

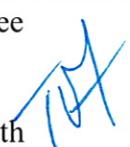
Thomas O. Forslund, Director

Governor Matthew H. Mead

MEMORANDUM

Date: November 1, 2014

To: Joint Labor, Health and Social Services Interim Committee
Joint Appropriations Committee

From: Thomas O. Forslund, Director 
Wyoming Department of Health

Subject: Facilities Task Force - Interim Report

Ref: F-2014-592

House Enrolled Act 41, the General Government Appropriations bill passed by the Sixty-Second Legislature in the 2014 Budget Session, established a Joint Executive and Legislative Task Force on Department of Health Facilities. Section 329(d) states:

(d) The task force shall develop findings, strategies and recommendations on the use, populations served, services offered, capital construction requirements, consolidation or closure of individual buildings, financing and proposed timeline for facility demolition or improvements of department of health institutional facilities. While developing the findings and recommendations required under this subsection, the task force shall meet at least once in Buffalo, Evanston and Lander. These meetings shall be open to the public. The task force shall meet as necessary to timely accomplish the following assignments:

(i) On or before May 15, 2014, provide the joint appropriations interim committee and the joint labor, health and social services interim committee an outline of the objectives, timelines and deliverables of the task force;

(ii) Provide an interim report on the activities of the task force to the joint appropriations interim committee and the joint labor, health and social services interim committee not later than November 1, 2014;

Attached is the report that fulfills the legislative mandate specified in 329(d)(ii).

TOF

c: Governor Matthew H. Mead
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Task Force on Department of Health Facilities

**Report to the Joint Appropriations Interim Committee and
Joint Labor, Health and Social Services Committee**

Interim Report - the Missions of Department of Health Facilities

Prepared by:

**Mr. Joseph Gallagher
Chairman**

Task Force on Department of Health Facilities

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November 1, 2014

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Section 1. Executive Summary

During the 2014 Budget Session, the Wyoming Legislature established a Joint Executive and Legislative Task Force on Wyoming Department of Health Facilities. The originating legislation specified that the Task Force provide an interim report on its activities to the Joint Labor, Health and Social Services Interim Committee and the Joint Appropriations Interim Committee by November 1st, 2014.

This report provides four options for the use, populations served and services offered for the five facilities operated by the Department of Health -- the Wyoming State Hospital (WSH), the Wyoming Life Resource Center (WLRC), the Retirement Center (WRC), the Veterans' Home (VH) and the Pioneer Home (PH).

The Task Force recommends that one option be selected by the Governor and Legislature, so capital construction requirements can be determined in detail.

Options Developed by Task Force

During its meeting in Casper on October 3, 2014 and its meeting in Cheyenne on October 22nd, the Task Force developed four distinct options – Option 1(a), Option 1(b), Option 2, and Option 3 – to present to the Governor and Legislature concerning the need to integrate care across the State Hospital, the Life Resource Center and the Retirement Center.

For the Veterans' Home, which currently provides only Domiciliary-level care, the Task Force recommends demolition of the non-historic buildings and reconstruction of the facility to include Skilled Nursing Facility level of care. Both Domiciliary-level and Skilled Nursing-level care should be delivered along the lines of the Green House model.

For the Pioneer Home, the Task Force recommends studying the privatization or long-term lease of the facility.

For all facilities, the Task Force recommends implementing enterprise fund accounting to show the degree of State General Fund subsidy each facility receives once revenues (e.g. private pay, VA, Medicaid) are accounted for.

Table 1, on the next page, summarizes the options developed by the Task Force for all five facilities. The following information is included in the Table:

- The core populations served by each facility for each option;
- Any facility changes needed for each option, including capital construction as well as changes in populations served and type of care delivered;
- Estimated capital requirements for each option;
- How the Task Force ranked each option in order of preference, and
- Legislation required for each option.

Table 1: Options for State Hospital, Life Resource Center and Retirement Center.

Options	Option 1(a)	Option 1(b)	Option 2	Option 3
	"One campus, long streets"		"Status quo plus upgrades"	"One facility"
Task Force Preference	1	2	3	4
Task Force Vote for Preference	7 for, 1 against	7 for, 1 against	7 for, 1 against	6 for, 2 against
Core Populations	Change population mix to focus on core clients: ABI/DD with exceptionally-difficult behaviors, Title 25 and Title 7 commitments, "gero-psych", high-medical, "hard to place" and emergency placements.		No changes to populations served or patient care delivered. This option is inconsistent with the Task Force "safety net" recommendation.	Change population mix to focus on core clients: ABI/DD with exceptionally-difficult behaviors, Title 25 and Title 7 commitments, "gero-psych", "hard to place" high-medical and emergency placements.
Facility Changes	State Hospital focuses on acute crisis-stabilization.		Implement recommended upgrades to the WSH and WLRC, right-size for the future per the HDR study	Close all three facilities, construct new facility (one campus, multiple licensures) with smaller footprint.
	WRLC focuses on intermediate and long-term care.	WLRC focuses on intermediate care (i.e., discharge plan to community in place).		
	Retirement Center is privatized or closed.	Retirement Center focuses on long-term care.		
Est. Capital Requirements	TBD	\$113,000,000	\$113,000,000	~\$90,000,000
Rank of Est. Cost Savings (Appendix A)	2	3	4	1
Legislation	Appropriation		Appropriation	Appropriation
	Upgrading of employee positions (<5)			Possible Constitutional amendment
	Change to facility missions			Change to facility missions
	Elimination of choice btw. facility and community			Elimination of choice btw. facility and community

