	Part of Care Arrangement Cost		3.61/hr.[a]	
Diagnosis and Evaluation	10	45/hrs.[a]	52.00/hr.[a]	2340.
Outpatient Counsel/Therapy	10	10/hrs.[a]	34.00/hr.[e]	340.

TABLE III. H. 2g
COMMUNITY SUPPORT SERVICES
COSTS AND UTILIZATION RATES FOR
CLIENTS IN LESS RESTRICTIVE CARE FACILITIES

	Percent Utilizing Services and Level of Use (Hrs.)			
Services	Percent	Units	Unit Cost	Cost Per Client
Advocacy/Case Mgmt.	100[d]	14/hrs.[a]	32.50/hr.[a]	455.
Emergency Housing Svc.	NA	NA	37.50/day[d]	NA
House Finding Svcs.	NA	NA	32.58/con[tactd]	NA
Life Skills Training	20	450/hrs.	4.75/hr.[a]	2138.
Vocational Svc.	6	43/days	21.50/day[a]	925.
Transportation	75[o]	150/trips	2.00/trip[b]	300.
Physician Svc.	60	4/visits	20.40/visit[f]	82.
Dental Svcs.	50.0	4/visits	27.25/visit[f]	109.
Medication Monitoring	90	64/hrs.[a]	46.00/hr.[a]	2944.
Drugs	90	365/days[d]	0.67/day[d]	245.
Emergency Svc.	15	3/hrs.[a]	66.00/hr.[a]	198.
Day Treatment	12[d]	42/days[a]	23.50/day[c]	987.
Partial Hospital	15[o]	16/days[a]	45.89/day[a]	734.
Social-Recreational Svcs.	33[d]	220/hrs.[a]	3.61/hr.[a]	794.
Diagnosis and Evaluation	92[d]	45/hrs.[a]	52.00/hr.[a]	2340.
Outpatient Counsel/Therapy	60[d]	10/hrs.[a]	34.00/hr.[e]	340.

FOOTNOTES TO TABLES III H. 2 f & g

a. Porter, Robert C., "Cost Analysis of a Mental Health Delivery System," prepared for the Health Care Financing Administration--based on a study Former Mental Hospital Patients served by the Brockton Multi-Service Center in Massachusetts in 79/80

b. Ashbaugh, John, W. Northeast Pilot Area: Patient, Staff, and Cost Projections, 1974-75, Pennsylvania Department of Public Welfare

c. United Social and Mental Health Services, Inc., Grant Application, 7/16/79

d. Average Daily Wholesale Cost of six of the most popular Antipsychotic Drugs

e. Minnehan, Robert F., "Cost Projections for non-inpatient Mental Health Services," prepared for HSRI, October, 1980 Figures based on cost analyses of CMHC's in:

    a. HHS Region III
    b. Atlanta, GA Metropolitan Area

f. Estimate provided by Blue Cross/Blue Shield of Connecticut, Arlene Sayers, November 24, 1980

TABLE III H. 3c

COMMUNITY PROGRAM ALTERNATIVES: CARE ARRANGEMENT COSTS BY SOURCE PROJECTED 1983-84

Care Arrangements	Total Cost	Sources: Federal Medicaid	Medicare	SSI	Voc. Rehab.	CMHC	NIDA	NIAAA	State Medicaid	SSI	Voc. Rehab.	CMHC	Drug CADAC	Alcohol CADAC	Other	Other Pvt. Ins.	Medicare	Misc.
Permanent (More Restrictive):																		
Skilled Nursing Facilities	2,278,480	578,236	244,518						578,237						81,636	653,087	61,130	81,636
Intermediate Care Facilities	1,254,572	408,869							408,868						43,684	349,468		43,683
Intermediate Care Facilities - MR	705,699	229,352							229,352						49,399			197,596
Permanent (Less Restrictive):																		
Family Care	78,702			28,185						23,060					5,491			21,966
Supervised Apts.	182,750			67,709						51,079					12,793			51,169
Independent Living	221,410			83,724						63,161					14,905			59,620
Temporary:																		
D&A Intermediate	385,616			135,297				3,066		102,067				12,264	26,585			106,337
MI & MR Transitional Living										102,067								
D&A Intensive Treatment																		
D&A Shelter																		
Detoxification - Free Standing																		
Detoxification - General Hospital																		
Psy. Inpatient - General Hospital																		
Total	5,107,229	1,216,457	244,518	314,915				3,066	1,216,457	239,367				12,264	234,493	1,002,556	61,130	562,007

TABLE III H. 3d

COMMUNITY PROGRAM ALTERNATIVES: CARE ARRANGEMENT COSTS BY SOURCE PROJECTED 1984-85

Care Arrangements	Total Cost	Sources: Federal Medicaid	Medicare	SSI	Voc. Rehab.	CMHC	NIDA	NIAAA	State Medicaid	SSI	Voc. Rehab.	CMHC	Drug CADAC	Alcohol CADAC	Other	Other Pvt. Ins.	Medicare	Mis.
Permanent (More Restrictive):																		
Skilled Nursing Facilities	2,283,648	578,359	245,707						578,358						81,979	655,838	61,427	81,980
Intermediate Care Facilities	1,266,332	412,680							412,679						44,098	352,779		44,097
Intermediate Care Facilities - MR	706,820	229,717							229,716						49,477			197,910
Permanent (Less Restrictive):																		
Family Care	79,040			28,306						23,159					5,515			22,060
Supervised Apts.	183,900			68,136						51,400					12,873			51,491
Independent Living	223,301			84,425						63,689					15,037			60,150
Temporary:																		
D&A Intermediate MI & MR Transitional Living	387,576			136,025				3,066		102,614				12,264	26,721			106,886
D&A Intensive Treatment	32,850							4,927						19,710	1,643			6,570
D&A Shelter	6,023							903						3,614	301			1,205
Detoxification - Free Standing	91,944	34,479							34,479						4,597			18,389
Detoxification - General Hospital	288,828	108,310							108,311						14,441			57,766
Psy. Inpatient - General Hospital	4,643,170	1,173,019	501,132						1,173,019							1,336,574	125,283	334,143
Total	10,193,432	2,536,564	746,839	316,892				8,896	2,536,562	240,862				35,588	256,682	2,345,190	186,710	982,647

