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Utah State Legislature
Executive Appropriations Committee

Feasibility Study on the Privatization of Portions of the Utah State Hospital and the Utah State Developmental Center

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Office of the Legislative Fiscal Analyst
W310 State Capitol Complex
Salt Lake City, UT 84114

PUBLIC CONSULTING GROUP

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EXECUTIVE SUMMARY

Most facilities could benefit from reviewing alternative organizational and operational models; no system is perfect, and systems can learn from the experience and expertise of others. Utah's budget situation demands that all options be explored to make the best use of limited resources. Despite those constraints, the Division of Substance Abuse and Mental Health and the Division of Services for People with Disabilities ultimately remain responsible for the safe, secure, and constitutional operation of care for persons residing in state and privately-operated facilities. The agencies must continue to fulfill those statutory obligations regardless of privatization.

The purpose of this report was for a vendor to conduct a feasibility study to determine whether units within one or both facilities can be operated by a private (non-governmental) entity. To do this, Public Consulting Group (PCG) developed baseline models for the Forensic Unit within the Utah State Hospital (USH) and the Transitional Living Center (TLC) and Woodland units within the Utah State Developmental Center (USDC). These baseline models were constructed to reflect the units' current cost and programmatic operations. Our team then researched peer facilities to develop models by which to compare current operations within the respective units. In addition, PCG talked with stakeholders from across Utah to gather information and feedback on the potential privatization of the units. From that analysis, PCG then created privatization scenarios to examine different ways by which the state could implement privatization[1].

Throughout our analysis, the major hypothesis was whether the units within USH and USDC could be operated by a private entity for the same or less cost, at the same or higher level of service. In the sections that follow, PCG has provided research and modeling that suggest private entities can provide the same level of service at the facilities for the same cost. PCG also found that private firms could provide additional therapy hours to patients at the facilities for a cost savings or at the same cost. However, PCG believes that the cost savings could come with an adverse impact to quality of care for patients, and therefore this may not be an option that the state wants to pursue.

PCG's analysis shows that the primary driver for cost savings may stem from a reduction in overall staff compensation, specifically related to the benefits to salary ratio paid to employees. This reduced ratio of benefits to salary, however, may correlate to staff turnover, which could potentially have a negative effect on the level and quality of the services provided to patients at the units studied. While PCG's report modeling focuses on the quantitative level of services provided, through increasing the quantity of therapy hours to patients, this does not model the quality of the staff or the therapy hours. Quality is not something that can be modeled like cost or hours. Our report, however, strives to get at the underlying question of what quality is. It is important to understand that wholesale staff turnover within these units may come at a risk to the

[1] Please see the respective sections of this report for details on our baseline models, peer facilities, and stakeholder feedback.

quality outcomes and continuity of care for the patients within the Forensic Unit at USH and the TLC and Woodland units at USDC.

Below is a summary of PCG's findings by hypothesis on the feasibility of a private entity operating the units within the scope of this report. As our report will show, PCG did not come to these conclusions without thorough analysis, and many of them are qualified by significant concerns.

Table 1: Findings Summary

Project Hypothesis	USH	USDC
1. Is it feasible for the current level of services provided at the facilities to be provided for the same cost?	Yes	Yes
2. Is it feasible for the current level of services to be improved for a cost savings to the state?	No	No
3. Is it feasible for the current level of services to be improved for the same cost to the state?	No	No

PCG has examined available literature, requested peer state privatization proposals, conducted interviews with facility staff and stakeholders, analyzed other resources on privatization of institutional mental health/forensic and developmental disability services, and talked to state mental health and developmental disability agencies as well as private organizations that operate such units around the country. Our analysis will demonstrate that private entities could potentially provide the same level of services in the units for less cost. For example, the total cost per patient day for operating the Forensic Unit at USH equates to $412.80. Through our analysis, we determined that this cost tends to be higher than peer facility costs. In the case of TLC and Woodland, the total cost per patient day is $643.13, which is in line with peer facility costs. The cost per patient day for both facilities, however, could be reduced by a private entity by altering the benefits to salary ratio that currently exists, to put it more in line with what private entities pay. Such reduction at both facilities would provide considerable cost savings to the state. The benefits-to-salary ratio at the Forensic Unit is equal to 49 percent, where benefits represent 49 percent of total salaries. In a privately operated facility identified by PCG, the ratio is closer to 20 percent. For TLC and Woodland, the benefits-to-salary ratio is 64 percent, as compared with 35 percent in the private sector for comparable positions. By privatizing the forensic staff, USH could realize more than $1.7 million in gross savings, or 11.5 percent of total cost, and through a similar scenario, USDC would realize close to $117,000 in gross cost savings, or 4.2 percent of total cost.

These savings, however, may come at a price. At the end of our research and analysis we were left with one constant in defining quality of service and that is staff. Existing research does not contain sufficient empirical information to account for the effect a privatization change would have on the quality and retention of staff or on the consistency of assignments. However,

substantial existing research shows that both the retention and consistency of staff assignments do impact the quality of services and that a reduction in salary and benefits would adversely affect these key elements that help to define quality of care.[2]

PCG has found that for state employees at USH and USDC, a conversion from a state-operated unit to a private entity could result in a substantial decrease in total compensation, stemming from a reduction in the benefits to salary ratio. A report by the American Civil Liberties Union estimated that most employees would receive a salary reduction of 33 to 45 percent based on privatization of prison facilities.[3] A reduction in the overall compensation for the employees could decrease the demand for jobs at the Forensic Unit at USH and TLC and Woodland units at USDC, which in turn would increase staff turnover.

There is substantial evidence that links wages and benefits with staff turnover and with quality and level of patient care. For example, a 2003 study reviewed issues of recruitment and retention related to the direct support staff and how these issues affect the lives of people with developmental disabilities.[4] The report found that turnover rates and recruitment are a serious problem due to low wages and that high turnover for direct support staff and high vacancy rates have negative consequences for many people who receive supports.

Retention of staff and consistent assignments has long been associated with quality of service in the health care field. For example, Colorado makes incentive Medicaid payments to nursing facilities for improved retention of staff and consistent assignments of staff to patients.[5] A 2008 report commissioned by the Centers for Medicare and Medicaid Services (CMS) found that, for public reporting, a high priority should be placed on registered nurse staffing levels, turnover, and tenure, in addition to licensed staff turnover and tenure.[6] CMS has steadily increased its focus on staffing, and the recently enacted national health care reform bill, House Resolution 3590, requires the federal Health and Human Services Department to report staffing levels in nursing homes on its Nursing Home Compare website, as well as to explain to website users the importance of staffing and quality of care.[7] In addition, the studies in the appendix of this report

[2] See Appendix G for a listing of reports linking quality of care with staff retention and continuity.
[3] ACLU of Texas, *TDCJ White Paper: Privatization of TDCJ Facilities*, 2003 (http://www.aclutx.org/files/TDCJ%20Privatization%20White%20Paper.pdf).
[4] Statewide study of the direct support staff workforce, Intellectual and Developmental Disabilities (IDD) Journal (formerly Mental Retardation Journal) - 2003 Aug;41(4):276-85.
[5] See Colorado regulations at 8.443. Retrieved 8-2-2010 from http://www.sos.state.co.us/CCR/Rule.do?deptID=7&deptName=2505,1305 Department of Health Care Policy and Financing&agencyID=69&agencyName=2505 Medical Services Boar&ccrDocID=2921&ccrDocName=10 CCR 2505-10 8.400 MEDICAL ASSISTANCE - SECTION 8.400&subDocID=50025&subDocName=8.443 NURSING FACILITY REIMBURSEMENT&version=20
[6] Development of Staffing Quality Measures Phase I: Continuation, Final Report – May 2, 2008, CMS Contract: HHSM-500-2005-CO001C; Modification No. CO0027
[7] See sections 6103 through 6107 of H.R. 3590, the Patient Protection and Affordable Care Act. Retrieved on 7-23-10 from http://thomas.loc.gov. Enacted as Public Law No. 111-148.

discuss the relationships among wages and salaries, staff recruitment and turnover, and quality of care.

Some private entities have experienced success privatizing prisons and prison health operations across the United States. Some of those same entities have moved into the treatment of forensic populations, citing similarities in the populations and treatment modalities. Many private entities have also been successful in operating community-based programs or developmental center-type facilities. The difference between the private entities having success with prisons and community-based programs and the feasibility of privatizing the Forensic Unit at USH and the TLC and Woodland units at USDC, is the population characteristics exhibited by those in the units that PCG studied. Prison populations exhibit considerably different characteristics than the complex diagnoses with mental health and substance abuse issues of the patients in the Forensic Unit. Similarly, private community-based programs and developmental centers often do not have the means or semi-secure facilities to appropriately care for patients with the same level and mix of complex co-occurring mental health and medical problems, developmental disabilities, and behavioral issues as those patients seen in TLC and Woodland.

PCG has found that the drive to privatize in many cases stems from the fact that a facility is in "crisis" or having problems with the health or safety of patients, services are not producing required or necessary outcomes, costs related to service delivery are considerably out of line with peer facilities, or there are issues with the management of facilities that leads to inappropriate behavior by staff. PCG has not found these conditions to exist in our analysis of the Forensic Unit or TLC and Woodland units. Our interviews with stakeholders familiar with the USH's operations reveal that the Forensic Unit is well regarded and is perceived to operate efficiently, a perception that was corroborated in the January 2008 legislative audit.[8] Stakeholders interviewed expressed the view that substantive changes to the hospital's operations could result in longer timelines to restore competency, thus affecting what PCG found in our comparative analysis to be a shorter average length of stay than comparable programs. Likewise, the TLC and Woodland units operate in line or better than peer facilities in certain key areas. The effective operating procedures in place at both facilities limit the immediate need to seek alternate management or direct care staff.

PCG understands that change is sometimes necessary, especially when facilities are faced with a crisis. It is important, however, that the drive to privatize focus on a change in programmatic modeling. For example, mental health agencies may develop more community housing and support programs for their populations. Developmental disability agencies may push for more consumer direction, choice, and home and community-based placements, thus limiting the number of institutional beds available. The ability to improve programs and outcomes at a

[8] Office of the Legislative Auditor General, (2008, January), *A Performance Audit of the Utah State Hospital*, Salt Lake City, UT. Retrieved on 8-2-2010 from http://www.le.state.ut.us/audit/08_04rpt.pdf

cheaper cost should ultimately drive privatization efforts, and not cost savings that come at the price of level and potential quality of service.

PCG has developed this report with a balanced, unbiased eye towards answering the Executive Appropriations Committee's (EAC) questions identified in our scope of work. Based on our research, analysis, and the body of evidence before you, PCG does not believe privatizing the Forensic Unit at USH or the TLC and Woodland units at USDC would be in the best interest of the state. PCG's analysis shows that while it is possible to privatize the units at a cost savings, it may result in a reduction in the quality and continuity of care provided to the patients within the units studied. If the state decides to pursue privatization, PCG recommends that clear standards are set which define staffing ratios, minimum clinician licensure levels, and other metrics that ensure that at least the same level of service is provided by the prospective vendor as is currently provided by the facilities in the units under study.