Additional Recommendations

- 1. Veterans' Home.** Construct new Domiciliary-level and Skilled Nursing Facility based around the Green House concept. Keep historic buildings, raze remainder.
- 2. Pioneer Home.** Study the potential for privatization/long-term lease of the Pioneer Home.
- 3. All Facilities.** Implement enterprise fund model (i.e. looking to operate in a break-even manner as much as possible, given private pay and Medicaid) under State ownership for the WSH, WLRC, WRC, Pioneer Home and Veterans' Home.

Section 2. Specific Requirements of Statute

The General Government Appropriation bill passed by the Sixty-Second Legislature in the Wyoming 2014 Budget Session as House Enrolled Act 41, states in Section 329:

(a) There is created the joint legislative and executive task force on department of health facilities.

(b) The task force shall be comprised of:

(i) Two (2) members of the senate, appointed by the president of the senate;

(ii) Two (2) members of the house of representatives, appointed by the speaker of the house;

(iii) Four (4) members appointed by the governor. In considering appointments to the task force who are not members of the legislature, the governor shall consider the expertise required to produce timelines, outlines, deliverables and recommendations as provided in this section.

(c) The governor shall appoint a chairman from among the voting members of the task force to preside over meetings.

(d) The task force shall develop findings, strategies and recommendations on the use, populations served, services offered, capital construction requirements, consolidation or closure of individual buildings, financing and proposed timeline for facility demolition or improvements of department of health institutional facilities. While developing the findings and recommendations required under this subsection, the task force shall meet at least once in Buffalo, Evanston and Lander. These meetings shall be open to the public. The task force shall meet as necessary to timely accomplish the following assignments:

(i) On or before May 15, 2014, provide the joint appropriations interim committee and the joint labor, health and social services interim committee an outline of the objectives, timelines and deliverables of the task force;

(ii) Provide an interim report on the activities of the task force to the joint appropriations interim committee and the joint labor, health and social services interim committee not later than November 1, 2014;

(iii) Provide recommendations for legislative action as provided in subsection (g) of this section.

(e) ~~**[The task force shall be staffed by the legislative service office.]**~~ The department of administration and information shall serve in an advisory capacity to the task force and shall provide technical and other relevant information as requested. [BRACKETED LANGUAGE SHOWN IN BOLD AND AS STRICKEN WAS VETOED BY GOVERNOR MARCH 5, 2014.]

(f) The task force shall terminate on December 1, 2015.

(g) Recommendations of the task force created by this section shall be submitted for legislative action to the joint appropriations interim committee and the joint labor, health and social services interim committee not later than November 1, 2015.

(h) The task force may contract with experts as necessary to fulfill the duties assigned under this section upon majority vote of the task force and with the approval of the governor. No contract under this subsection shall be subject to the procurement provisions of W.S. 9-2-1016.

(j)

(i) There is appropriated twenty-five thousand dollars (\$25,000.00) from the general fund to the legislative service office. This appropriation shall be for the period beginning with the effective date of this section and ending December 1, 2015. This appropriation shall only be expended for the purpose of funding salary, mileage and per diem of legislative members of the task force. Notwithstanding any other provision of law, this appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2016;

(ii) There is appropriated two hundred twenty-five thousand dollars (\$225,000.00) from the general fund to the governor's office for the purposes of this section. This appropriation shall only be expended for mileage and per diem expenses of the non-legislative members of the task force and to contract with experts as provided in this section. Notwithstanding any other provision of law, this appropriation shall not be transferred or expended for any other purpose and any unexpended, unobligated funds remaining from this appropriation shall revert as provided by law on June 30, 2016.

(k) This section is effective immediately.

Section 3. Response to Specific Requirements of Statute

Task Force Objectives

As noted in the May 15th outline, the legislative directives for the Task Force separated logically into two sequential phases:

Phase I: Determining the missions for each State-run facility. Missions must specify the “use, populations served [and] services offered” for each facility, as specified in Section 329(d) of the authorizing legislation.