TABLE III H. 3e

COMMUNITY PROGRAM ALTERNATIVES: CARE ARRANGEMENT COSTS BY SOURCE PROJECTED 1985-86

Care Arrangements	Total Cost	Sources: Federal Medicaid	Medicare	SSI	Voc. Rehab.	CMHC	NIDA	NIAAA	State Medicaid	SSI	Voc. Rehab.	CMHC	Drug CADAC	Alcohol CADAC	Other	Other Pvt. Ins.	Medicare	Misc.
Permanent (More Restrictive):																		
Skilled Nursing Facilities	2,324,802	589,719	249,634						589,720						83,332	666,656	62,409	83,332
Intermediate Care Facilities	1,288,431	420,071							420,070						44,829	358,632		44,829
Intermediate Care Facilities - MR	721,570	234,510							234,510						50,510			202,040
Permanent (Less Restrictive):																		
Family Care	80,529			28,838						23,595					5,619			22,477
Supervised Apts.	186,975			69,275						52,259					13,087			52,354
Independent Living	226,187			85,494						64,496					15,239			60,958
Temporary:																		
D&A Intermediate MI & MR Transitional Living	398,888			138,327				3,830		104,351				15,322	27,412			109,646
D&A Intensive Treatment	36,135							5,420						21,681	1,807			7,227
D&A Shelter	6,633							995						3,980	332			1,326
Detoxification - Free Standing	101,160	37,935							37,935						5,058			20,232
Detoxification - General Hospital	317,530	119,073							119,074						15,877			63,506
Psy. Inpatient - General Hospital	4,808,150	1,214,677	518,950					10,245	1,214,676							1,384,088	129,738	346,021
Total	10,496,990	2,615,985	768,584	321,934				10,245	2,615,985	244,701				40,983	263,102	2,409,376	192,147	1,044,948

TABLE III H. 4c

COMMUNITY PROGRAM ALTERNATIVES:
SUPPORT SERVICE OPERATING COSTS BY SOURCE
PROJECTED 1983-84

Support Services	Total Cost	Sources: Federal Medicaid	Medicare	SSI	Voc. Rehab.	CMHC	NIDA	NIAAA	State Medicaid	SSI	Voc. Rehab.	CMHC	Drug CADAC	Alcohol CADAC	Other	Other Pvt. Ins.	Medicare	Mis.
Advocacy/Case Management	171,421					14,400	11,314	1,714				14,399	9,542	6,857	115,195			
Emergency Housing Services	9,279					751	946	37				752	631	149	6,013			
House Finding Services	5,761					466	588	23				467	392	92	3,733			
Life Skills Training	117,825					9,661	11,311	471				9,662	7,541	1,885	77,294			
Vocational Services	18,186				4,098	1,237					1,024	1,236			10,591			
Transportation	86,610	24,208				3,819			24,207			3,820			15,278			15,278
Physician Services	42,693	5,107	4,186						5,106						12,999	11,398	1,047	2,850
Dental Services	40,603	4,492							4,442						13,326			18,393
Medication Monitoring	672,998	62,741	62,724			21,435			62,749			21,435			126,242		15,681	
Drugs	164,273	22,477	15,966						22,477						72,157		3,992	27,204
Emergency Services	12,375					2,091						2,091			4,182	3,209		802
Day Treatment	30,084	7,321				4,560			7,321			4,560			1,609			4,713
Partial Hospitalization	27,965					8,162						8,161			2,880	7,010		1,752
Social-Recreational Services	66,553					6,656						6,655			35,672			17,570
Diagnosis and Evaluation	66,171	16,266	6,158			2,115			16,265			2,114			632	16,865	1,540	4,216
Outpatient Counsel/Therapy	68,510	8,474	6,422			4,745			8,473			4,745			12,078	17,574	1,606	4,393
Total	1,601,307	151,036	95,456		4,098	80,098	24,159	2,245	151,031	-	1,024	80,097	16,106	8,983	809,881	56,056	23,866	97,171

TABLE III H. 4d

COMMUNITY PROGRAM ALTERNATIVES: SUPPORT SERVICE OPERATING COSTS BY SOURCE PROJECTED 1984-85

Support Services	Total Cost	Sources: Federal Medicaid	Medicare	SSI	Voc. Rehab.	CMHC	NIDA	NIAAA	State Medicaid	SSI	Voc. Rehab.	CMHC	Drug CADAC	Alcohol CADAC	Other	Other Pvt. Ins.	Medicare	Mis.
Advocacy/Case Management	172,673					14,505	11,396	1,727				14,504	7,598	6,907	116,036			
Emergency Housing Services	9,352					767	898	37				767	598	150	6,135			
House Finding Services	5,806					476	557	23				476	372	93	3,809			
Life Skills Training	119,236					9,897	10,731	477				9,896	7,154	1,908	79,173			
Vocational Services	18,324				4,086	1,252					1,022	1,252			10,712			
Transportation	87,240	24,372				3,850			24,372			3,849			15,398			15,399
Physician Services	42,976	5,135	4,222						5,135						13,070	11,488	1,055	2,871
Dental Services	40,875	4,399							4,398						13,195			18,883
Medication Monitoring	678,298	63,906	62,186			25,949			63,906			25,950			420,854		15,547	
Drugs	165,375	22,516	16,194						22,516						72,566		4,048	27,535
Emergency Services	12,494					2,107						2,106			4,213	3,254		814
Day Treatment	30,321	7,374				4,598			7,373			4,598			1,623			4,755
Partial Hospitalization	28,186					8,224						8,224			2,903	7,068		1,767
Social-Recreational Services	67,077					6,708						6,707			35,954			17,708
Diagnosis and Evaluation	66,671	16,378	6,210			2,130			16,378			2,129			636	17,006	1,553	4,251
Outpatient Counsel/Therapy	69,020	8,530	6,478			4,777			8,530			4,776			12,159	17,721	1,619	4,430
Total	1,613,924	152,610	95,290	-	4,086	85,240	23,582	2,264	152,608	-	1,022	85,234	15,722	9,058	808,436	56,537	23,822	98,413