1. BACKGROUND AND APPROACH

A. Project Overview

The Utah State Legislature contracted with Public Consulting Group (PCG) to conduct a feasibility study to determine if the Forensic Unit of the Utah State Hospital (USH) and the Semi-secure Units at the Utah State Developmental Center (USDC) can be operated by a private entity. Through the Request for Proposals (RFP) released in November 2009, the Executive Appropriations Committee (EAC) of the legislature sought a qualified person or entity to:

1. Conduct a feasibility study to determine whether one or both of the facilities (USH Forensic Unit and USDC Semi-secure Units) can be operated by a private (non-governmental) entity in a manner that will result in one of the following:

    a. The provision of services that are currently provided at or for the facilities, at the same cost at which those services are currently provided at or for the facilities.
    b. A savings to the state while providing services at the same level or a higher level than is currently provided at or for the facilities.
    c. The provision of services at a higher level than is currently provided at or for the facilities, at the same cost at which current services are provided at or for the facilities.

2. Advise the Executive Appropriations Committee of the best options and methods to obtain a result described above and the benefits and drawbacks of each option and method.

3. Provide the EAC with a detailed report of the data, assumptions, financial analysis, and other criteria considered in making the determination and rendering the advice described above.

PCG was selected through a competitive procurement and began work in April 2010.

B. Utah State Hospital

USH is a 354-bed psychiatric facility located on a 314-acre campus in Provo, Utah. The facility is operated under the direction of the Division of Substance Abuse and Mental Health, which is overseen by the Utah Department of Human Services. The facility provides residential mental health services to individuals referred there from one of the 11 community mental health centers, to children ages 6 to 18, and to individuals committed by the courts for mental health treatment and/or evaluation.

For purposes of this study, PCG focused only on the Forensic Unit at USH. The hospital is equipped with four maximum security inpatient psychiatric units that provide housing and services to 100 male and female patients. Patients are placed in the facility by court order pursuant to the Utah Criminal Code. Most patients have been found to be not competent to proceed, and therefore, have been ordered to the facility to undergo competency restoration evaluation and/or treatment. Other patients, however, have been adjudicated by the courts and are ordered to the USH Forensic Unit for treatment of their mental illness. USH also has an agreement with the Division of Services for People with Disabilities and the USDC to help treat approximately eight patients within the criminal justice system who are dually diagnosed with mental illness and mental retardation, due to the fact that the USDC facilities are not as secure. The patients admitted to these beds are typically sent by the courts as Not Competent to Proceed. While these patients are not USDC patients, USH works with USDC on discharge planning and programming for these patients due to their dual diagnosis.

USH provides treatment programs and services to patients residing in the Forensic Unit. These services include a combination of medication; individual, group, and family therapy; work opportunities; physical therapy; and occupational therapy, all of which are tailored to meet the patient's specific needs. Discussions with staff and reviews of hospital reports show that USH maintains a robust data system that tracks and reports on the progress of patients. Staff uses this information to evaluate both the effectiveness of treatment plans and the progress towards competency restoration.

C. Utah State Developmental Center

Located in American Fork, USDC is the only state-operated ICF/MR facility in Utah. The Division of Services for People with Disabilities determines eligibility for, and the appropriateness of, placement in USDC based on federal and state criteria. The facility provides intensive residential care and treatment services to each patient on a 24-hour per day, seven days per week basis. Services provided include on-site medical and dental services, recreational programs, physical therapy, assistive technology, speech/audiology services, psychology services, social work, music therapy, food service, sewing room services, security services, volunteer services, employment services, and activities both on- and off-site.

For purposes of this study, PCG focused only on the two Semi-secure Units of USDC, Transitional Living Center (TLC) and Woodland. None of the units at USDC are fully secure or lock-down facilities, but rather they have a level of security that provides for a safe environment for those living in those facilities and those living in other units on the USDC campus. Security at the units includes things such as time-delay locks, higher staffing, and partially fenced areas. TLC houses up to seven teenagers and Woodland houses up to nine adults. Patients may be moved from one facility to another, including from semi-secure to non-secure, non-secure to semi-secure, and semi-secure to semi-secure, based on evaluations and on progress within their treatment plans.

D. National Privatization Efforts

Privatization efforts across the county seem to ebb and flow with the economy. When tax revenues are down, states begin to look for alternative and creative ways to continue to provide services to citizens. Privatization also offers states a means to improve a failing or troubled facility. Privatization, however, is not always the cure-all that state officials are seeking. Very few states have ceded management of entire facilities or separate units within state-operated psychiatric hospitals. It is important to understand that each state-operated facility is unique and it is difficult to identify privatization efforts that focus on similar facilities to both the Forensic Unit at USH and the TLC and Woodland units at USDC.

Psychiatric Hospital Privatization

The results of privatization vary greatly across the country with Florida being one of the few states in which there has been a successful movement towards privatization in both prison facilities and mental health facilities. The Florida Department of Children and Families has contracted with a private entity to run a civil mental health institution, South Florida State Hospital, as well two forensic only mental health institutions, South Florida Evaluation & Treatment Center and Treasure Coast Forensic Treatment Center. State Representative Janet Adkins proposed a study to the Speaker and House leadership to authorize a Florida state auditor's review of the state mental health treatment facilities that have been privatized to examine the impact on clinical care, forensic mental health issues, or use of jails and to determine whether this state policy has met the expectations of the legislature. This study was in response to a push to privatize Department of Children and Families psychiatric hospitals and forensic units in the Jacksonville and Tallahassee area. This report has not yet been released as of July 2010.[9]

Georgia, in January of 2009, and Pennsylvania, in the fall of 2007, issued RFPs to solicit bids to privatize forensic operations in state hospitals and both efforts were stopped before the bidding process was completed.[10]

While its facilities are not currently under privatized operation, Louisiana recently released an RFP seeking a private entity to operate an approximate 82-bed Secure Forensic Facility (SFF) on

[9] See Representative Akin's website http://www.janetadkins.com/news/11309.htm

[10] See Pennsylvania legislative comment to this proposal at http://www.reprapp.com/NewsItem.aspx?NewsID=7611 PCG requested copies of the bids submitted in response to these RFPs. Pennsylvania told PCG that the responses had not been kept and Georgia informed PCG that the bidding was stopped before responses were received. The Georgia request for proposals was posted January 15, 2009, and as of 8-2-2010 was retrievable from http://www.ecplaza.net/tender/14800/privatization_of_ga_regional.html?Country=&pubdate_from=&pubdate_to=10%2F04%2F2010&keywords=&CurPage=18

the campus of the Eastern Louisiana Mental Health System (ELMHS).[11] After review of both the RFP and provider proposals supplied by the state of Louisiana, PCG determined that the level of care at this facility would not be an appropriate match for comparison to that of the USH Forensic Unit. The SFF is to be created as a new program intended to take a selected part of the forensic population at the East Louisiana State Hospital out of a hospital environment and place them into a secure intermediate level of care facility, with the goal of eventually restoring life skills and transitioning patients to a less restrictive or community environment. The main forensic population in the ELMHS would remain under the control of the state. Although this facility will not be comparable to the USH Forensic Unit in terms of overall population and treatment levels, PCG believes that certain points about the privatization process in Louisiana can be considered as valuable background to the question of feasibility in privatizing the forensic population at USH.

The SFF in Louisiana is to be placed at existing facilities on the campus of ELMHS. If the state were to privatize populations at either USH or USDC, it is likely that the existing facilities would also be used. In the privatization process, Louisiana decided to keep all psychiatry, pharmacology, ancillary, capital, security, and other overhead costs under the control of the ELMHS. The private entity will be in charge of only the direct care staff, including nursing and therapy staff, and the administrative staff required to operate the SFF. This option was likely chosen because the care of only a select portion of the forensic population in the ELMHS is to be privatized, and keeping an overall collaborative control on the population remains important for the state of Louisiana. A similar consideration would need to be made in Utah if the state decides to privatize.

Another example of a privatization effort is in Montgomery County, Texas where officials recently agreed to build a 113-bed, $31.8 million forensic mental health facility adjacent to the current county detention center. The facility will house inmates committed by the court, those incompetent to stand trial, and those guilty by reason of insanity. That facility will be completed in March 2011 and will serve an eight-county region. Montgomery County plans to contract with a private entity to operate the facility, much the same as they have for the county detention center, with the expectation that a private entity can operate the facility at a lower cost than if it was run by the county.

Developmental Center Privatization

Unlike psychiatric facilities, ICF/MR facilities, or developmental centers, are frequently owned and operated by private, non-governmental entities. There has been a strong push to lessen the use of institutionalized care and to provide more community-based supports. Approximately

[11] The Louisiana RFP was issued by the Department of Health and Hospitals, Office of Mental Health, on April 15, 2010 and was titled "Secure Forensic Facility for Forensic Residents"
http://www.dhh.state.la.us/offices/publications/pubs-103/SFF%20for%20Forensic%20Residents%20ELMHS.pdf

eleven states have completely closed their state-operated ICF/MR facilities.[12] Two general reasons are cited for these closures: the first is the policy preference that individuals should be served in a community setting; and secondly, that home and community-based services are more affordable.[13] Both Michigan and Kentucky have privatized supports and services. In Michigan, the formerly state-operated Macomb-Oakland Regional Center (MORC) provides services to more than 5,000 children and adults with developmental disabilities. The organization has been operating as a non-profit since 1996, but prior to 1996, MORC operated as a Michigan state agency. In Kentucky, ResCare has been managing the state-owned Outwood ICF/MR in Dawson Springs for fifteen years. Idaho has recently undertaken efforts to transition residents at the Idaho State School and Hospital (ISSH) to the community, including looking at specific strategies for transitioning residents to community placements.[14]

USDC is somewhat unique, however, in that it operates the TLC and Woodland Semi-secure Units within the developmental center, and the populations in those units tend to be those that private providers in the community cannot treat. Typically, community based providers are not equipped to appropriately provide care and services to patients with such complex diagnoses as those who reside in either TLC or Woodland. PCG's research shows only 14 percent of publicly operated facilities offer secure, semi-secure, or forensic units, and it was difficult to find a privately operated facility that treated a similar population to the ones found in TLC and Woodland.

Transition Steps

Through PCG's research into the privatization bids in Louisiana, our teams examined the description of the expected transition process steps as identified by the private entities submitting bids. The main steps that providers outlined included the following:

1. Set up an implementation team.
    a. Assign provider management staff.

[12] Alaska, the District of Columbia, Hawaii, Indiana Maine, New Hampshire, New Mexico, Oregon, Rhode Island, Vermont, and West Virginia have closed all of their public institutions for people with intellectual and developmental disabilities.