Determining the role of State government in providing facility-level care for vulnerable populations and thereby establishing the specific missions of each WDH facility was the primary public responsibility of this Task Force. In making its decision, the Task Force weighed:

- Defining vulnerable populations.
- The most effective way to provide care to vulnerable populations throughout the State.
- The proper role of the State in providing that care in a facility setting.
- The role of the private sector in providing care.
- The impact of change on facility residents who might be transitioned.
- The economic impact of change on the communities in which facilities are located.

Phase I was further divided into two sequential objectives:

Objective 1: Role of the State. Before determining the mission of each facility, the Task Force gave extensive thought to the proper role of the State in caring for vulnerable populations *generally*. Which populations should be served in a State-run facility setting? What type of care should be provided (crisis stabilization / rehabilitation / long-term care) to each group?

Objective 2: Facility Missions. Once the role of the State was established, the Task Force allocated that role across specific facilities through various options in order to effectively determine each facility’s mission.

Phase II: Develop a work plan; that is, a plan on how to allocate resources to ensure those missions can be accomplished. This “how” includes the “capital construction requirements, consolidation or closure of individual buildings, financing, and proposed timeline for facility demolition or improvements” as specified by Section 329(d).

Purpose of this Report

The purpose of this report is to clarify the mission of each facility by describing its use, the populations served and the services offered, per Section 329(d). In other words, this report establishes options for the ultimate purpose of each facility.

Detailed plans for “capital construction requirements, consolidation or closure of individual buildings, financing, and proposed timeline for facility demolition or improvements ...” will be established in Phase II of this project.

Definitions of Services Offered

This report categorizes services offered at each facility into three broad types of care:

- Acute - Intended for crisis stabilization. Generally short-term.
- Intermediate - Post-acute rehabilitation. Discharge plan to the community in place.
- Long-term - Extended services to maintain functional level. Transition to less-restrictive facility as appropriate.

Role of the State

The Task Force recommends that the role of the State be that of a “safety net” provider; i.e., the State should not compete with the private sector for care provision outside of the “safety net.”

The “safety net” concept refers to the State’s obligation to ensure access as a provider of last resort to facility-level services for those individuals who would otherwise be critically endangered or a threat to public health and safety.

In this framework, the Task Force recommends that the State should have a role in providing facility-level services to the following populations:

- Individuals with Acquired Brain Injuries or Developmental Disabilities who manifest exceptionally-difficult behaviors;
- Title 25 involuntary civil commitments;
- Title 7 forensic psychiatric cases;
- Geriatric-psychiatric clients;
- Clients with high medical needs;
- “Hard to place”¹ clients; and
- Emergency placements.

¹ An example of a “hard to place” client would be an individual in need of Skilled Nursing services, but is rejected from private nursing homes due to a history of sex offenses.

A more detailed matrix by population and type of care can be seen below. Dark shaded boxes indicate that the State should maintain a facility for that population at that type of care.

Table 2: Recommended role of the State

	Type of Care		
	Acute	Intermediate	Long-term
Acquired Brain Injury			
Adult Developmental Disability			
Child Developmental Disability			
Dual-diagnosed (MH/DD-ABI)			
ABI/DD with exceptionally difficult behaviors			
Severe and Persistent Mental Illness (SPMI)			
Non-SPMI			
Title 25 - Civil Commitments			
Title 7 - Forensic Psych			
Gero-psych			
High Medical			
Medium Medical			
Low Medical			
“Hard to place”			
Emergency placements			

Note in the table above that the Task Force believes the State should not play a role in providing direct facility-based services to ABI, DD, or dually-diagnosed individuals who do not manifest exceptionally difficult behaviors.

Similarly, the State should not provide direct facility-based services to individuals with mental illness who have not been involuntarily committed under Title 25, Title 7 or a court order. All of these populations are better served by providers in the community.

While the State should continue its financial support for these populations, it is not the role of the State to run a facility for their care.

Legacy Population

The Task Force defines the “legacy population” as the current residents of the Wyoming Life Resource Center (as of October, 2014). Where other current facility residents may be able to transfer between facilities (e.g. Retirement Center to WLRC) during a transition, current WLRC clients are too fragile to transfer.

Under no circumstances, therefore, does the Task Force recommend forced transition of any of these residents.

Facility Missions

The Task Force proposes that the Legislature consider four options for clarifying the mission of the State Hospital, the Life Resource Center and the Retirement Center.

These options are listed in order of Task Force preference.

Option 1(a): “One Campus, Long Streets”

This option integrates acute, intermediate and long-term care across the Wyoming State Hospital and the Wyoming Life Resource Center.

The Wyoming State Hospital would focus on acute crisis stabilization and the Wyoming Life Resource Center would focus on intermediate and long-term care. The same “safety net” populations listed on page 5 would be prioritized under this option.

In this option, the Wyoming Retirement Center would be privatized or closed.