TABLE III H. 4e

COMMUNITY PROGRAM ALTERNATIVES:
SUPPORT SERVICE OPERATING COSTS BY SOURCE
PROJECTED 1985-86

Support Services	Total Cost	Sources: Federal Medicaid	Medicare	SSI	Voc. Rehab.	CMHC	NIDA	NIAAA	State Medicaid	SSI	Voc. Rehab.	CMHC	Drug CADAC	Alcohol CADAC	Other	Other Pvt. Ins.	Medicare	Mis.
Advocacy/Case Management	208,731					17,534	13,776	2,087				17,533	9,184	8,350	140,267			
Emergency Housing Services	9,461					776	908	38				776	606	151	6,206			
House Finding Services	5,874					481	564	23				482	376	94	3,854			
Life Skills Training	121,032					10,045	10,893	484				10,046	7,262	1,936	80,366			
Vocational Services	18,555				4,138	1,267					1,035	1,268			10,847			
Transportation	88,395	24,693				3,901			24,693			3,901			15,604			15,603
Physician Services	43,616	5,212	4,285						5,211						13,265	11,658	1,071	2,914
Dental Services	41,475	4,463							4,463						13,388			19,161
Medication Monitoring	686,246	64,655	62,915			26,254			64,654			26,253			425,786		15,729	
Drugs	167,800	22,783	16,485						22,783						73,597		4,121	28,031
Emergency Services	12,662					2,135						2,135			4,270	3,298		824
Day Treatment	30,676	7,452				4,657			7,452			4,656			1,643			4,816
Partial Hospitalization	28,494					8,308						8,307			2,932	7,158		1,789
Social-Recreational Services	67,863					6,787						6,786			36,374			17,916
Diagnosis and Evaluation	67,504	16,571	6,295			2,154			16,571			2,154			644	17,233	1,574	4,308
Outpatient Counsel/Therapy	69,904	8,634	6,566			4,835			8,634			4,835			12,307	17,961	1,642	4,490
Total	1,668,288	154,463	96,546		4,138	89,134	26,141	2,632	154,461		1,035	89,132	17,428	10,531	840,810	57,308	24,137	99,852

I. Non-recurring Implementation Costs

The one-time costs associated with administering the mental hospital's closing, relocating patients and staff, and developing alternative service arrangements are sizable.

The cost estimates presented in this section do not include:

- The salaries and fringe benefits of the many existing department and hospital staff members who would have to devote much of their time to activities surrounding the hospital's closing. These costs would be absorbed in the ongoing hospital and department budgets.
- The one-time administrative costs involved in such activities as the closing out of the hospital's books and the preparing of patient records for transfer; and the costs of maintaining the facility until it is readied for other use, or disposed of. These costs are shown in the 1985-86 hospital operating costs (Tables III F 1 e and III F 2 e.)
- The costs and revenues associated with the demolishing and salvaging of facilities and equipment should a decision be made to abandon the facility.
- Unemployment benefits for furloughed employees
- Staff retraining costs

This section does include:

- The estimated costs of additional case managers, hospital social workers and supervisors, and other direct costs of managing the patient transfer and placement process. (client management)
- The estimated cost of additional staff to manage the employee changes required. (personnel management)
- The estimated cost of staff and other direct costs of planning and coordinating the overall system change process. (project management)
- The start-up funds required to initiate the development of additional supervised apartments and transitional living arrangements. These funds cover the planning, design, staffing and organizing, training, purchasing, and other initial activities assoicated with the beginning of a service prior to its becoming fully operational (start-up costs).

1. Project Management

A full-time project manager should be assigned or hired on contract (temporarily) to plan, monitor, and help coordinate all activities pursuant to the hospital's closure. At a minimum the project manager should have four half-time planning assistants--one devoted to each hospital and one to the community. The manager should also have one full-time administrative assistant/secretary and a separate office. Experienced consultants should be employed to advise and assist the project manager as needed.

Estimated Annual Cost
1981-82 - 1985-86

	1981-82	1982-83 1983-84	All Other Years
Salaries and Fringe Benefits			
Project Manager	$ 30,000	$ 30,000	$ 30,000
Planning Assistants	45,000	45,000	45,000
Administrative Assistant/ Secretary	15,000	15,000	15,000
Economic Impact and Alternative Use Study	100,000		
Consultants		20,000	
Other Direct Expenses @ 50% of Salaries	45,000	45,000	45,000
	$235,000	$155,000	$135,000

2. Client Management

One additional social services staff person should be temporarily assigned or hired for every 100 patients to be moved under the plan. These individuals would augment the regular social services staff working with the patients and families involved in preparation for each patients' placement or transfer, and assisting in the patient assessment and follow-up activities.

1983-84-1984-85	7	Social Services Staff @$20,000	$140,000
1982-83-1985-86	3.5	Social Services Staff @ 20,000	70,000

3. Personnel Management

One experienced personnel manager should be assigned to work with the Project Manager full-time and should be provided with a full-time administrative assistant secretary. In addition one personnel manager at the Fairfield Hills Hospital and at the Connecticut Valley Hospital should be assigned to the project half-time, and one full-time personnel manager should be assigned from Norwich Hospital.

Estimated Cost

		1981-82	1982-83 thru 1985-86
1	Department Personnel Manager	$29,000	$ 29,000
2	Hospital Personnel Managers	40,000	40,000
1	Administrative Assistant/Secretary	15,000	15,000
1	Other Direct Costs (50% of Salaries and Fringe Benefits)	42,000	42,000
	Hospital Staffing Requirements Study and Staff Preference Survey	60,000	
		186,000	126,000

4. Start-up Costs

Start-up costs are essential to defray inevitable front-end expenses associated with the development of new services, particularly less restrictive residential alternatives. We estimate that $25,000 in start-up funds would be required in 1982-83 for the development or expansion of supervised patient and transitional living programs under the "Hospital/Community Development" Strategy.

5. Summary

These non-recurring costs of managing the implementation process are summarized in Table III I. 1.