[13] The cost effectiveness of community services has been long studied. For example, an early work was the study of closure of the Pennhurst Developmental Center. U.S. Department of Health and Human Services, (1985, March) *The Pennhurst Longitudinal Study*, A report prepared by the Human Services Research Institute, Cambridge, MA. http://www.hsri.org/publication/Pennhurst_Longitudinal_Study_Combined_Report_of_Five_Years_of_Research/ The cost effectiveness of community services spans a large literature and a current example is Kaye, H., LaPlante, M. & Harrington, C. (January, 2009), *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?* Health Affairs, Vol. 28, No. 1 pp. 262-272. An abstract of the article can be found at http://content.healthaffairs.org/cgi/content/abstract/28/1/262

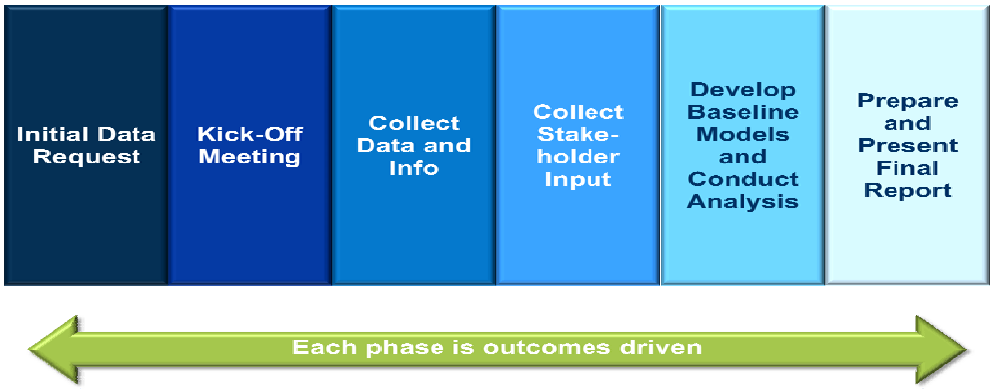
[14] Idaho has adopted a careful methodical planning process. For example, see, retrieved on 6- 24-2010 http://www.icdd.idaho.gov/pdf/Legislative%20Advocacy/ISSH%20Review/ISSH%20Final%20Report_%20Rev-1_27_2010.pdf

   b. Meet with state and hospital staff.
2. Recruitment and retention of employees.
   a. Reach out to current state employees.
   b. Recruit additional staff.
      i. Screening.
      ii. Hiring.
3. Develop implementation plan.
   a. Written plan submitted to state.
   b. Progress reports submitted to state.
4. Employee training and orientation.
   a. Initial orientation and training.
   b. Additional training.
5. Establish program operation policies and procedures.
   a. Operating manual submitted to state.
6. Set up the unit.
   a. Identify existing facilities and equipment.
   b. Determine additional needs.
   c. Develop utilization plan for space.
   d. Develop security policies.
7. Transition of patients.
   a. Identify patients to be transferred.
   b. Meet with hospital staff.
   c. Inform families.
   d. Arrange for transfer admissions.
   e. Set up records.
   f. Develop service plans for each patient.
8. Information transfer.
   a. Hospital staff.
   b. Court system.
   c. Other state officials.
   d. Set up data system.
9. Develop quality assurance program.

The overall estimated time period for setting up and transferring patients appeared to be in the range of several months. These steps and timeframes were developed with regard to a hospital forensic population; however, the general process outline would likely apply to either the privatization of the USH Forensic Unit or the USDC Semi-secure Units. The outline would be important background to consider if the state decides to privatize.

E. Approach

PCG developed an approach to address the scope of work outlined in the procurement and detailed in the preceding sections. The approach has six main steps, as identified in the graphic below, each of which builds upon the previous step. PCG's approach focused on establishing solid baseline models that create an accurate picture of the financial and programmatic elements of operations within the Forensic Unit at USH and the TLC and Woodland units within USDC.



1. Initial Data Request

In April 2010, PCG developed data requests for the Office of the Legislative Fiscal Analyst, USH, and USDC. These requests were designed to provide our team with a broad overview of the facilities. We used this opportunity to familiarize ourselves with the environment and to begin our initial analysis. PCG began collecting utilization and financial data specific to the Forensic Unit at USH and the TLC and Woodland units at USDC. For example, some of the initial information on the data requests included:

- Medicare (CMS-2552) and Medicaid cost reports to document facility based expense, revenue, FTE, utilization, and capacity.
- Medicaid Disproportionate Share Hospital (DSH) payments and reports.
- State Plan Amendment (SPA) for State Operated Psychiatric Hospitals and ICF/MRs.
- Medicaid Provider Tax (if applicable).
- State Mental Health/Forensic Commitment Policy and Regulations.

A complete description of the facility and unit-specific information that PCG requested can be found in Appendices E and F of this report.

2. Kick-off Meeting

In April 2010, PCG had a conference call with the Office of the Legislative Fiscal Analyst to review the work plan, develop a detailed list of contacts, and finalize the project schedule. The

Office of the Legislative Fiscal Analyst aided PCG in identifying key stakeholders and identifying a location for our stakeholder sessions.

3. Collect Data and Stakeholder Input

PCG's data collection process was designed to ensure that the models developed and recommendations presented to the EAC are comprehensive and compliant with all relevant state and federal regulations. Our process began with the collection of the necessary regulatory information. Through this, we documented the state regulations and statutes that pertain to both state-operated and private hospitals and ICF/MRs, as well as applicable statutes pertaining to forensic clients. PCG also conducted a thorough search for any federal regulations relevant to the privatization of hospitals and ICF/MRs, and for the care of clients housed in secure or semi-secure units.

In addition to the regulatory analysis, PCG collected existing process flow charts/maps, regulatory/compliance manuals, operational policies and procedures, FTE counts and roles/job descriptions, organizational charts, budgetary information, and service information related to the units being studied. This combination of information, together with input from stakeholder groups, became the foundation for the baseline models.

Stakeholder Input

PCG has found that stakeholders can provide valuable information about existing processes, the opportunity for improvement, and the system's ability to change. As such, PCG worked with the Office of the Legislative Fiscal Analyst, USH, and USDC staff to identify key stakeholders in the privatization efforts. Our team conducted on-site and telephone interviews with stakeholders throughout May, June, and July 2010 to gather information and to gain a better understanding of the Utah system.[15] The feedback obtained allowed PCG to understand the components of the current system that are working well, along with the identification of those elements that could be improved.

The goal of the interview process was to obtain feedback on three important topics:

1. Perceptions of the overall strengths of USH and USDC.
2. Perceptions of the overall weaknesses or gaps within the current service delivery at USH and USDC.
3. Opinions related to privatization options.

In the following paragraphs, we have summarized our findings and the feedback we received as a result of these stakeholder meetings.

[15] Please see Appendix D for a full list of stakeholders contacted.

Overall Strengths of USH and USDC

The first discussion topic was to identify the overall strengths of USH and USDC. Any recommendations provided by PCG needed to replicate and preserve the continuation of the components of the facilities that are most valued and most effective. PCG gathered this information through a series of meetings and interviews with stakeholder groups. The table below summarizes the strengths expressed by participants.

Table 2: Overall USH and USDC Program Strengths

USH Strengths	USDC Strengths
Staffing: • Relatively low turnover • Quality of staff • Expertise and experience of staff	**Staffing:** • Relatively low turnover • Quality of staff • Works with the families
Assessments: • Comprehensive assessments and tests carried out to determine competency level • Repeated testing • Competency restoration achieved in most cases in timely way • The electronic medical record makes tracking and reporting more efficient	**Assessments:** • Comprehensive evaluations provide staff and families with greater understanding of family member's needs • Assessments provide means to develop individualized treatment plans
Direct Services: • Wide array of services • Competency restoration is at the center • Minimal use of restraints	**Direct Services:** • Wide array of services • Some unique services provided by USDC (horseback riding) • Treatment plans designed for the individual • Persons are served here when they cannot be served in the community
Community Relationships: • Strong volunteer base • Strong relationships with area universities • Respected in community • Cooperation with Provo community	**Community Relationships:** • Strong volunteer base • Effectively place patients in communities, as necessary • Strong family advocates base

Overall Weaknesses of USH and USDC

The second topic discussed with stakeholders was to obtain information about gaps or weaknesses associated with the current service delivery models at USH and USDC. Comments made are summarized in the table below:

Table 3: Overall USH and USDC Program Weaknesses

USH Weaknesses	USDC Weaknesses
Staffing: ▪ Though not seen as a current concern, staff turnover is something to be monitored	**Staffing:** ▪ Though not seen as a current concern, staff turnover is something to be monitored

USH Weaknesses	USDC Weaknesses
Assessments: ▪ Minimal issues with assessments were noted	**Assessments:** ▪ Current assessment and testing practices make it difficult to quantitatively measure progress over time ▪ Generally, paper based records are used
Direct Services: ▪ Minimal issues with staff were noted	**Direct Services:** ▪ Cost of providing the services is perceived as high, in some cases ▪ There is a belief by community providers that some persons served in USDC could be served for less cost in the community
Community Relationships: ▪ Relationships with counties were changed in recent years after Legislative audit findings indicated long wait lists	**Community Relationships:** ▪ Some patient incidents have caused concern for community members ▪ It is not clear to prosecutors how a person with an intellectual or developmental disability can be adjudicated to USDC for competency restoration.

Opinions Related to Privatization Options

The third discussion topic regarded the privatization feasibility options outlined within the RFP. The table below summarizes the key points voiced by stakeholders and shows that the key points are similar regardless of which option was discussed.

Table 4: Opinions Related to Privatization Options

Private Entity Providing Current Level of Services at the Same, or Lower Cost	Private Entity Providing a Higher Level of Service, at the Same or Lower Cost
Staffing: ▪ Quality of staff is crucial ▪ Turnover/retention must be considered	**Staffing:** ▪ Even if the number of staff is increased, quality of staff must be considered ▪ Turnover/retention must be considered
Assessments: ▪ Assurance needed that the same assessment tools would be in place ▪ Measuring outcomes is key	**Assessments:** ▪ Assurance needed that the same assessment tools would be in place ▪ Assessments should be outcomes-driven and focus on progress made
Direct Services: ▪ Increased medication is possible ▪ Increased use of seclusion and/or restraints is possible ▪ Quality of staff is key	**Direct Services:** ▪ To ensure medication is not substituted for treatment, continue to focus on assessments ▪ Increased use of seclusion and/or restraints is possible ▪ Staff numbers may increase, but the quality of staff must be the same or greater

Community Relationships: ▪ Strong community relationships may be jeopardized with private entity ▪ Must continue to work closely with community members, advocates, and family members	**Community Relationships:** ▪ Strong community relationships may be jeopardized with private entity ▪ Must continue to work closely with community members, advocates, and family members

4. Baseline Model Development

Our team used the information gathered in the previous steps to develop an in-depth understanding of the current operations and the budgetary considerations of the Forensic Unit at USH and the USDC Semi-secure Units. PCG then developed baseline models that provide an accurate picture of the cost and programmatic structures in place at the facilities.

