

E X E C U T I V E S U M M A R Y

The Utility of Trouble

Maximizing the Value of Our Human Services Dollars

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

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Massachusetts Taxpayers Foundation

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Executive Summary

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

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

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

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

The analysis in this paper focuses on the seven largest human services agencies within the EOHHS: the Departments of Mental Health (DMH), Public Health (DPH), Transitional Assistance (DTA), Children and Families (DCF, formerly the Department of Social Services), Developmental Services (DDS, formerly the Department of Mental Retardation) and Youth Services (DYS), as well as the Massachusetts Rehabilitation Commission (MRC). MassHealth, the Commonwealth's Medicaid program, is included in some of our

analysis, but does not use area or regional offices or operate institutions.

Recommendations

- I. EOHHS should consolidate its 149 individual area offices into 20 to 24 comprehensive EOHHS centers serving consistently defined service delivery areas, which would save approximately \$15 million annually and improve services to clients.
- II. The Department of Developmental Services and Department of Mental Health should close ten antiquated and expensive institutions, which would reduce an estimated \$50 million in expenditures annually and ensure that all clients can live, receive services and participate in their communities near their families.

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

What are the human services addressed in this paper?

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

Recommendation I: Standardize Service Delivery Areas and Consolidate Area Offices

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

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

Realizing Economies of Scale. With 149 local offices, many of them quite small, the state is unable to take advantage of economies of scale or share common resources or space. For example, each office needs space for meeting with clients, providers or community organizations, and each office requires telecommunications and other office equipment. In addition, a recent study² found that square footage allowances in many locations exceed industry standards. Combining area offices would create savings through shared space and resources, while reducing management and administrative staffing. Twenty to 24 standard areas, each served by a comprehensive office including all EOHHS area staff, would be an appropriate balance between providing geographic accessibility for clients and cost effectiveness for the state.

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

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

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

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

TABLE 1

Savings from Consolidation of EOHHS Areas Offices

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

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

Recommendation II: Closure of Antiquated Institutions

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

Providing a Life in the Community for People with Disabilities. Forty years ago, Massachusetts was a leader in closing institutions to serve people in the community, but we have now fallen behind other states. Today human services systems strive to serve people in the least restrictive setting that meets their needs. Indeed,

states are now required to implement the U.S. Supreme Court's 1999 *Olmstead* decision³ mandating that they provide community-based services rather than institutional placements for most individuals with disabilities.⁴ Most other states in New England—Maine, Vermont, and New Hampshire—serve people with developmental disabilities solely in the community, and Connecticut operates just one institution. In addition, new psychiatric treatments have drastically improved the prospects of people with serious mental illnesses over the past

TABLE 2

Massachusetts State Institutions: FY2009

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

Calculation error due to rounding.

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

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

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

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

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

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

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

TABLE 3

Comparative Costs of Institution and Community Care

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

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

Projected Cost Savings

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

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

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

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

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

demolition and remediation costs for vacating Westborough. DMH is building a new 320-bed facility on the grounds of Worcester State Hospital to be opened in 2012. At that time, DMH should close the 60-bed Lindemann Center (in downtown Boston) and move those clients to Worcester. This will allow for the transfer of operating funds to the new facility, but there would be minimal savings. DMH should then determine how best to reduce capacity at its remaining facilities to reach a total of approximately 626 beds.

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

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

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

TABLE 4
Cost Savings from Present and Future Institutional Closures After Investment in Community Care (\$ Millions)

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

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

Conclusion

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

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

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