TABLE III I. 1

NON-RECURRING IMPLEMENTATION COSTS
PROJECTED 1981-82 THROUGH 1985-86

	1981-82	1982-83	1983-84	1984-85	1985-86
Total	421,000	376,000	421,000	401,000	331,000
Project Management	235,000	155,000	155,000	135,000	135,000
Client Management	-	70,000	140,000	140,000	70,000
Personnel Management	186,000	126,000	126,000	126,000	126,000
Start-up Costs	-	25,000	-	-	-

J. Total Costs

The cost figures presented in Table III J. 1 represent the total costs as shared by the federal and state governments, and private sector for:

- hospital operation under all three strategies
- hospital building renovation under the "Inter-hospital" strategy
- implementation of either "Closure" strategy
- alternative community care arrangements under the "Hospital/Community" strategy
- alternative community support services under the "Hospital/Community" strategy

In 1981-82 and 1982-83, the estimated costs are identical under the "Closure" and "Non-closure" strategies except for the one-time implementation planning, and architectual and engineering costs. However, beginning in 1983-84, the point where patients begin to relocate, the costs under the "Closure" and "Non-closure" strategies begin to diverge.

In 1983-84 and 1984-85, under the "Inter-hospital" strategy, the total costs increase significantly due to the costs of building renovation. In 1985-86, after the renovation funds have been expended, the costs decline. Beginning in 1985-86, the "Inter-hospital" strategy is projected to yield an overall annual savings of approximately $4 million over the "Non-closure" strategy, $3 million of which would accrue to the state.

As no renovation is required under the "Hospital/Community" strategy, total costs are not projected to increase much relative to the "Non-closure" strategy. Savings in annual operating costs are not projected to accrue until 1984-85, one year after the first group of patients would have been placed in the community. Beginning in 1985-86, the "Hospital/Community" strategy is projected to yield an overall annual cost savings of nearly $9 million. The annual savings to the state could be as high as $12 million. This added savings to the state would come largely at the expense of the federal

government. The federal government picks up an increased share of the cost of caring for chronically ill (work-disabled) and indigent patients in community settings under the Medicaid and Supplemental Security Income programs.

TABLE III J. 1

TOTAL COST BY SOURCE: UNDER NON-CLOSURE STRATEGY AND UNDER INTER-HOSPITAL AND HOSPITAL/COMMUNITY CLOSURE STRATEGIES, PROJECTED 1981-82 THROUGH 1985-86

(figures in thousands of dollars)

	Non-Closure Strategy:				Closure Strategies:							
					Inter-Hospital				Hospital/Community			
Costs	Total Cost	Federal Share	State Share	Private Share	Total Cost	Federal Share	State Share	Private Share	Total Cost	Federal Share	State Share	Private Share
Total 1981-82	62305	5358	48972	7975	62726	5358	49393	7975	62726	5358	49393	7975
Hospital Operating	62305	5358	48972	7975	62305	5358	48972	7975	62305	5358	48972	7975
Hospital Building Renovation	—	—	—	—	—	—	—	—	—	—	—	—
Non-Recurring Implementation	—	—	—	—	421	—	421	—	421	—	421	—
Community Care	—	—	—	—	—	—	—	—	—	—	—	—
Support Services	—	—	—	—	—	—	—	—	—	—	—	—
Total 1982-83	61317	5273	48195	7849	62645	5273	49523	7849	61693	5273	48571	7849
Hospital Operating	61317	5273	48195	7849	61317	5273	48195	7849	61317	5273	48195	7849
Hospital Building Renovation	—	—	—	—	952	—	952	—	—	—	—	—
Non-Recurring Implementation	—	—	—	—	376	—	376	—	376	—	376	—
Community Care	—	—	—	—	—	—	—	—	—	—	—	—
Support Services	—	—	—	—	—	—	—	—	—	—	—	—
Total 1983-84	61621	5298	48435	7888	73115	5433	59595	8087	62310	5978	48790	7542
Hospital Operating	61621	5298	48435	7888	63178	5433	49658	8087	55179	3842	45599	5738
Hospital Building Renovation	—	—	—	—	9516	—	9516	—	—	—	—	—
Non-Recurring Implementation	—	—	—	—	421	—	421	—	421	—	421	—
Community Care	—	—	—	—	—	—	—	—	5008	1779	1703	1626
Support Services	—	—	—	—	—	—	—	—	1601	357	1067	177
Total 1984-85	64229	5523	50485	8221	63461	5341	50170	7950	57915	7631	41074	9210
Hospital Operating	64229	5523	50485	8221	62108	5341	48817	7950	45706	3659	36531	5516
Hospital Building Renovation	—	—	—	—	952	—	952	—	—	—	—	—
Non-Recurring Implementation	—	—	—	—	401	—	401	—	401	—	401	—
Community Care	—	—	—	—	—	—	—	—	10194	3609	3070	3515
Support Services	—	—	—	—	—	—	—	—	1614	363	1072	179
Total 1985-86	64729	5566	50878	8285	60869	5206	47914	7749	55999	7803	38874	9322
Hospital Operating	64729	5566	50878	8285	60538	5206	47583	7749	43503	3713	34264	5526
Hospital Building Renovation	—	—	—	—	—	—	—	—	—	—	—	—
Non-Recurring Implementation	—	—	—	—	331	—	331	—	331	—	331	—
Community Care	—	—	—	—	—	—	—	—	10497	3717	3165	3615
Support Services	—	—	—	—	—	—	—	—	1668	373	1114	181

APPENDIX A

DIRECT CARE STAFF

ALLOCATION FORM

Direct Care Staff

Allocation Form

INSTRUCTIONS

Column 1: Number of Full-Time Equivalent (FTE) Staff Positions

Indicate the number of FTE staff positions established for each job classification as of June 30, 1980. A part-time position authorized to work 17.5 hours per week would be counted as ½.

Column 2: Job Classifications

We've tried to list all direct care job classifications appropriate to a given service. If there are "other" established positions which should be listed, please write them in.

Columns 3-41: Estimated Percent of Time Devoted to each "Ward"

- Indicate the code (number) identifying each ward along the upper margin.
- Estimate the average percent of time devoted by the persons in each job classification to each ward during a typical month.
  Include time spent in non face-to-face activities (e.g., charting, case coordination, case conferences, etc.) as well as time spent face-to-face with patients.

Column 42: Estimated Percent of Time Devoted to "Other Administrative Activities"

Estimate the average percent of time devoted by the persons in each job classification to other administrative and support activities--time not related to a particular patient ward.

Note: The estimated percentages for each job classification should total 100%.