Baseline Model for the USH Forensic Unit

In developing the baseline model for the USH Forensic Unit, PCG focused on key elements in the existing service provision.

- Expenditure detail by unit.
  - Fixed, Variable, Semi-Fixed, Semi-Variable.
- Reimbursement detail by unit.
  - State appropriations, Medicare, Medicaid, Medicaid DSH, Commercial.
- Staffing levels by unit.
  - RN to Patient ratios, Mental Health Worker to Patient ratios.
- Utilization by unit.
  - Days, Discharges.
- Capacity by unit.
  - Average Census, Average Length of Stay.

For the development of the baseline model, PCG focused on identifying the expenditure detail. While we were cognizant of the reimbursement details for the USH Forensic Unit, this was not a focal point of our analysis as forensic units are largely non-reimbursable through Medicare and Medicaid. However, potential changes to the cost structure of USH due to a privatization of the Forensic Unit could have an impact on the reimbursement associated with the Child/Adolescent and Adult units at the hospital. For example, Forensic Unit costs are currently included with all inpatient unit costs on the cost report. These costs are used to drive Medicaid reimbursement calculations, and therefore, any significant reduction in these costs could impact reimbursement for the facility as a whole.

Staffing and capacity details were then used to quantify the level of care that is currently provided in the Forensic Unit. We examined the levels and types of service provided at the facility using the following data sources:

- Internal definition and description of services.
    - Written policies and procedures.
- Staffing ratios.
    - Job classifications, shifts.
- Hours of service reported.
    - Individual, Group, etc.
- Outcome descriptions.
    - Test scores and measurements.

PCG met with USH staff to ensure that the baseline model developed provides accurate details on the costs of operating the units as well as the level of care provided in each of its units.

Baseline Model for the USDC Semi-Secure Units

Similar to the baseline model developed for the Forensic Unit at USH, PCG's baseline model for the TLC and Woodland units was developed to isolate those costs and service metrics associated with operating the Semi-secure Units within the facility rather than studying USDC as a whole.

USDC is not required to submit a Medicare cost report; therefore, the fiscal reporting requirements are different from USH. PCG worked with USDC to isolate fiscal year 2009 direct and indirect costs for the TLC and Woodland units, and we included that information in our baseline model. PCG focused on key cost centers based on USDC state reporting requirements such as residential service costs. The baseline model varies slightly from the model developed for the USH Forensic Unit, but this model accurately represents the costs as reported by USDC. PCG's full cost model for TLC and Woodland focused on the following elements of cost:

- Direct Expenditures by Unit (TLC and Woodland).
    - Salary, Benefits, and Patient Care.
- Indirect Expenditures by Unit (TLC and Woodland).
    - Support, Non-direct medical, and Administration.
- Staffing levels by unit.
    - Direct Care, Physician.
- Utilization by unit.
    - Days and Beds.
- Capacity by unit.
    - Occupancy.

PCG used the same methodology used for the USH Forensic Unit programmatic review to review the level of services provided at TLC and Woodland. Our team examined the levels and types of service provided at the units using the following data sources:

- Internal definition and description of services.

  - Written policies and procedures.
- Staffing ratios.
  - Job classifications, shifts.
- Hours of service reported.
  - Individual, Group, etc.
- Outcome descriptions.
  - Test scores and measurements.

PCG talked with USDC staff to ensure that the baseline model developed provides an accurate representation of the costs of operating the units and of the level of care provided in each unit.

5. Comparative Model Development

After completing the baseline models for the Forensic Unit at USH and the TLC and Woodland units at USDC, PCG developed peer facility comparative models to illustrate the range of costs for services and key operating metrics at similar facilities across the country. For the Forensic Unit at USH, PCG used CMS-2552 cost reports for four peer facilities, three of which are state-operated psychiatric facilities with forensic units and one of which is a privately operated, state-owned psychiatric hospital. PCG also looked at other state-operated psychiatric hospitals with forensic units, but was not confident that their available data provided for a complete comparison.

For the Semi-secure Units at USDC, the data for peer facilities was not as readily available as it was for the USH Forensic Unit. To gather peer facility data, PCG researched facilities throughout the country that provided services similar to those provided in the TLC and Woodland units. This research, which is explained at greater length in the appendix H, yielded useful data for four facilities that were included in the peer facility comparative model.

6. Privatization Scenario Development

Once the baseline and comparative models were created, PCG developed models for the options available to the state for privatizing the Forensic Unit at USH and the Semi-secure Units at USDC. The models were created to examine the feasibility of a private entity providing services:

- At or for the facilities at the same cost currently expended for those services.
- At or for the facilities at a lesser cost, but at the same level or a higher level of service than is currently provided.
- At a higher level than is currently provided at the same cost currently expended for those services.

In developing conclusions on the feasibility of privatization, PCG needed to consider three key concepts. The first concept is “feasibility.” As defined by Webster’s Dictionary, “feasible”

means "Capable of being done, executed, or effected; practicable."[16] PCG approached the determination of feasibility in a multi-dimensional way, looking at both the financial and potential organizational consequences of a privatization. In examining the results of our data collection and analyses, PCG used the point of view that a significant change is feasible only when it is feasible on all significant dimensions.

A second key concept is "savings." PCG approached this from an immediate financial perspective. Savings had to be realizable soon; within the next fiscal year. Long-term, less quantifiable savings, such as future reductions in state pension spending, were excluded from the analysis.

The third key concept is that of "higher level of services." There are at least two ways of conceptualizing "higher": qualitatively and quantitatively. Measuring an increase in quality proved to be very difficult. For example, there are no standardized measures for comparing the quality of services across state mental health hospitals or developmental centers. Even if all facilities used the same tests, the characteristics of persons taking the tests would need to be controlled for before differences in test results could be assumed to link to staff practices. Lacking transparent ways to measure quality, PCG's analysis focused on only the quantitative side to "higher" by examining changes in the volume of services provided through increased staff hours or ratios. This one-dimensional view of "higher level of services" is only intended to show if it is possible for additional service hours to be provided. It should not be interpreted as an increase in the quality of services provided.

PCG collected information from peer states and from privately operated hospitals and developmental centers across the country. Comparing that data to the baseline models, as well as considering the above interpretations, PCG developed recommendations outlining the feasibility of privatizing the units within USH and USDC.

[16] Webster's Online Dictionary, retrieved 8-2-10 from http://www.websters-online-dictionary.org/definitions/feasible?cx=partner-pub-0939450753529744%3Av0qd01-tdlq&cof=FORID%3A9&ie=UTF-8&q=feasible&sa=Search#922

2. UTAH STATE HOSPITAL FORENSIC UNIT

A. Utah State Hospital Forensic Unit Financial Baseline Model

Scope and Methodology

PCG was tasked with identifying the cost of providing services and a way to measure service delivery in the Forensic Unit at USH, as well as subsequently determine the feasibility of privatizing this unit. To do this, PCG worked with staff at USH to obtain the financial and service information necessary to show an accurate picture of how this unit operates today. The information includes the development of a Forensic Unit cost report for USH and the identification of services provided by USH. The resulting baseline models reflect the costs and current service delivery within the Forensic Unit at USH for fiscal year 2009.

Utah State Hospital Forensic Unit Cost Report

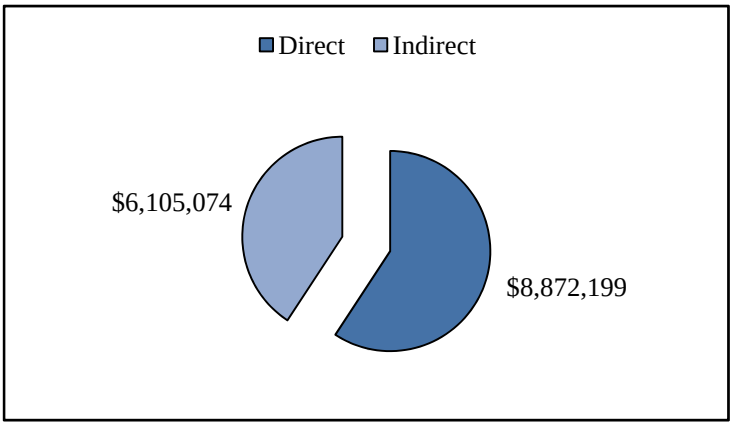
After reviewing the Medicare CMS-2552 cost report, it was clear that the Forensic Unit costs were not discretely broken out from the rest of the inpatient units at the hospital. PCG therefore worked with USH staff to gather the necessary cost, utilization, and allocation data to create a new Forensic Unit cost report in which the Forensic Unit would be broken out from the rest of the inpatient units as a distinct cost center with both direct and indirect costs.

PCG created the Forensic Unit cost report using the documentation provided by USH for the direct costs, then recreated the allocations in the cost report by breaking out items between the forensic and remaining inpatient units for items such as square footage, dietary meals served, and patient days. The resulting cost report allowed for PCG to determine the actual costs associated with the Forensic Unit.

Using the Forensic Unit cost report, the total expenditures for the Forensic Unit equaled $14,977,273, with $8,872,199 in direct expenditures and $6,105,074 in indirect expenditures.[17] The direct expenditures included the salary, benefits, and other expenses directly attributable to the Forensic Unit.[18] The indirect expenditures included the overhead costs of depreciation, administration, plant maintenance and operations, housekeeping, laundry, and dietary. An allocation of ancillary services was also completed to break out the costs for ancillary services like radiology, physical therapy, and pharmacy between the Forensic Unit and inpatient units.

[17] Data Source: Utah State Hospital, 2010.
[18] Please see Appendix E for additional detail on financial data for USH.

Figure 5: FY 2009 Total Expenditures[19]



PCG used the Forensic Unit cost report along with the facility documentation for the staffing plans and salaries to create a baseline model to be used in all comparative analyses. PCG used the new Forensic Unit cost report to break out the direct expenditures, taken from Worksheet A, Column 7 and the indirect expenditures from Worksheet B Part I, Column 27 of the Medicare CMS-2552 cost report. The indirect expenditures were broken out based on the cost centers in the cost report so that each expenditure could be compared discretely to those expenditures of the peer facilities.

Table 6: Utah State Hospital Forensic Costs[20]

	Utah State Hospital
Total Direct (Salary & Other)	$ 244.53
Direct Care Costs per Patient Day	**$ 244.53**
New B&F	$ 6.47
New MME	$ 0.33
Capital Costs per Patient Day	**$ 6.81**
Administration	$ 46.88
Admin Costs per Patient Day	**$ 46.88**
Maintenance	$ 0.18
Plant Operations	$ 17.02
Laundry	$ 1.79
Housekeeping	$ 8.09
Dietary	$ 30.15
Nursing Administration	$ 10.18
Central Service & Supplies	$ 3.44
Medical Records	$ 5.58
Overhead Costs per Patient Day	**$ 76.42**
Radiology	$ 0.59
Physical Therapy	$ 1.31
Drugs Charged to Patients	$ 36.25
Ancillary Costs per Patient Day	**$ 38.15**
Total Cost Per Patient Day	**$ 412.80**

[19] Data Source: Utah State Hospital, 2010.
[20] Data Source: Utah State Hospital, 2010. B&F is Building and Fixtures, MME is Major Movable Equipment.