This option was ranked number 1 in order of preference by the Task Force.

The Task Force believes that restricting populations to the “safety-net” criteria will require some consolidation. Specifically maintaining a facility in Basin to provide long-term care to a handful of “high medical” and “gero-psych” clients will likely not be cost-effective. Additionally, Basin is one of the more difficult locations to recruit qualified staff for the most difficult clients.

Capital construction requirements are difficult to estimate in this option, due to the need to build a Skilled Nursing Facility at the WLRC.

Populations, Settings and Demand for Option 1(a)

	Type of Care			Estimated Demand
	Acute	Intermediate	Long-term	
ABI/DD with exceptionally difficult behaviors				20
Title 25 - Civil Commitments				55
Title 7 - Forensic Psych				32
Gero-psych				27
High Medical				20
“Hard to Place”				15
“Emergency Placements”				1

Key

- The Wyoming State Hospital
- The Wyoming Life Resource Center

Option 1(b): “One Campus, Long Streets”

In Option 1(b), all facilities would remain in place, but the “safety net” populations would be prioritized and the facilities would specialize in the type of care offered.

Three facilities – the Wyoming State Hospital, Wyoming Life Resource Center, and Wyoming Retirement Center – would work together to treat populations requiring acute, intermediate, or long-term care: hence the concept: “one campus, long streets.” These three facilities’ missions would be changed to focus on populations identified by the Task Force as meeting the state’s “safety net” criteria:

- ABI/DD with exceptionally difficult behaviors;
- Title 25 and Title 7 commitments;
- Geriatric-psychiatric (“gero-psych”);
- “Hard-to-place”, and
- Emergency placements.

The Wyoming State Hospital would focus on acute crisis stabilization; the Wyoming Life Resource Center would focus on intermediate care, and the Wyoming Retirement Center would focus on long-term care.

This option was ranked number 2 in order of preference by the Task Force. Capital construction requirements are estimated at \$113 million for the three facilities.

Populations, Settings and Demand for Option 1(b)

	Type of Care			Estimated Demand
	Acute	Intermediate	Long-term	
ABI/DD with exceptionally difficult behaviors				20
Title 25 - Civil Commitments				55
Title 7 - Forensic Psych				32
Gero-psych				27
High Medical				20
“Hard to Place”				15
“Emergency Placements”				1

- Key**
- The Wyoming State Hospital
 - The Wyoming Life Resource Center
 - The Wyoming Retirement Center
 - WSH / WLRC / WRC as appropriate

Option 2: “Status quo plus upgrades”

This is the status-quo option, though facilities would be “right-sized” in accordance with the Master Plan proposed by HDR Architecture in 2013.

Aside from implementing the upgrades and addressing the capital construction requirements identified by HDR (\$113 million, excluding the estimated costs for the Veterans’ Home), each facility would remain in place, and would serve the same populations and deliver the same types of care.

Note that this option is inconsistent with the recommendations of the Task Force to prioritize the populations served in the State’s “safety net.”

This option was ranked number 3 in order of preference by the Task Force.

Populations, Settings and Demand for Option 2

	Type of Care			Current Demand
	Acute	Intermediate	Long-term	
Acquired Brain Injury				10
Adult Developmental Disability				38
Dual-diagnosed (MH/DD-ABI)				31
ABI/DD with exceptionally difficult behaviors				16
Title 25 - Civil Commitments				36
Title 7 - Forensic Psych				26
Gero-psych				26
High Medical				11
Medium Medical				4
Low Medical				47
“Hard to place”				3
Emergency placements				1

- Key**
- The Wyoming State Hospital
 - The Wyoming Life Resource Center
 - The Wyoming Retirement Center
 - WSH / WLRC / WRC as appropriate

Option 3: “One Facility”

Option 3 is the most drastic: three facilities – the Wyoming State Hospital, Wyoming Life Resource Center, and Wyoming Retirement Center – would be closed. A new facility would be constructed with a consolidated campus and multiple licensures. Caring for the Task Force’s “safety net” populations would be prioritized under this option.

Constructing a new facility to treat Wyoming’s core “safety net” populations would better integrate care across the spectrum of needs (e.g. if a client in intermediate care has a crisis, acute-care staff and facilities would be nearby) and would also be the most cost-effective option.

A new 170-bed facility with only 204,000 ft² (as compared with a combined 1,045,772 ft² for the three existing facilities) would require approximately 60% of the staff. Capital construction requirements are estimated at approximately \$90 million.

This option represents the biggest shock to the system and to the communities where current facilities are located; as such, the option was ranked last in order of preference by the Task Force.