DIRECT CARE STAFF
ALLOCATION CHART
Rehabilitation Therapies

Hospital

Name of Contact Person

No. of Full-time Equivalent Staff	Job Classification	Estimated Percent of Time Devoted To: WARD no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no.	Other (Admin. Activit
	Director of Rehabilitative Therapies		
	Occupational Therapist III		
	Occupational Therapist II		
	Occupational Therapist I		
	Therapy Aide III		
	Therapy Aide II		
	Therapy Aide I		
	Music Therapist		
	Recreation Worker		
	Recreation Aide		
	Vocational Rehabilitation Counselor		
	Graphic Artist II		
	State School Teacher III		
	State School Teacher II		
	State School Teacher I		
	State School Instructor		
	State School Vocational		
	Other _____ (please specify)		

DIRECT CARE STAFF
ALLOCATION CHART
Nursing Services

lospital ____________________

Name of Contact Person ____________________

of ll-time uivalent aff	Job Classification	Estimated Percent of Time Devoted To: WARD no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	Other (Admin. Activity
	Rehabilitation Counselor III (drugs)																																						
	Rehabilitation Counselor II (drugs)																																						
	Rehabilitation Counselor I (drugs)																																						
	State School Teacher III																																						
	State School Teacher II																																						
	Other (please specify ____)																																						

Hospital

DIRECT CARE STAFF ALLOCATION CHART
Nursing Services

Name of Contact Person

No. of Full-time Equivalent Staff	Job Classification	Estimated Percent of Time Devoted To: WARD no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	no.	Other (Admin Activi
	Director of Nursing II (psy.)																																							
	Director of Nursing I (psy.)																																							
	Nurse Supervisor (psy.)																																							
	Nurse Clin. Spec. Psy.																																							
	Head Nurse (psy.)																																							
	Staff Nurse																																							
	Medical Review Nurse II																																							
	Medical Review Nurse I																																							
	Psychiatric Aide IV (adm.)																																							
	Psychiatric Aide III (adm.)																																							
	Psychiatric Aide IV (clin.)																																							
	Psychiatric Aide III (clin.)																																							
	Psychiatric Aide II																																							
	Psychiatric Aide I																																							
	Psychiatric Aide Trainee																																							
	Rehabilitation Counselor III (alcohol)																																							
	Rehabilitation Counselor II (alcohol)																																							
	Rehabilitation Counselor I (alcohol)																																							

Hospital

DIRECT CARE STAFF
ALLOCATION CHART
Physical Therapy

Name of Contact Person

No. of Full-time Equivalent Staff	Job Classification	Estimated Percent of Time Devoted To: WARD no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no.	Other (Admin. Activit
	Physical Therapy		
	Physical Therapist 1]		
	Physical Therapy Supervisor		
	Other _____ (please specify)		

DIRECT CARE STAFF
ALLOCATION CHART
Social Services

Hospital

Name of Contact Person

No. of Full-time Equivalent Staff	Job Classification	Estimated Percent of Time Devoted To: WARD no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no.	Other (Admin. Activit
	Psychiatric Social Worker Chief		
	Psychiatric Social Worker Supervisor		
	Psychiatric Social Worker Associate		
	Psychiatric Social Worker		
	Psychiatric Social Worker Assistant		
	Psychiatric Social Worker Trainee		
	Rehabilitation Counselor I		
	Other _____ (please specify)		

DIRECT CARE STAFF
ALLOCATION CHART
Psychological Services

Hospital

Name of Contact Person

No. of Full-time Equivalent Staff	Job Classification	Estimated Percent of Time Devoted To: WARD no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no.	Other (Admin Activ
	Chief of Psychological Services		
	Psychologist III (clin.)		
	Psychologist II (clin.)		
	Psychologist I (clin.)		
	Psychology Associate II		
	Psychology Associate I		
	Psychology Assistant II		
	Psychology Assistant I		
	Psychology Research Intern		
	Psychology Intern		
	Mental Health Director of Research		
	Other _____ (please specify)		

Hospital

DIRECT CARE STAFF ALLOCATION CHART
Medical/Psychiatric Services

Name of Contact Person

No. of Full-time Equivalent Staff	Job Classification	Estimated Percent of Time Devoted To: WARD no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no. no.	Other (Admi Activ
	Senior Physician		
	Physician		
	Physician Assistant		
	Internist		
	Mental Health Administrator of Alcohol Services		
	Mental Health Administrator of Geriatric Services		
	Hospital Clinical Director		
	Chief of Professional Services		
	Professional Specialist		
	Psychiatrist IV		
	Psychiatrist III		
	Psychiatrist II		
	Psychiatrist I		
	Senior Medical Technician		
	Radiologist		
	Respiratory Therapist		
	Medical Review Nurse II		
	Medical Review Nurse I		
	Other _____ (please specify)		

APPENDIX B

PRELIMINARY PATIENT ASSESSMENT FORM

PRELIMINARY PATIENT ASSESSMENT FORM

These forms should be completed by the Unit Chiefs in consultation with direct care staff familiar with each patient.

Human Services Research Institute staff members will collect the completed forms at the following locations, on the following dates:

- Connecticut Valley Hospital on Wednesday, October 29th.
- Fairfield Hills Hospital on Thursday, October 30th.
- Norwich Hospital on Friday, October 31st.

If you have any questions, or if further clarification is required, please call John W. Ashbaugh, (202) 638-2564 or Mary Ann Allard (617) 491-6520 at the Human Services Research Institute.

Thank you.

INSTRUCTIONS

Patient Case Numbers

The case numbers identify all patients on the books as of June 30, 1980. However, if a particular patient was not still in residence or on leave at that time please "line-out" the case number.

Current Status (As of October 27, 1980)

Record the appropriate code number:

1. In-residence
2. Discharged
3. Transferred
4. General Hospital Transfer
5. Deceased
6. Short-term Leave
7. Extended Leave
8. AWOL

If the patient has been discharged (Code 2) or transferred (Code 3), is deceased (Code 5) or AWOL (Code 8), or is on Extended Leave, do not complete the remaining items.

Projected Length-of-Stay

In your judgment, given adequate preparation, care and support services the patient should be able to leave the hospital's care (indicate the appropriate code number):

1. Within 3 months
2. Within 12 months
3. Within 24 months
4. Within 36 months
5. Sometime after 36 months
6. Most likely the patient will never be able to leave hospital's care.