As indicated in the table above, the total cost per patient day for the Forensic Unit is $412.80. This cost includes direct care, capital, administration, overhead, and ancillary costs for the Forensic Unit.

In addition to the expenditure data, PCG captured the utilization and staffing data for the Forensic Unit at USH. This included the number of beds, patient days, discharges, and number of employees as measured in full time equivalents (FTE). This data allows for comparisons of average length of stay, FTE per bed, and when combined with the expenditure data, cost per patient day.

Table 7: Utah State Hospital Forensic Financial Metrics[21]

	Utah State Hospital
Total Cost	$ 14,977,273
Total Patient Days	36,282
Total Beds	100
Total Discharges	93
Total Direct Care FTE	156.00
Total Cost per Patient Day	$ 412.80
Average Length of Stay	390
Direct Care FTE per Bed	1.56

B. Utah State Hospital Forensic Unit Programmatic Baseline Model

Scope and Methodology

PCG worked with USH to obtain necessary data to develop a method by which to quantify the services currently provided in the Forensic Unit. PCG examined four ways of defining the level of service at the USH Forensic Unit:

1. Description of services.
2. Staffing ratios.
3. Hours of service reported.
4. Outcome descriptions.

Description of Services

To create the foundation for our programmatic baseline model, PCG reviewed the written reports and statements from staff to identify the current services provided to patients in the Forensic

[21] Data Source: Utah State Hospital, 2010.

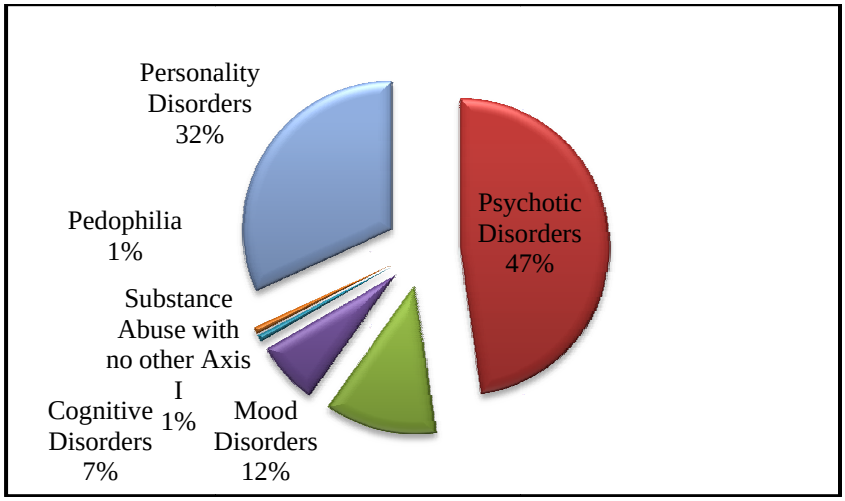
Unit. Utah statutes and regulations outline specifically the role of the Forensic Unit as a means to ensure that persons are mentally competent to participate in their defense and court trial.

The Utah Code of Criminal Procedure at 77-15-5(4)(a) provides a thorough definition for competency[22] and outlines that the individual must demonstrate the following abilities:

- Comprehend and appreciate the charges or allegations against him.
- Disclose to counsel pertinent facts, events, and states of mind.
- Comprehend and appreciate the range and nature of possible penalties, if applicable, that may be imposed in the proceedings against him.
- Engage in reasoned choice of legal strategies and options.
- Understand the adversary nature of the proceedings against him.
- Manifest appropriate courtroom behavior.
- Testify relevantly, if applicable.

Competency restoration, however, is never a straightforward procedure. Persons adjudicated to the Forensic Unit often present themselves with substantial mental health issues. The figure below shows the mental health diagnoses for patients admitted to the Forensic Unit in January 2010. Patients have multiple diagnoses.[23]

Figure 8: Diagnoses of Current Patients[24]



[22] See, retrieved on 6-19-2010 from http://le.utah.gov/~code/TITLE77/htm/77_15_000500.htm
[23] Please see Appendix E for additional detail on programmatic data for USH.
[24] Data Source: Utah State Hospital, 2010.

The table below illustrates the reasons persons were admitted from 2007 through 2009.

Table 9: Reasons for Admittance to Utah State Hospital Forensic Unit 2007-2009[25]

	FY 2007		FY 2008		FY 2009	
	Count	Percent	Count	Percent	Count	Percent
Competency Evaluation	2	2%	0	0%	0	0%
Guilty and Mentally Ill	3	3%	9	10%	10	10%
Prison Transfer	6	6%	9	10%	7	7%
Not Competent to Proceed	84	88%	76	81%	88	84%
Not Guilty by Reason of Insanity	0	0%	0	0%	0	0%
Condition of Probation	0	0%	0	0%	0	0%
Total	**95**		**94**		**105**	

As the table shows, approximately 84 percent of persons were admitted because they were not competent to proceed with their trial. Persons who have the legal status of guilty and mentally ill make up the second largest group admitted to the USH Forensic Unit and are admitted for treatment until they can be safely transferred to community and local mental health programs.

Once patients have been admitted to the facility, the Forensic Unit policy manual outlines specific actions that are designed to achieve the goals of competency restoration and a return to the community.[26] These actions include the following:

- Admission evaluation completed within 8 hours of admission.
- Social work admission note completed within 60 hours of admission.
- Provisional treatment plan completed within 72 hours of admission.
- Social work assessment completed within 14 days of admission.
- Individualized Comprehensive Treatment Plan (ICTP) completed within 14 days of admission.
- Initial competency screening.
- Competency evaluation.

Depending on the circumstances of the person being admitted, Forensic Unit staff may also conduct psychological assessments, neuropsychological assessments, or malingering evaluations. The ICTP is reviewed every 30 days to reevaluate the effectiveness and appropriateness of the treatment plan. Through the ICTP, staff determines the appropriate levels and types of therapy (group, individuals, and milieu), medications, and other necessary actions needed to achieve the goals of the treatment plan.

[25] Data Source: Utah State Hospital, 2010.
[26] Don Rosenbaum, *Utah State Hospital Forensic Services.* A document obtained in May 2010 from the Utah State Hospital administration.

Staffing Ratios

Staffing ratios also play an important role in identifying the level of service currently in place at the Forensic Unit. The Forensic Unit facility consists of four units that can each accommodate approximately 25 patients. As of June 2010, the Forensic Unit employed 156 staff including 21 registered nurses (RN), 12 licensed practical nurses (LPN), and 91 psychiatric technicians (PT).

Additional 2010 staffing data indicates that during the day and afternoon shifts, each of the four units' staff consisted of one RN, one LPN, and four PTs. The unit administrative director, unit clinical director, and unit nursing director were all also scheduled during these shifts. During the night shifts, staffing changed to one RN and two PTs. Two additional PTs are on duty during each shift and assigned to the locked control room.

Table 10: Staffing in a unit of Utah State Hospital Forensic Unit in June 2010[27]

Day Shift		
Registered Nurse	*Licensed Practical Nurse*	*Psychiatric Technician*
1	1	4
Afternoon Shift		
Registered Nurse	*Licensed Practical Nurse*	*Psychiatric Technician*
1	1	4
Night Shift		
Registered Nurse	*Licensed Practical Nurse*	*Psychiatric Technician*
1	0	2

The average daily census during 2009 was approximately 97 patients. Using that data and the aforementioned staffing information, there is a 1:6 staffing ratio during the day and afternoon shifts and a 1:8 staffing ratio during the night shifts. These staffing ratios do not include other therapists, social workers, unit managers, or office staff who may be on duty during these shifts.

Hours of Service Provided

To enhance our baseline model further, our team also examined the number of hours of services that were reported and/or provided to patients at the Forensic Unit. USH has robust data systems that collect, track, and report on a series of measurements, and included in those measurements is the number of hours of group and individual therapy provided. A review of those reports indicates that the Forensic Unit provides approximately 75 hours of service each month to each patient. This service consists of five types of services plus other additional activities provided to patients.

In 2009, the Forensic Unit provided 1,427 hours per week, or 5,708 hours per month, of group and individual therapies. These hours do not reflect all hours of therapy provided in the Forensic

[27] Data Source: Utah State Hospital, 2010.

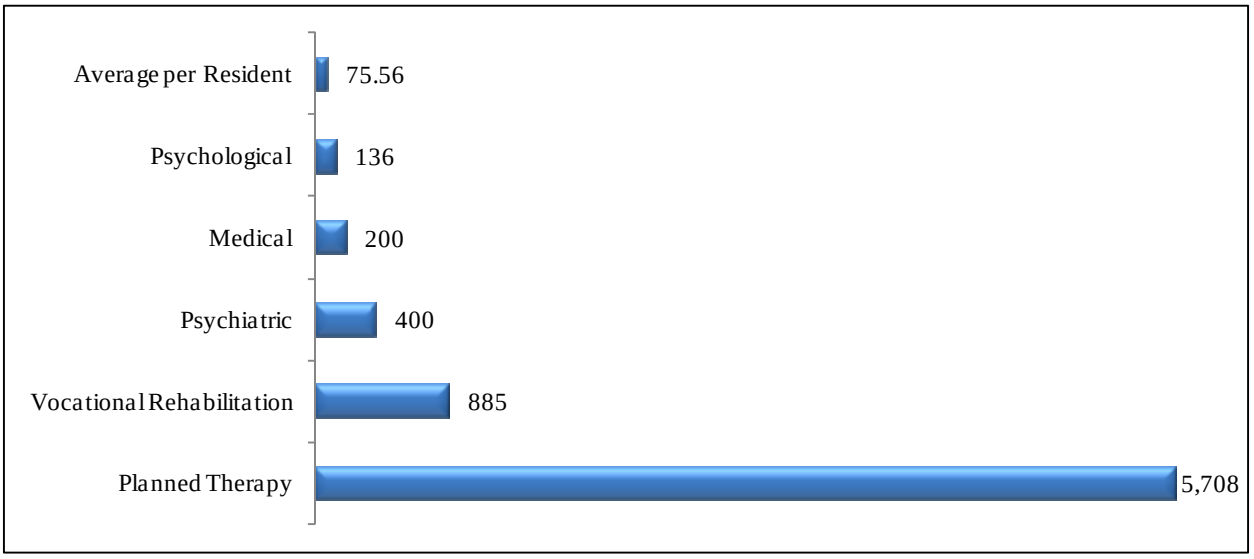
Unit, as the average shown below of 14.71 represents only the weekly hours of services per patient that are captured in the electronic patient record.