Populations, Settings and Demand for Option 3

	Type of Care			Estimated Demand
	Acute	Intermediate	Long-term	
ABI/DD with exceptionally difficult behaviors				20
Title 25 - Civil Commitments				55
Title 7 - Forensic Psych				32
Gero-psych				27
High Medical				20
“Hard to Place”				15
“Emergency Placements”				1

Key
 New Facility – Consolidated Campus

Wyoming Pioneer Home

The Task Force recommends that the Legislature convene a study of the Wyoming Pioneer Home to examine the potential for privatization or long-term lease of the facility.

The Task Force does not believe that the Pioneer Home, as an Assisted Living Facility, serves as part of the “safety net” described in this report.

Wyoming Veteran’s Home

The Task Force recommends that the historic buildings located on the Veteran’s Home Buffalo campus be kept for posterity, but that a new domiciliary-level and skilled nursing facility (SNF) be constructed on the Buffalo campus based upon the “Green House”² concept. Once constructed, existing non-historic buildings should be demolished.

SNF-level care should further be specified in the statutory mission of the Veterans’ Home.

Capital requirements would have to be studied in more detail; the complexities of the Green House SNF concept, plus the ability to secure construction funding from the Veterans’ Administration make an estimate impossible at this time.

All Facilities

The Task Force recommends implementing an enterprise fund accounting model at all five facilities. This would clearly show the degree of State General Fund subsidy at each facility by showing revenue received balanced against total expenditures, encouraging facilities to operate as close to “break-even” (no SGF subsidy) as possible.

² The Green House concept refers to a model for long-term care designed to feel like a home.
<http://thegreenhouseproject.org/>

Appendix A: Estimates of Cost Savings

Table 1 of the Executive Summary of this report contains an estimated rank of cost-effectiveness for each option, compared against the status quo (Option 2).

Options 1(a) and 1(b) were ranked by examining facility budgets (e.g. closure of the Retirement Center). Option 3, however, required more detailed analysis, which follows.

Option 3: Single Facility Cost Estimate

If the State Hospital, Life Resource Center and Retirement Center were consolidated into a single facility, the Department of Health estimates total annual savings to be between \$26 and \$31 million.

This represents the operating cost of existing facilities less the operating cost of the new facility and the cost of caring for clients who would be transitioned into the community.

While future demands from an aging population may increase requirements on any new facility, these factors do not meaningfully affect annual operating savings -- the three existing facilities would have to expand with increased demand as well.

Generally speaking, savings come from reducing staff by approximately 40%. Staffing requirements are lower in a consolidated facility for two main reasons:

(a) Capacity drops approximately 36% as certain populations are prioritized for facility-based care.

(b) Along with the drop in capacity, the new facility is “right-sized”; ultimately the State goes from maintaining over 1 million square feet across three facilities to approximately 200,000 square feet.

These costs and savings are summarized in the table below:

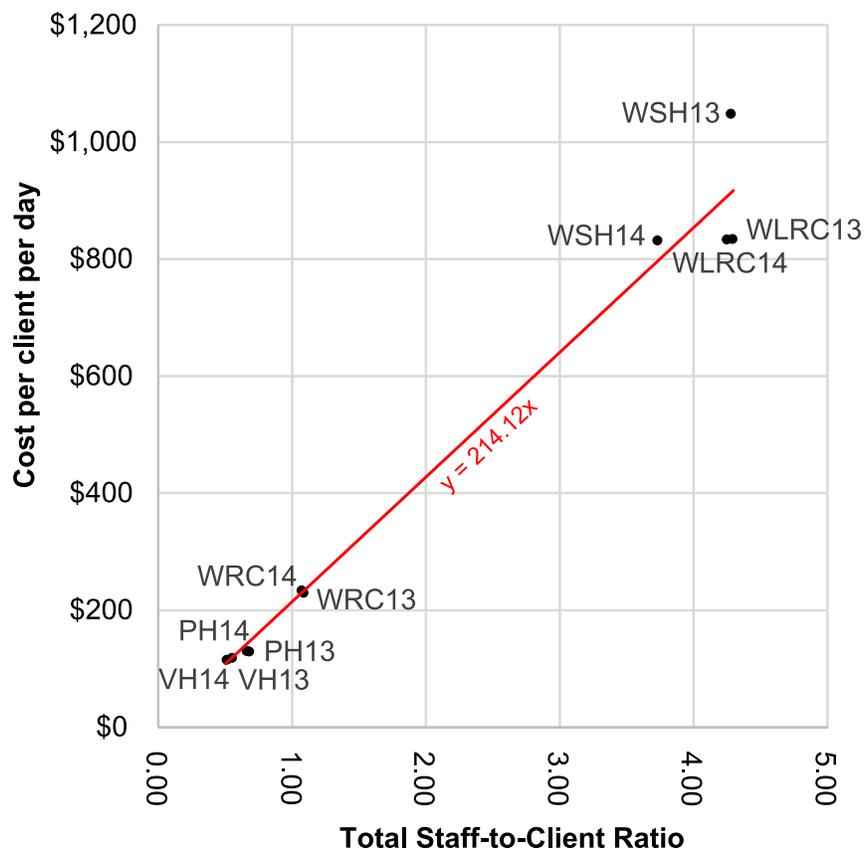
	Current Facilities	New Facility
Annual operating cost	\$71 million	\$35 - \$38 million
Community care cost	N/A	\$5 - \$7 million
Clients served	242	153
Capacity	285	170
Facility size	1,045,772 ft ²	204,000 ft ²
Total staff	783	486