Appropriate Residential/Care Alternative

If and when the patient does leave the hospital's care, the most appropriate residential/care alternative would be (indicate the appropriate code number):

1. Private Mental Hospital
2. Forensic Hospital
3. General Hospital
4. Skilled Nursing Facility
5. Intermediate Care Facility
6. 1/4, 1/2, 3/4-Way House
7. Group Home
8. Supervised Apartment
9. Foster Home
10. Board and Care Home
11. Family Home
12. Independent Living
13. Other _____ (Please Specify)
14. Not Applicable

Factors Prohibiting Patient Outplacement

Please indicate the code numbers of those patient characteristics which apply:

1. Expresses unwillingness to leave hospital
2. Engages in self-injurious behavior resulting in injuries severe enough to require medical attention by physician
3. Makes frequent suicidal threats or gestures
4. Has attempted to take own life
5. Engages in violent episodes involving serious injury to others
6. Makes frequent homicidal threats or gestures
7. History of destroying property/setting fires
8. Frequently engages in disruptive and distracting behavior
9. Undresses in public and/or engages in sexual behavior that regularly disturbs or disrupts others

10. Totally withdrawn and requires constant encouragement/supervision

11. Suffers from a medical condition which inhibits all functioning and requires extensive psychiatric nursing intervention

12. Frequently runs away and wanders

13. Frequently resists taking medication necessary for mental and physical health

14. Is too emotionally unstable to care for self

15. Is mentally incompetent to care for self

16. Is non-ambulatory

17. Is deaf

18. Is dumb

19. Is blind

20. Other _____ Please Specify

Hospital

Contact Person

PRELIMINARY PATIENT ASSESSMENT FORM

Ward/Unit No.	Patients on Books as of June 30, 1980	Current Status	Projected Length-of-Stay	Appropriate Residential/ Care Alternative	Factors Prohibiting Client Outplacement

APPENDIX C

RENOVATION AND UTILITIES COST ESTIMATE

nvironmental
esign
roup Inc.

14 Arrow Street, Cambridge, Massachusetts 02138 · 617-868-6850

January 13, 1980

John Ashbaugh
Human Services Research Institute
Suite 1030
1522 K Street NW
Washington, DC 20005

Dear John,

I have read your draft report, and I am enclosing a corrected draft which differs from what you have now as follows: (see enclosure A)

Hospital Renovation Costs: What we did was take the total estimated renovation costs including air conditioning and add 5% for food services, delete the 10% contingency and add 20% for the contractor's administrative profit and overhead.

Call this figure construction costs.

Divide it by the number of beds to get the cost per bed.

Add to this figure:

Architects and engineers fees @10% of construction costs
plus
Furnishings and equipment @10% of construction costs.

This gives you a total cost of the project.

This figure does not include a contingency factor and is in 1980 dollars.

You may include this information about how we arrived at figures in your report; which by the way is a very nice job that we are proud to have been involved with and to sign our names to.

We agree you may give us titles if you feel it is more professional. How about:

Environmental Design Group
Bob Nicodemus Vice President
Steve Whittet Cost Research Director
Wen Chi Chou Hospital Renovation Designer

Finally the non-hospital support service arrangements and estimated costs; Table II I.4 (Estimated Cost of Current and Alternate Power Systems For Selected Hospital Buildings) should be corrected as shown: (see enclosure)

nvironmental
esign
roup inc.

Table II I.4

I am enclosing typed changes to your report as a final draft of our report hoping you will find it convenient to include them in this way.

Considering how large this proposed renovation is and how far off timewise it would be possible for a small deviation to grow quite large. With your help we have checked and cross checked our figures against each other and as many variables as possible have been eliminated. We expect that inflation will have its effect but for the most part we believe these numbers accurately reflect the relative cost of the proposed work and its feasability.

Sincerely,

ENVIRONMENTAL DESIGN GROUP, INC.

Steve Whittet

SW/dt
encl

A REPORT ON COSTS OF REHABILITATION OF

CERTAIN CONNECTICUT MENTAL HEALTH HOSPITAL BUILDINGS

PREPARED BY:

ENVIRONMENTAL DESIGN GROUP
CAMBRIDGE, MA

PROJECT STAFF

Bob Nicodemus - Vice President

Steve Whitney - Cost Research Director

Wen Chi Chou - Staff Hospital Renovation Design Consultant

FOR THE HUMAN SERVICES RESEARCH INSTITUTE

January 13, 1981

SHEPARD

FIELD DATA:				
	WALL PERIMETER	560	NO. OF BEDS	88
	WALL HEIGHT	24	NO. OF WINDOWS	100
	WALL AREA	11040	NO. OF SPACES	150

RENOVATION COSTS

Windows Estimate 100 @ 300 each	$ 30000.00
Electrical Outlets 4 x 150 x $30	18000.00
Wall Area 11040 x 4 = Paint	44160.00
Floor Covering = Sq. Ft.	26101.00
Elevator @ 180,000	120000.00
3 Stairs, 3 Landings, 9 Doors @ 500	4500.00
Repoint Brick @ 10% of Wall Area x 4	4416.00
Roofing Not Necessary	
Lighting = Sq. Ft.	26101.00
Ventilation @ $15/Sq. Ft.	391515.00
Insulate @ 300 x 150 Spaces	45000.00
Demolition Interior Partitions = Sq. Ft.	88790.00
Plumbing Fixtures @ 1000 Fixture	136000.00
Dropped Ceiling @ 1.5 x Sq. Ft.	39152.00
New Door Every 4 Beds x 500	17000.00
Electric Heat - $12 Per Perimeter Foot x # of Floors	16800.00
Change Floor Panels 100-300A @ 2000 Floors	5000.00
New Partitions $300 Per Bed	40800.00
Smoke Alarms @ $25 Per Space	3750.00
Air Conditioning @ $6 Per Sq. Ft. (Optional)	156606.00
	$1213691.00
Food Services	150000.00
	$1363691.00
Contractors Administrative Profit = 20%	272738.20
CONSTRUCTION COST	$1636429.20
ARCHITECTS & ENGINEERS	163643.00
FURNISHINGS & EQUIPMENT	163643.00
TOTAL COST	$1963715.20

CONCLUSION: SHEPARD HAS ONE OF THE HIGHEST COST PER SQ. FT. YET LOWEST COST PER BED RATIOS OF ALL THE BUILDINGS DUE TO ITS DORMITORY LIKE LAYOUT AND LACK OF AN ELEVATOR.