Table 11: Average Hours per Week of Planned Schedule Treatment in Utah State Hospital Forensic Unit, 2009[28]

Forensic Unit	Avg. Patient Census	Avg. Hours per Week in Planned Scheduled Treatment
Area 1	22	13.95
Area 2	26	13.76
Area 3	26	12.25
Area 4	26	17.08
Average		**14.71**

In addition to planned hours of therapy, data below shows that the Forensic Unit provided approximately 885 hours per month of vocational rehabilitation treatment and approximately 136 hours of psychological services. The Forensic Unit employs two advanced-practice registered nurses (APRN) who provide nearly 200 hours of care per month for those individuals who have specific medical needs, and the four psychiatrists provide approximately 400 hours of psychiatric care for patients.

Figure 12: Estimated Hours by Type of Service Provided per Month in Forensic Unit[29]



The Forensic Unit also provides additional programming and service opportunities for the patients. On average, there are nearly 85 separate activities accounting for 340 hours per month.

[28] Data Source: Utah State Hospital, 2010.
[29] Data Source: Utah State Hospital, 2010.

These activities include things such as billiards, movies, classes, and social events. Staff estimates that the average patient spends approximately ten hours per month on these activities.

Outcomes Descriptions

Finally, PCG examined the outcomes descriptions to create a complete picture of the current level of service. Outcomes are measured through tests and evaluations. Testing must be done adroitly in the context of a forensic unit as approximately 10 to 15 percent of the patients entering such a unit attempt to portray their mental health symptoms such that they appear to be more severe than they actually are.[30] The Forensic Unit employs multiple mental and social assessment tools, but collects the most data on two specific tests: the Brief Psychiatric Rating Scale (BPRS) and the Severe Outcome Questionnaire. The BPRS measures status on 24 mental constructs such as depression, self-neglect, and elated mood. Staff uses the SOQ test for individuals who have severe psychopathology, with the results being used in conjunction with the individual treatment plans.

USH reports longitudinal data on the results of its testing. The first table below reports on the results of clinical testing using the BPRS and shows that over the three-year period, 2007-2009, an average of 83 percent of those tested showed clinical improvement over time.

Table 13: Clinical Improvement and Declines on the BPRS 2007-2009[31]

	FY 2007		FY 2008		FY 2009		Overall	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Clinical Improvement	67	87.0%	58	80.6%	81	82.7%	206	83.4%
Clinical Decline	4	5.2%	0	0.0%	0	0.0%	4	1.6%
No Change	6	7.8%	14	19.4%	17	17.3%	37	15.0%

The table below shows the results for the SOQ test. The results indicate that over the same three-year period as reported above, an average of 64 percent of those tested with the SOQ showed clinical improvement.

[30] An estimate based on the experience of staff and reported in interviews. This common tendency exists since the consequence of being competent to stand trial is a potential jail or prison sentence.
[31] Data Source: Utah State Hospital, 2010.

Table 14: Clinical Improvement and Declines on the SOQ 2007-2009[32]

	FY 2007		FY 2008		FY 2009		Overall	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Clinical Improvement	38	58.5%	33	60.0%	56	71.8%	127	64.1%
Clinical Decline	26	40.0%	21	38.2%	20	25.6%	67	33.8%
No Change	1	1.5%	1	1.8%	2	2.6%	4	2.0%

In addition to measuring outcomes, USH has a detailed eleven-page quarterly quality assurance report that reviews all charts, patient records, and assessments. This extensive and detailed quality assurance work can also be used as a measurement of process outcomes that a privatization effort must perform.

Programmatic Metrics

Quantifying programs and services is more complex than examining total costs associated with the Forensic Unit. PCG interviewed staff and reviewed available documentation to develop a baseline model for the services provided at the USH Forensic Unit. Based on our analysis, we determined that staffing ratios and hours of service per patient per month provide a means by which to compare the USH Forensic Unit with peer facilities. While these ratios are useful, they do not necessarily account for the quality of service provided. They do, however, provide a way by which to determine whether the quantitative level of service within the facility has changed.

Based on fiscal year 2009 data, USH Forensic Unit has a 1 staff person to 6 patients ratio during the day shift and a 1 staff person to 8 patients ratio during the night shifts. Throughout the course of a month, patients typically receive 75.56 hours of service while housed in the Forensic Unit. Services include group and individual therapy, vocational rehabilitation treatment, and psychological services.

Table 15: Utah State Hospital Forensic Programmatic Metrics[33]

Utah State Hospital	
Total Staff	156.00
Total Services reported per Month	3,058
Total Residents	97
Staff Ratio	1:6 (day shift) 1:8 (night shift)
Services per Patient per Month	75.56

[32] Data Source: Utah State Hospital, 2010.
[33] Data Source: Utah State Hospital, 2010.

PCG used the data outlined in this summary chart as well as the financial metrics through the comparative model development.

C. Utah State Hospital Forensic Unit Comparative Models

Scope and Methodology

PCG leveraged extensive knowledge of the state hospital system throughout the United States to prepare comparative models for peer facilities of the Forensic Unit at USH. The peer facilities selected include state-operated facilities with like unit structures and populations to those within the Forensic Unit.

For the peer facilities, PCG identified state psychiatric hospitals that had forensic units. From there, PCG relied on the CMS-2552 Medicare cost reports for fiscal year 2009, which PCG obtained from each of the facilities. The reports were first reviewed to ensure that the forensic unit costs were discretely broken out from the rest of the inpatient unit costs. If they were not, PCG recreated the cost report to discretely show the forensic unit costs when raw data information was available. While no two facilities are exactly alike, PCG believes that the facilities selected provide for a good comparison because they are similar in structure, have similar patient population characteristics, or have a forensic unit(s):

Fulton State Hospital
Fulton State Hospital is a 475-bed[34] facility operated by the Missouri Department of Mental Health. Of the 475 beds, 201 beds are in the maximum security Biggs Forensic Center and 200 beds are in the Guhleman Forensic Center. The 401 beds in Biggs and Guhleman are for forensic clients committed following an adjudication of Incompetent to Stand Trial, Not Guilty by Reason of Mental Disease or Defect (NGRI), or Pre-Trial Evaluation.

The forensic costs for Fulton State Hospital were not originally identified separately on the cost report, but the report was recreated, similar to USH, using the raw data provided to extract the forensic unit costs. The forensic units were identified in Line 36, Other Long Term Care, of the revised Medicare CMS-2552 cost report. The costs associated with the Department of Corrections (DOC) units, which include two of the units within the Biggs Forensic Center, were not included with the forensic unit costs. These costs were excluded, as the DOC units are not considered part of Fulton's forensic units.

[34] The bed counts used in completing the peer facility analysis were taken directly from the Medicare cost reports. Websites for each facility were reviewed however in some cases these provided conflicting bed count numbers. When conflicting numbers existed, the Medicare cost report data was used as these reports are updated annually and used in Federal Reimbursement calculations.

Florida State Hospital
Florida State Hospital is a 1,230-bed facility operated by the Florida Department of Children and Families. The hospital serves persons 18 years and older who have exhausted the less restrictive available alternatives in the communities and may come through voluntary admissions or involuntary admissions by means of judicial orders. All forensic residents have been committed by the court as Incompetent to Proceed or Not Guilty by Reason of Insanity.

The forensic costs for Florida State Hospital were not originally identified separately on the cost report, but the report was recreated using the raw data provided to extract the forensic unit costs. PCG created Line 29.01, Forensic Unit, to identify these costs within the Medicare CMS-2552 cost report.

East Louisiana State Hospital
East Louisiana State Hospital, operated by the Louisiana Department of Health and Hospitals, Office of Mental Health, is a 600-bed organization comprised of the Jackson and Greenwell Springs Campuses.

East Louisiana State Hospital's cost report had two lines referencing forensic unit costs. Line 96.07, Gabriel Forensic, and Line 100.09, Forensic Unit, were pulled from the Medicare CMS-2552 cost report to determine the total amount of forensic cost at the facility.

South Florida State Hospital
South Florida State Hospital is a 350-bed facility operated by a private entity through a contract with the Florida Department of Children and Families. This facility operates a 55-bed geriatric acute care unit with the remaining 295 beds serving civil mental health commitments. This analysis used data from the Medicare CMS-2552 cost report, found on Line 36, Other Long Term Care, associated with the 295 non-geriatric beds.

While this facility does not include a forensic unit, it was included in the analysis as it was the best example of a privately operated, state psychiatric hospital. The inclusion of South Florida State Hospital allows for a comparison of the cost structure between psychiatric facilities operated by states and one operated by a private company.

Other State Facilities
In addition to the facilities identified above, PCG also researched the feasibility of including additional state psychiatric hospitals with forensic units in the analysis. PCG reviewed other state psychiatric hospitals including the Alaska Psychiatric Institute (API), Bryce Hospital in Alabama, Arizona State Hospital, Wyoming State Hospital, Patton State Hospital in California, and the Hawaii State Hospital. It was determined, however, that these facilities were not appropriate for this analysis for one of two reasons:

1. If they had a Medicare cost report, it was not clear that the forensic unit costs were discretely broken out from the rest of the inpatient units. For API and Bryce Hospital, it

was determined all inpatient unit costs were included in one line and the forensic unit costs could not be easily broken out. For Wyoming State Hospital, inpatient costs were broken out between two cost centers; however, it was determined after speaking with a representative from the facility that the forensic unit was not discreetly identified within either of these cost centers.

2. Hospitals that only serve forensic patients, such as Patton State Hospital and Hawaii State Hospital, do not have Medicare business, and therefore do not complete Medicare cost reports. Data for these facilities was not publicly available for use in this analysis.

PCG completed an analysis of the data included in the Medicare cost reports for USH and the peer facilities noted above. In completing this analysis, PCG focused on three main components that can be gathered from the cost report: cost, utilization, and staffing. PCG's cost analysis was driven by the data included on Worksheet A, Reclassification and Adjustment of Trial Balance of Expenses for Direct Expenditures and Worksheet B Part I, Cost Allocation – General Service Costs from the Medicare CMS-2552 cost report. Utilization and staffing analysis was driven by the data from Worksheet S-3 Part 1, Hospital Statistical Data from the Medicare CMS-2552 cost report.

Peer Facility Cost per Patient Day Comparison

PCG performed a detailed analysis of each facility's cost structure by creating a side-by-side comparison of data from each line of the cost report. The data was converted to cost per patient day-based values to facilitate a comparison between facilities. To standardize the data and account for the geographic differences in cost of living and wages, PCG researched the relative wage indices for each hospital's locality and applied them to the direct care lines for each facility. The wage indices, taken from the CMS Fiscal Year 2009 Inpatient Psychiatric Facility PPS Calculator, were applied to the direct care category only, because this category consists almost entirely of salary costs related to the respective units being studied. The following table shows the wage indices for each facility in the comparison.