Assumptions

(1) Per-client costs at State facilities are driven largely by personnel. Figure 1, below, compares all five Department of Health facilities by the average (filled) staff-to-client ratio and client cost per day for 2013 and for 2014 year to date, as of the facilities operations report released in April 2014. Totals were averaged across each year in order to ensure a smoother value.

As can be seen in the figure, for every increase in the staff-to-client ratio by 1 at WDH facilities, per-client costs per day are expected to increase, on average, by \$214. A facility with a staff to client ratio of 3:1, for example, would likely have per-client per-day costs of around \$642 ($\214×3).

Figure 1: Association between staff-to-client ratio and client cost per day



(2) Total annual operating cost can therefore be estimated from knowing (a) the number of clients and (b) the total staff-to-client ratio for a given facility, which yields an estimated Cost per Client per Day.

$$[\text{Annual Operating Cost}] = [\text{Cost per Client Per Day}] \times [\text{Number of Clients}] \times 365.24$$

(3) Total staff requirements. Personnel can be divided into five categories, each requirement of which scales according to different factors:

- *Direct Care Staff* are proportionate to number of clients, by client type.
- *Medical Staff* are proportionate to number of clients, by client type.
- *Kitchen Staff* are proportionate to meals prepared (excluding clients that are tube-fed).
- *Operations Staff* are proportionate to total facility square footage.
- *Administrative Staff* are proportionate to total of the other staff categories.

Process

The cost-estimation process begins with the determination of which clients will be served and which will not, estimates the potential mix of clients, determines total facility size based on required number of beds, and ultimately calculates a total operational cost based on the required total staff-to-client ratio.

(1) Determining total number of clients. The total number of clients at the facility depends on the populations served and the total estimated demand in each population group.

(a) Based on the decisions of the Task Force, only the populations shown in Table 2 (page 6 of this report) would be served in the new facility.

(b) Based on these groups, the facility will have an estimated 170 beds and serving 153 clients.

Bed demand and average daily census (ADC) for these populations is estimated in the table on the next page. Psychiatric bed estimates came from the 2023 “right size” estimate of the HDR Architecture report.

“Hard to place,” High Medical and ABI/DD with exceptionally-difficult behaviors were estimated from counts across the system. There are 16 ABI/DD with exceptionally-difficult behaviors, for example, at both the State Hospital and Life Resource Center.

While growth in these populations -- and local communities’ ability to care for them -- are difficult to project into the future, any potential factors affecting bed demand would likely affect the existing three facilities in the same way. Future projections are thus not considered in this analysis.

Table 3: Estimated bed demand and ADC for the new facility

Client Type	Beds	ADC (90%)
Title 25	55	49.5
Gero-psych	27	24.3
Title 7	32	28.8
ABI/DD with exceptionally-difficult behaviors	20	18
High medical	20	18
"Hard to place"	16	14.4
Total	170	152

(2) Facility size. Once total number of beds is known, total square footage can be calculated using the “right size” square footage per bed figure from the HDR report.

In this case, a facility with 170 beds and 1,200 ft² per bed (includes support spaces) would have a total size of approximately 204,000 ft².

Table 4: “Right size” ft²/bed calculation

	WSH	WLRC	WRC
HDR "Right size" ft ²	188,277	103,312	34,774
HDR "Right size" beds	162	86	30
HDR "Right size" ft ² /bed	1,162	1,201	1,159
New facility ft²/bed	1200		

(3) Staff Requirements. As mentioned above, each category of staff scales according to different factors.

(a) Direct Care Staff are proportionate to the number of clients, but different clients have different needs. The State Hospital currently staffs at a total ratio of 1.3 direct care staff per client, which allows a 1:4 ratio for three shifts.