ESTIMATE 3 YEARS FROM LEGISLATIVE APPROVAL TO OPENING OF ANY BUILDINGS

RUSSELL

FIELD DATA:				
	WALL PERIMETER	1171	NO. OF BEDS	136
	WALL HEIGHT	33	NO. OF WINDOWS	250
	WALL AREA	28343	NO. OF SPACES	150

RENOVATION COSTS

Windows Estimate 150 @ 300 each	$ 75000.00
Electrical Outlets 4 x 150 x $30	18000.00
Wall Area = 27815 x 4 - Paint	111260.00
Floor Covering = Sq. Ft.	54368.00
Stair Tower @ 10,000 + 200 Riser	19900.00
4 Stairs, 4 Landings, 16 Doors @ 500	8000.00
Repoint Brick @ 10% of Wall Area x 4	11126.00
Roofing Not Necessary	
Lighting = Sq. Ft.	54368.00
Ventilation @ $15/Sq. Ft.	815520.00
Insulate @ 300 x 150 Spaces	45000.00
Demolition Interior Partitions = Sq. Ft.	54368.00
Plumbing Fixtures @ 1000 Bed	90000.00
Dropped Ceiling @ 1.50 x Sq. Ft.	81552.00
New Door Every 4 Beds x 500	11500.00
Electric Heat - $12 Per Perimeter Foot x # of Floors	29118.00
Change Floor Panels 100-300A @ 2000 Floors	6000.00
New Partitions $300 Per Bed	27000.00
Smoke Alarms @ $25 Per Space	2250.00
Air Conditioning @ $6 Per Sq. Ft. (Optional)	326208.00
	$1840538.00
Contractors Administrative Profit = 20%	368108.00
CONSTRUCTION COST	$2208646.00
ARCHITECTS & ENGINEERS	220865.00
FURNISHINGS & EQUIPMENT	220865.00
TOTAL COST	$2650376.00

DIX

FIELD DATA:				
	WALL AREA	38112	NO. OF BEDS	200
	NO. OF SPACES	200	WALL HEIGHT	48
	NO. OF WINDOWS	400	NO. OF FLOORS	4

RENOVATION COSTS

Windows Estimate 400 @ 300 each	120000.00
Electrical Outlets 4 x 200 x $30	24000.00
Wall Area 38112 x 4 = Paint	152448.00
Floor Covering = Sq. Ft.	88790.00
Stair Tower @ 10,000 + 200 Riser	24400.00
3 Stairs, 5 Landings, 15 Doors @ 500	7500.00
Repoint Brick @ 40% of Wall Area x 4	60979.00
Roofing Not Necessary	
Lighting = Sq. Ft.	88790.00
Ventilation @ $15/Sq. Ft.	1331850.00
Insulate @ 300 x 200 Spaces	60000.00
Demolition Interior Partitions = Sq. Ft.	88790.00
Plumbing Fixtures @ 1000 Bed	200000.00
Dropped Ceiling @ 1.5 x Sq. Ft.	133185.00
New Door Every 4 Beds x 500	25000.00
Electric Heat - $12 Per Perimeter Foot x # of Floors	48144.00
Change Floor Panels 100A-300 @ 2000 Floors	8000.00
New Partitions $300 Per Bed	60000.00
Smoke Alarms @ 25 Per Space	5000.00
Air Conditioning @ $6 Per Sq. Ft. (Optional)	532740.00
	$3059616.00
Food Services	152951.00
	$3212597.00
Contractors Administrative Profit = 20%	642519.00
CONSTRUCTION COST	$3855116.00
ARCHITECTS & ENGINEERS	385512.00
FURNISHINGS & EQUIPMENT	385512.00
TOTAL COST	$4626140.00

BEERS

FIELD DATA:	WALL AREA	18871	NO. OF BEDS	111
	NO. OF SPACES	150	WALL HEIGHT	44
	NO. OF WINDOWS	200	NO. OF FLOORS	4

RENOVATION COSTS

Windows Estimate 200 @ 300 each	$ 60000.00
Electrical Outlets 4 x 150 x $30	18000.00
Wall Area 18871 x 4 = Paint	75484.00
Floor Covering = Sq. Ft.	40275.00
Stair Tower @ 10,000 + 200 Riser	23200.00
2 Stairs, 5 Landings, 10 Doors @ 500	5000.00
Repoint Brick @ 10% of Wall Area x 4	7548.00
Roofing Not Necessary	
Lighting = Sq. Ft.	40275.00
Ventilation @ $15/Sq. Ft.	604125.00
Insulate @ 300 x 150 Spaces	45000.00
Demolition Interior Partitions = Sq. Ft.	40275.00
Plumbing Fixtures @ 1000 Bed	100000.00
Dropped Ceiling @ 1.5 x Sq. Ft.	60412.00
New Door Every 4 Beds x 500	12500.00
Electric Heat - $12 Per Perimeter Foot x # of Floors	25728.00
Change Floor Panels 100-200A @ 2000 Floors	8000.00
New Partitions $300 Per Bed	30000.00
Smoke Alarms @ 25 Per Space	3750.00
Air Conditioning @ $6 Per Sq. Ft. (Optional)	241650.00
	$1441223.00
Food Services	72061.00
	$1513284.00
Contractors Administrative Profit = 20%	302669.00
CONSTRUCTION COST	$1815953.00
ARCHITECTS & ENGINEERS	181595.00
FURNISHINGS & EQUIPMENT	181595.00
TOTAL COST	$2179143.00

CONNECTICUT MENTAL HEALTH FEASIBILITY STUDY COST ESTIMATES

PRESENT OPERATING COSTS

FACILITY	ELECTRIC	HEAT	TOTAL	TOTAL SQ.FT.
CONNECTICUT VALLEY				
Regional Laundry	59650	48052	107702	41424
Riverview Childrens	56633	46635	103268	78685
Whiting Forensic	62640	50460	113100	87000
NORWICH				
Regional Laundry	44640	35960	80600	31000
Regional Transit	30000	-----	30000	20000
Ribicoff	22980	18512	41492	31917
FAIRFIELD				
Regional Laundry	36790	29636	66426	25548
Non Meadow E	16027	12911	28938	22260
Nor Meadow W	16027	12911	28938	22260
Housatonic	52430	42241	94671	72830