Table 16: Wage Indices per Peer Facility

Utah State Hospital	Fulton State Hospital	Florida State Hospital	East Louisiana State Hospital	South Florida State Hospital
0.9557	0.8478	0.9025	0.8034	1.0229

The table below shows the peer facility cost per patient day comparison, with cost report lines grouped into five main categories: direct care costs, capital costs, administrative costs, overhead costs, and ancillary costs.

Table 17: Hospital Cost Comparison[35]

	Utah State Hospital	Fulton State Hospital	Florida State Hospital	East Louisiana State Hospital	South Florida State Hospital
Total Direct (Salary & Other)	$ 255.87	$ 199.47	$ 127.21	$ 321.45	$ 88.51
Benefits	$ -	$ 6.37	$ 50.31	$ 94.33	$ 17.31
Direct Care Costs per Patient Day	**$ 255.87**	**$ 205.84**	**$ 177.51**	**$ 415.78**	**$ 105.82**
New B&F	$ 6.47	$ 4.23	$ 0.93	$ 0.18	$ 2.33
New MME	$ 0.33	$ 1.90	$ 0.93	$ 0.25	$ 1.53
Old Cap B&F	$ -	$ -	$ -	$ 8.86	$ -
Old Cap B&F	$ -	$ -	$ -	$ 14.47	$ -
Capital Costs per Patient Day	**$ 6.81**	**$ 6.13**	**$ 1.86**	**$ 23.76**	**$ 3.86**
Administration	$ 46.88	$ 17.62	$ 36.56	$ 47.48	$ 16.36
Admin Costs per Patient Day	**$ 46.88**	**$ 17.62**	**$ 36.56**	**$ 47.48**	**$ 16.36**
Maintenance	$ 0.18	$ 6.52	$ 8.78	$ 10.82	$ 7.83
Plant Operations	$ 17.02	$ 13.16	$ 13.95	$ 3.94	$ 14.41
Laundry	$ 1.79	$ 3.41	$ 2.77	$ 3.68	$ 2.32
Housekeeping	$ 8.09	$ 11.02	$ 7.19	$ 4.23	$ 7.48
Dietary	$ 30.15	$ 33.33	$ 25.20	$ 24.60	$ 13.25
Nursing Administration	$ 10.18	$ 2.26	$ -	$ 8.93	$ 9.67
Central Service & Supplies	$ 3.44	$ -	$ -	$ -	$ 2.46
Medical Records	$ 5.58	$ 4.58	$ 1.48	$ 5.76	$ 3.51
Social Services	$ -	$ 0.66	$ 0.90	$ 14.57	$ 8.51
Medical Services	$ -	$ -	$ -	$ -	$ 4.44
Physicians	$ -	$ -	$ 3.26	$ -	$ -
Overhead Costs per Patient Day	**$ 76.42**	**$ 74.95**	**$ 63.54**	**$ 76.53**	**$ 73.87**
Activity Recreation Therapy	$ -	$ -	$ -	$ 1.03	$ -
Patient Transport	$ -	$ -	$ -	$ 9.73	$ -
Radiology	$ 0.59	$ 1.55	$ 0.77	$ 0.74	$ 0.57
Laboratory	$ -	$ 1.54	$ 2.72	$ 2.79	$ 1.39
Respiratory Therapy	$ -	$ -	$ 0.59	$ -	$ -
Physical Therapy	$ 1.31	$ 0.16	$ -	$ -	$ 0.54
Occupational Therapy	$ -	$ -	$ 20.38	$ -	$ -
Speech Pathology	$ -	$ 0.20	$ -	$ -	$ 0.17
EKG	$ -	$ 0.06	$ -	$ 0.02	$ -
EEG	$ -	$ 0.09	$ -	$ -	$ -
Pharmacy	$ -	$ -	$ 31.37	$ 11.64	$ 24.61
Drugs Charged to Patients	$ 36.25	$ 34.29	$ -	$ -	$ -
Ancillary Costs per Patient Day	**$ 38.15**	**$ 37.89**	**$ 55.84**	**$ 25.94**	**$ 27.28**
Total Cost Per Patient Day	**$ 424.14**	**$ 342.43**	**$ 335.32**	**$ 589.49**	**$ 227.19**

As shown in the table, the most significant source of cost for the Forensic Unit is the direct care category, which includes mainly salary and benefits of staff related to the Forensic Unit. This is true for all of the facilities, but the Forensic Unit shows a fairly high amount of cost per patient day in this category compared to the peers, with the exception of East Louisiana State Hospital.

[35] Data Source: Medicare CMS-2552 cost reports for each respective facility.

The administration costs per patient day at the Forensic Unit are also slightly high compared to the peer facilities, except for East Louisiana State Hospital; however, the overall amount of cost in this category is much less than in direct care. The other allocated cost categories, including capital, overhead, and ancillary costs per patient day are in line with the average peer facility costs per patient day in each category.

Peer Facility Summary Comparison

The table below shows a higher level comparison of each facility. It includes summary cost and utilization statistics as well as selected comparative ratios, including total cost per patient day, average length of stay, and direct care FTE per bed. Again, cost values shown include the application of wage indices to each facility's direct care cost category.

Table 18: Hospital Metrics[36]

	Utah State Hospital	Fulton State Hospital	Florida State Hospital	East Louisiana State Hospital	South Florida State Hospital
Total Cost	$ 15,388,530	$ 50,532,348	$ 60,158,903	$ 54,762,734	$ 25,078,318
Total Patient Days	36,282	147,569	179,410	92,898	110,387
Total Beds	100	379	620	255	295
Total Discharges	93	174	563	114	299
Total Direct Care FTE	156.00	519.19	663.00	417.00	356.00
Total Cost per Patient Day	$ 424.14	$ 342.43	$ 335.32	$ 589.49	$ 227.19
Average Length of Stay	390	848	319	815	369
Direct Care FTE per Bed	1.56	1.37	1.07	1.64	1.21

As shown in the table, the Forensic Unit is the smallest within the peer facility comparison at 100 beds and 36,282 patient days. However, the three comparative metrics illustrate key points about the Forensic Unit compared to the other peer facilities.

Both the cost per patient day and direct care FTE per bed ratios are the second highest in the group, behind only East Louisiana State Hospital. It is expected that these two ratios would be correlated, because as shown in the previous cost breakdown, direct care costs that include staff salary and benefits make up the majority of each facility's overall cost per patient day. Therefore, a higher direct care FTE per bed ratio would likely be the cause of a higher cost per patient day ratio.

The final metric for the Forensic Unit, average length of stay (ALOS), is the second lowest among the forensic peer facilities. The Forensic Unit is slightly higher than Florida State Hospital, but still shows a value less than half of both Fulton State Hospital and East Louisiana State Hospital. South Florida State Hospital shows a slightly lower ALOS as well, but this facility is non-forensic. The ALOS measure takes into account the number of discharges from the facility in comparison to the number of total patient days. Therefore, a shorter ALOS metric

[36] Data Source: Medicare CMS-2552 cost reports for each respective facility.

suggests that patients are being restored quickly and spending less time in the hospital. This metric is also a function of a strong community support and court system, but reflects well on the performance of the Forensic Unit.

Overall, the analysis marks important points about the Forensic Unit in that it is in the mid to high range of cost and staffing levels when compared with peer facilities. However, the Forensic Unit maintains one of the lower ALOS values among the forensic peers. This implies that patients are restored to competency faster and returned to the judicial system significantly faster than at other forensic facilities analyzed.

Without a national standard for staffing ratios for forensic units at psychiatric hospitals it is difficult to perform an analysis of the staffing ratio at the Forensic Unit other than to say that it is high compared to the peer facilities. It may be possible for the Forensic Unit to reduce their staffing ratios to mirror that of the peer facilities and potentially reduce the direct expenses at the facility; however, this option may come at the price of a reduction in the quality and efficiency of care provided in the Forensic Unit.

D. Utah State Hospital Forensic Unit Privatization Scenarios

After completing the peer facility analysis, PCG developed four scenarios that show options available to the state regarding the privatization of the Forensic Unit at USH. These scenarios also help us to analyze the feasibility of privatizing this unit. Below are the assumptions that PCG is using in the scenarios for the USH Forensic Unit.

Profit

A private entity taking over any portion of the Forensic Unit at USH would be operating that unit at a profit. This means that the overall costs per patient day that are presented in the scenarios have a built-in profit percentage. While this profit percentage could vary among providers, any dollar amount that is taken out for profit can only come at the price of cutting expenses. As a point of reference, PCG researched the proposed budgets of providers responding to Louisiana's Secure Forensic Facility RFP, the state of Louisiana's procurement to privatize a state-run forensic facility. The profits budgeted in these proposals were, on average, 8.17 percent of providers' overall budgeted amounts. It is assumed that private entities in Utah would look for a similar level of profit if they were to consider taking over the Forensic Unit at USH. For modeling purposes, PCG assumes that the profit percentage is included as part of the ratios or fees applied in the scenarios below, and it is not identified separately in our analysis.

Revenue

For all the scenarios below, PCG is assuming that the revenue generated by patient care billing/claiming within the Forensic Unit at USH, although minimal, will be retained by the state.

Private Entity Costs

In calculating the privatization scenarios, PCG utilized the South Florida State Hospital data as the basis for our privatization costs. It should be noted that South Florida State Hospital provides civil mental health services instead of forensic mental health services; however, it was the only privately operated, state-owned mental health hospital for which comparable cost data was publicly available. PCG attempted to identify additional privately run state hospitals; however, this is a small marketplace with little comparable data publicly available. In compiling the following privatization scenarios, PCG did not make any adjustments to the staffing ratios, staffing types, or base salary structure. This was done to acknowledge that, in order to operate the Forensic Unit, a private entity would have to maintain a similar staffing pattern as that currently maintained by USH. Only the costs that would likely be comparable across both the civil and forensic facilities, such as employee benefits, administration, and other overhead, have been modeled based on South Florida State Hospital.

Below are descriptions of four potential scenarios, each including a table showing the difference in cost or service structure between the described scenario and the current condition at the USH Forensic Unit. All privatization scenarios are compared against the current cost as determined in the USH Forensic Unit baseline model and not the cost following the adjustment for a wage index illustrated in the peer facility analysis.

Scenario One: Privatize Forensic Staff Only

The first scenario is to privatize only the staff that is directly related to the Forensic Unit, without reducing staffing levels. As previously mentioned, the cost analysis illustrates that the salary and benefit expenses are the most significant source of cost for the unit. In analyzing the data of the Forensic Unit and South Florida State Hospital, which as previously noted is a state-owned, privately operated psychiatric hospital, it was determined that the benefit structure at the Forensic Unit was significantly greater than that at the privately operated South Florida State Hospital. The analysis found that the benefits, which included health, dental, and life insurance; employer insurance; state retirement; FICA/Medicare tax; and incentive payments at the USH Forensic Unit were approximately 49 percent of total salaries.. At South Florida State Hospital, the ratio of benefits to salaries was approximately 20 percent; however, the break out of what this percent includes was not available at the same detailed level.