Table 5: Psychiatric Direct Care Staff Ratios

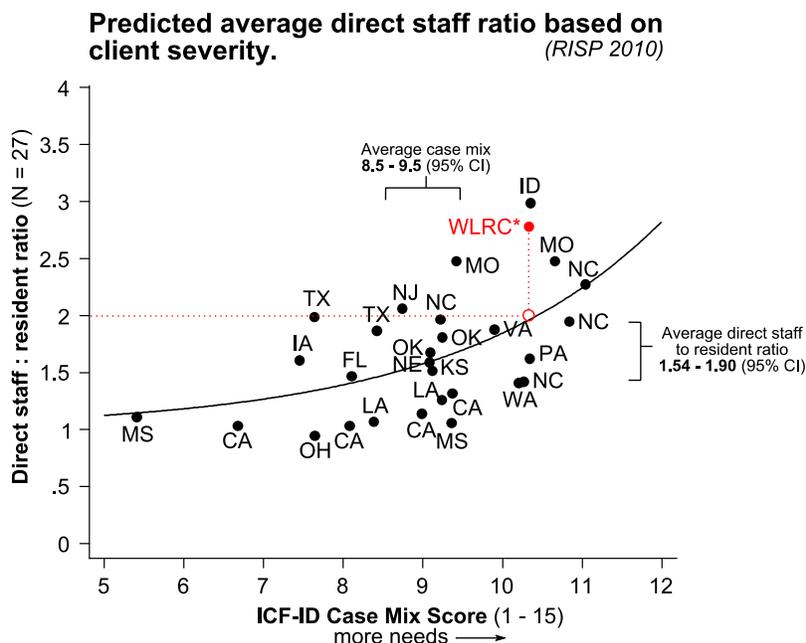
Client Type	Beds	ADC (90%)	Direct Care Ratio	Direct Care Staff
Title 25	55	49.5	1.3 (1:4 x 3 shifts)	66
Geropsych	27	24.3	1.3 (1:4 x 3 shifts)	32
Title 7	32	28.8	1.3 (1:4 x 3 shifts)	38

With the exception of ABI/DD with exceptionally difficult behaviors, the other populations require similar, if lower, direct care staffing ratios.

Table 6: Other Direct Care Staff Ratios

ABI/DD - Behaviors	20	18	2.5	45
High medical	20	18	1.3 (1:4 x 3 shifts)	23
"Hard to place"	16	14.4	1	14

ABI/DD with behaviors have a higher direct care staff requirement because of their unique needs. During the Department's study of the Wyoming Life Resource Center, analysis of direct care staff ratios across Intermediate Care Facilities nationally showed that the average ratio depended on the severity of the client case mix. Because ABI/DD with behaviors are some of the most challenging clients, this analysis estimates a ratio of 2.5 to correspond with a higher case-mix score, as shown in the figure below.

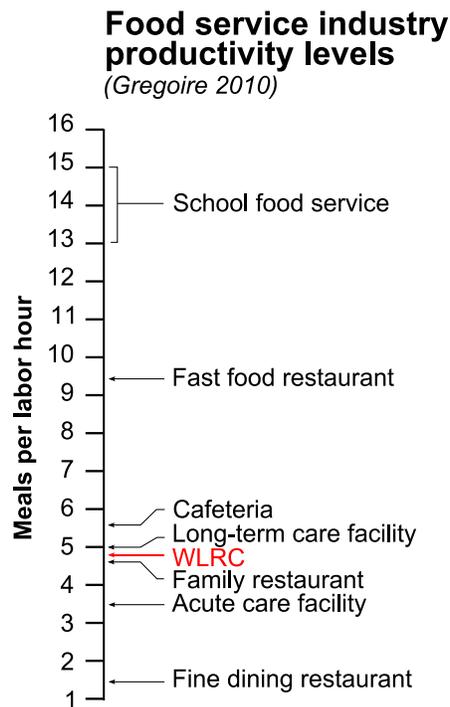


Adding up the direct care staff results in a total of 220.

(b) Medical staff ratios are also proportional to number of clients, but again, different clients have different needs. The current medical staff ratio for psychiatric clients at the State Hospital is 1.2; at the Life Resource Center, it is 0.7.

Applying both of these current ratios to the different populations in the new facilities indicates a required total of 160 medical staff for the 153 estimated clients.

(c) Kitchen staff are proportional to the required number of meals. Assuming that all “high medical” clients are tube-fed, the 135 remaining clients who are served meals will consume approximately 148,000 meals per year. Assuming each kitchen staff works 40 hours per week, 50 weeks per year and has a productivity of 5 meals per labor hour, this results in a kitchen staff size of 15. Staff productivity benchmarks are shown in the figure below. Note that the 5 meals per labor hour is in line with long-term care facility estimates.³



(d) Operations staff requirements are proportional to the square footage of the facility.

Current ratios at the State Hospital and the Life Resource Center are 7136 ft²/FTE and 11,398 ft²/FTE, respectively.

³ Gregoire, M. Foodservice Organizations, A Managerial and Systems Approach. Seventh Edition. Prentice Hall, 2010. pp. 450-451

This analysis uses the more conservative figure of 7200 ft²/FTE to estimate a required operations staff of 28 to maintain and operate the 204,000 ft² facility, assuming that the client mix is more challenging and imposes more wear and tear on the facility.