TYPICAL SEWAGE	MAINT	MAT	ELECT	TOTAL
Treatment Plant	53000	12000	10000	75000

CONNECTICUT MENTAL HEALTH FEASABILITY STUDY COST ESTIMATES

CAPITAL RENOVATION COSTS

FACILITY	BOILER	CONTROLS	ELECTRIC	TOTAL
CONNECTICUT VALLEY				
Regional Laundry	15000	10000	10000	35000
Riverview Childrens	10000	12000	10000	32000
Whiting Forensic	20000	12000	10000	42000
NORWICH				
Regional Laundry	15000	10000	10000	35000
Regional Transit	-----	-----	7000	7000
Ribicoff	10000	10000	10000	30000
FAIRFIELD				
Regional Laundry	15000	10000	10000	35000
Non Meadow E	15000	14000	5000	34000
Non Meadow W	15000	14000	5000	34000
Housatonic	12000	10000	10000	32000

TYPICAL SEWAGE	ELECTRIC HOOK UP	OTHER CHANGES	TOTAL
Treatment Plant	20000	20000	40000

CONNECTICUT MENTAL HEALTH FEASABILITY STUDY COST ESTIMATES

FACILITY	CURRENT CHARGES/ PROJECTED USAGE	ALTERNATIVE UTILITY COSTS FUEL	ELECTRIC	TOTAL	PERCENTAGE INCREASE PRESENT
CONNECTICUT VALLEY					
Regional Laundry	Very High	62000	50000	112000	+04%
Riverview Childrens	Below Av.	76765	46058	122823	+16%
Whiting Forensic	Medium	82000	50000	132000	+14%
NORWICH					
Regional Laundry	Very High	50000	34000	84000	+ 4%
Regional Transit	Low	-----	30000	30000	Same
Ribicoff	Medium	36000	12000	48000	+14%
FAIRFIELD					
Regional Laundry	Very High	38400	30600	69000	+ 4%
Non Meadow E	Above Av.	21000	10500	31500	+ 8%
Non Meadow W	Above Av.	21000	10500	31500	+ 8%
Housatonic	Low	74108	44466	118574	+20%
TYPICAL SEWAGE	MAINT	MAT	ELECT	TOTAL	
Treatment Plant	60000	15000	15000	90000	+17%

TABLE II I. 4

ESTIMATED COST OF CURRENT AND ALTERNATE
POWER SYSTEMS FOR SELECTED HOSPITAL BUILDINGS

	Current Operating Costs		Capital Conversion Costs		Alternate Power System Operating Costs	
ital/Building	Heat	Elect.	Heat	Elect.	Heat	Elect.
nnecticut Valley Hospital						
Regional Laundry	48,052	59,650	~~15,000~~	10,000	~~72,000~~	50,000
Riverview Children's Center	46,635	~~56,643~~	22,000	10,000	76,765	46,058
Whiting Forensic Institute	~~62,640~~	50,000	32,000	10,000	82,000	50,000
Sewage Treatment Plant	--	70,000	--	40,000	--	90,000
Fairfield Hills Hospital						
Regional Laundry	29,636	36,790	15,000	10,000	38,400	~~24,000~~
Housatonic Adolescent Hospital	42,241	52,430	22,000	10,000	74,108	44,466
Newtown Housing for the Elderly	25,822	32,054	58,000	10,000	42,000	21,000
Sewage Treatment Plant	--	70,000	--	40,000	--	90,000
Norwich Hospital						
Regional Laundry	35,960	44,640	25,000	10,000	50,000	34,000
Regional Transit Center	--	--	--	7,000	--	30,000
Ribicoff Research Center	18,512	22,980	20,000	10,000	36,000	12,000
Sewage Treatment Plant	--	75,000	--	40,000	--	90,000

TABLE III G. 1b

HOSPITAL RENOVATION COSTS:
INTER-HOSPITAL STRATEGY
PROJECTED 1982-83

Hospital Building	Capacity: Total Available Bed Capacity	Capacity: Existing Bed Capacity	Capacity: Additional Bed Capacity Required	Architect and Engineering Fees[c] @ 10% of a	Construction Costs[a] (INCLUDES GENERAL & ADMIN PROFIT) Total	Construction Costs[a] Cost Per Bed	Total Cost a+b+c	Funds[b] Expended @ 10% of a
Connecticut Valley Hospital: Total	1,186	684	502	951 615 ~~16,000~~	9,516 144 ~~10,580,265~~	22,743 (AVE)	11,419,374 ~~10,696,265~~	951,615 ~~16,000~~
Shepard Hall	75		75	163,643 ~~3,500~~	1,626,421 ~~1,819,072~~	21810 -24,265	1963 715 ~~1,823,372~~	163,643
Woodward Hall (new)	52	52						
Leak Hall	32	32						
Dutcher Hall	144	144						
Battell Hall	186	186						
Merritt Hall	258	258						
Dutton	12	12		220 865	2,208,646	16,240	2 650 376	
Russell Hall	136		136	~~4,000~~	~~2,544,350~~	~~18,708~~	2,548,350	220,865
Weeks Hall (new)				385,512	3,955,116	21,417	4 626 140	
Dix Hall	180		180	~~5,000~~	~~4,288,148~~	~~23,823~~	4,293,148	385,512
Beers Hall	111		111	~~3,500~~ 181595	~~2,027,895~~ 1,815,953	~~18,269~~ 16,36	~~2,031,395~~ 2179 143	181,595

CONSTRUCTION COSTS / REMODELING WITH & FOOD SERVICE

[a] Includes the cost of air conditioning, PLUS 20% FOR CONTRACTORS ADMINISTRATION, PROFIT & OVERHEAD

[b] Architect and engineering fees HAVE BEEN FIGURED @ 10% OF CONSTRUCTION COSTS

[c] FURNISHINGS HAVE BEEN FIGURED @ 10% OF CONSTRUCTION COSTS

D NO AMOUNT HAS BEEN INCLUDED FOR CONTINGENCIES OR INFLATION. ALL FIGURES ARE IN 1980 DOLLARS

APPENDIX D

LIST OF REFERENCES

PERTAINING TO QUALITATIVE IMPACTS

OF CLOSING A MENTAL HOSPITAL

SELECTED REFERENCES

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