(e) Administrative staff requirements are assumed to scale with the total number of other staff. At the State Hospital, the current ratio of administrative staff to other staff is 0.15. At the Life Resource Center, it is 0.17.

This analysis uses the lower estimate of 0.15 to estimate a total administrative staff requirement of 64 to support the 424 other staff.

Total estimated staff requirements are summarized in the table below:

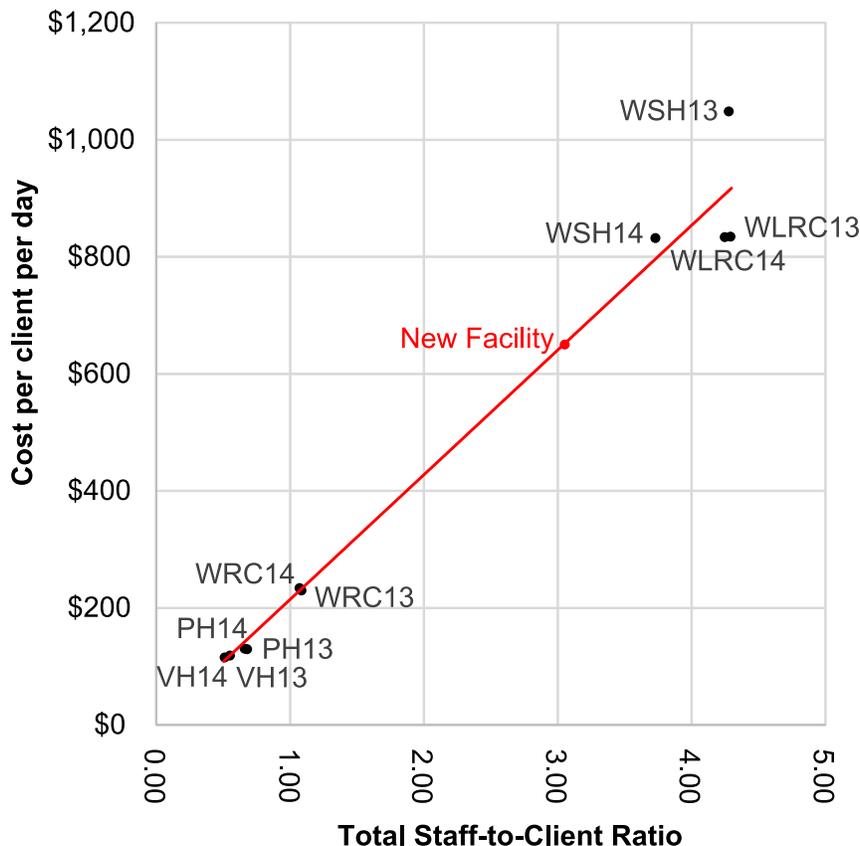
Table 6: Summary of estimated staff requirements

Category	Number
Direct Care	220
Medical	160
Kitchen	15
Operations	28
Administrative	64
Total	486

The 486 total staff for 153 clients results in a total staff:client ratio of 3.2. Efficiencies on administration (e.g. dropping to a ratio of 0.1 administrative staff to other staff) may drop this total to 3.0.

(4) Estimated Total Annual Operating Cost. Using the association (\$214) in Figure 1, a staff:client ratio of 3 - 3.2 results in estimated per-client per-day costs between \$642 and \$684. This is shown in the figure below.

Figure 4: Estimated Per-Client Per-Day Cost of the new facility.



Multiplied by the 153 clients and 365.24 days per year, we estimate total facility operations costs at between \$35 and \$38 million per year.

(5) Cost of clients not served. If only 153 clients are served in the new facility, the remaining 89 clients in the Life Resource Center, State Hospital and Retirement Center must be cared for in the community.

This analysis assumes an average annual cost between \$60,000 and \$70,000 to serve current facility clients in the community. This is slightly above the estimated annual cost of institutional (e.g. Skilled Nursing Facility) Medicaid clients,⁴ and assumes that the

⁴ According to the 2013 Medicaid report, the Aged, Blind and Disabled Institution per-member-per-month (PMPM) cost was \$4,707, or \$56,484. The average PMPM for Home and Community Based Waiver services was \$3,339 in 2013, or \$40,068.

highest-cost (e.g. behavioral, high medical, gero-psych) clients will remain in the new facility.

At \$60-\$70K per client, the 89 clients will cost an estimated \$5-7 million in the community. These costs must be deducted from any potential savings.

(6) Total Savings. If the State Hospital, Life Resource Center and Retirement Center were immediately consolidated into one facility, estimated total annual savings are between \$26 and \$31 million. This estimate is summarized in the table below:

Table 7: Summary of estimated savings

Cost	Amount (millions)
Current facility operations	\$71
(less) New facility operations	\$35 - \$38
(less) Community care cost	\$5 - \$7
Total annual savings	\$26 - \$31