In this privatization option, the only piece of the USH Forensic Unit that would be privatized would be direct staff. This would result in all staff being employed by the private entity with the assumption that the salary structure would remain the same, but the benefit structure would be reduced. It is assumed in this scenario that those functions needed to hire and oversee the staff would be provided by the private entity at no initial cost to the state. All other operations associated with the Forensic Unit including administration, plant maintenance and operations, laundry, housekeeping, and dietary would remain the responsibility of USH.

The table below shows a comparison of USH's Forensic Unit current cost summary and the scenario as described. Lines showing privatized costs are highlighted in green.

Table 19: Scenario One: Privatize Forensic Staff Only[37]

	USH Baseline	Scenario One
Direct Care Costs per Patient Day	$ 244.53	N/A
Private Direct Care Costs per Patient Day	N/A	$ 197.21
Capital Costs per Patient Day	$ 6.81	$ 6.81
Admin Costs per Patient Day	$ 46.88	$ 46.88
Overhead Costs per Patient Day	$ 76.42	$ 76.42
Ancillary Costs per Patient Day	$ 38.15	$ 38.15
Total Cost Per Patient Day	**$ 412.80**	**$ 365.48**
Total Cost	**$ 14,977,273**	**$ 13,260,405**

By applying the 20 percent benefit ratio from South Florida State Hospital to the Forensic Unit's total salaries, the direct care costs per patient day are significantly reduced from $244.53 to $197.21. This projects a total cost savings from scenario one of approximately $1.7 million, bringing the total cost of $14.9 million to $13.2 million. While there is a potential for cost savings through the privatization of the staff in the Forensic Unit, there are potential risks associated with such a change. The greatest risk would be that it would be difficult to retain the same staff currently working in the unit with a 50 percent reduction in their benefit structure. Further, it may become difficult to recruit and retain new staff with the lower benefits. The difficulty in retaining current staff and recruiting new staff may pose a risk to the current level of services, and thus quality of care, that is provided in the Forensic Unit. Any privatization proposals that the state solicits should be required to explain how such risks would be minimized.

Scenario Two: Privatize Forensic Staff and Administration

The second scenario is to privatize the direct care staff, as described in scenario one, as well as have the private entity provide the administrative functions related to the Forensic Unit. The administration category, which includes costs such as those for the CEO's office, human resources, billing, and legal, would likely not be significantly reduced through the introduction of a private firm managing the Forensic Unit. These administrative functions would still exist as they currently do and staff would perform the same tasks they currently perform on behalf of USH. Therefore, USH would still incur the same administrative costs as in the baseline model, but there would be an additional management fee from the private entity. For this analysis, PCG estimated this additional management fee at 13 percent of direct care costs.[38] As was the case

[37] Data Source: USH Medicare CMS-2552 and South Florida State Hospital Medicare CMS-2552.
[38] American Health Insurance Plans, (2008, May) .A Shared Responsibility: Advancing Toward a More Accessible, Safe, and Affordable Health Care, System for America, Washington, D.C.
http://www.americanhealthsolution.org/assets/Uploads/ahipaffordability.pdf
The AHIP report states that 13% is the national average administrative cost in its study of health plans.

with the first scenario above, the responsibility for plant maintenance and operations, laundry, housekeeping, and dietary would remain with USH.

The table below shows a comparison of the Forensic Unit's current cost summary and the scenario as described. Lines showing privatized costs are highlighted in green.

Table 20: Scenario 2: Privatize Forensic Staff and Administration[39]

	USH Baseline	Scenario Two
Direct Care Costs per Patient Day	$ 244.53	N/A
Private Direct Care Costs per Patient Day	N/A	$ 197.21
Capital Costs per Patient Day	$ 6.81	$ 6.81
Admin Costs per Patient Day	$ 46.88	$ 46.88
Private 13% Management Fee per Patient Day	N/A	$ 25.64
Overhead Costs per Patient Day	$ 76.42	$ 76.42
Ancillary Costs per Patient Day	$ 38.15	$ 38.15
Total Cost Per Patient Day	**$ 412.80**	**$ 391.12**
Total Cost	**$ 14,977,273**	**$ 14,190,598**

Scenario two shows the same cost savings from the direct care category as in scenario one; however, there is an additional cost for a private management fee while simultaneously retaining the USH administration costs. Therefore, while total costs are still reduced in comparison to the current costs at the Forensic Unit, they are higher than the option presented in scenario one by approximately $930,000. Just as with scenario one, the risks associated with staff turnover remain and must be taken into consideration before pursuing this scenario.

Scenario Three: Privatize the Entire Forensic Unit

The third scenario is to privatize the entire Forensic Unit. This includes privatizing the direct care staff, described in scenario one; the management, described in scenario two; and finally, all capital and other overhead costs. Therefore, direct care staffing estimates from scenario one and the extra administrative cost from scenario two are both applied to this scenario. Because USH would still need to maintain capital costs for the rest of the facility, an additional capital cost must be added in for the private entity running the Forensic Unit. This option assumes vacancy in the current USH Forensic Unit space. Additionally, all other overhead costs on the Forensic Unit that are variable including plant maintenance and operations, laundry, housekeeping, and dietary would be taken over by the private entity.

As South Florida State Hospital was identified in the peer facility analysis as the model for a state-owned, privately operated psychiatric hospital, we have used their cost per patient day structure in developing this privatization scenario.

[39] Data Source: USH Medicare CMS-2552 and South Florida State Hospital Medicare CMS-2552.

The table below shows a comparison of USH's current cost summary and the scenario as described. Lines showing privatized costs are highlighted in green.

Table 21: Scenario Three: Privatize the Entire Forensic Unit[40]

	USH Baseline	Scenario Three
Direct Care Costs per Patient Day	$ 244.53	N/A
Private Direct Care Costs per Patient Day	N/A	$ 197.21
Capital Costs per Patient Day	$ 6.81	$ 6.81
Private Capital Costs per Patient Day	N/A	$ 3.86
Admin Costs per Patient Day	$ 46.88	$ 46.88
Private 13% Management Fee per Patient Day	N/A	$ 25.64
Overhead Costs per Patient Day	$ 76.42	N/A
Private Overhead Costs per Patient Day	N/A	$ 73.87
Ancillary Costs per Patient Day	$ 38.15	N/A
Private Ancillary Costs per Patient Day	N/A	$ 27.28
Total Cost Per Patient Day	**$ 412.80**	**$ 381.55**
Total Cost	**$ 14,977,273**	**$ 13,843,573**

In scenario three, Utah would see the same significant cost savings in direct care as shown in scenario one, as well as minor savings from the overhead and ancillary cost categories. However, it requires the same additional administrative fee as in scenario two, as well as a new additional capital cost. In total, scenario three costs are lower than the Forensic Unit currently, but are again higher than the option presented in scenario one by approximately $580,000. Again, despite the cost savings, the risks associated with staff retention remain the same as with the previous two scenarios. Efforts to implement this scenario must take staffing concerns into consideration.

Scenario Four: Increasing Service Hours at the USH Forensic Unit

The fourth scenario examines providing additional service hours than are currently provided at the Forensic Unit. As is described previously in this report, PCG's analysis focuses on only the quantitative side to "higher" by examining changes in the volume of services provided through increased staff hours or ratios, due to the limitations in modeling the qualitative components of service delivery. This one-dimensional view of "higher level of services" is only intended to show if it is possible for additional service hours to be provided, and it should not be interpreted as an increase in the quality of services provided.

For this scenario, PCG assumes that the direct care staff at the Forensic Unit are fully utilized, or do not have any excess capacity to provide additional services to patients. Because of that, the only way that a private entity would be able to provide additional services would be to provide additional hours to patients (e.g. behavioral modification, counseling, or other therapy services). For modeling purposes, PCG identifies the point at which a private entity could increase the service hours, for the same amount of cost as is currently incurred by the USH Forensic Unit.

[40] Data Source: USH Medicare CMS-2552 and South Florida State Hospital Medicare CMS-2552.

This "breakeven" analysis will identify the total number of additional hours that could be provided by a private entity before it would cost them more than what it currently costs the USH Forensic Unit to provide services.

Under this scenario, to increase the treatment hours to patients for fully utilized direct care staff means that a private entity would need to increase staff costs either through overtime or by hiring additional staff. PCG is assuming that a private entity will incur the cost of hiring additional staff to provide the additional service hours at the Forensic Unit. In addition, PCG is assuming that the increase in staff would need to take place at the direct service level (e.g. medical staff, case workers, licensed clinical therapists, or other qualified professionals) as they are the kind of certified staff that must be available to provide additional therapy services.

This fourth scenario assumes that the Forensic Unit has been entirely privatized as described in scenario three above. PCG calculated an average hourly wage for the types of staff discussed, which came to $24.31. This amount was then used to determine the number of hours of service that could be added while still equaling the baseline costs. The private entity fringe benefit rate of 20 percent, as well as the additional adjustments shown in scenario three, remained constant for this scenario.

The table below shows a comparison of the Forensic Unit current cost summary and the scenario as described. Lines showing privatized costs are highlighted in green.

Table 22: Scenario Four: Increasing Services at the USH Forensic Unit[41]

	USH Baseline	Scenario Four
Direct Care Costs per Patient Day	$ 244.53	N/A
Additional Private Direct Care Staff Hours per Month	N/A	2,876.96
Hourly Rate for Direct Care Clinical Staff	N/A	$ 24.31
Additional Private Direct Care Salary Costs per Year	N/A	$ 839,195.12
Private Direct Care Costs per Patient Day	N/A	$ 224.87
Capital Costs per Patient Day	$ 6.81	$ 6.81
Private Capital Costs per Patient Day	N/A	$ 3.86
Admin Costs per Patient Day	$ 46.88	$ 46.88
Private 13% Management Fee per Patient Day	N/A	$ 29.23
Overhead Costs per Patient Day	$ 76.42	N/A
Private Overhead Costs per Patient Day	N/A	$ 73.87
Ancillary Costs per Patient Day	$ 38.15	N/A
Private Ancillary Costs per Patient Day	N/A	$ 27.28
Total Cost Per Patient Day	**$ 412.80**	**$ 412.80**
Total Cost	**$ 14,977,273**	**$ 14,977,272**

[41] Data Source: USH Medicare CMS-2552 and South Florida State Hospital Medicare CMS-2552.

In this scenario, the breakeven number of additional treatment hours that a private entity could provide before it would cost them more than what it currently costs the Forensic Unit to provide services, is 2,877 hours per month, or 29 additional treatment hours per patient per month. This scenario shows that the direct care staff costs would decrease to $224.87 per patient day from $244.53 per patient day in the baseline, even though there is an additional $839,195 per year in direct care salary costs. As in scenario one above, the $224.87 cost per patient day realized in this scenario is a result of the private entity benefits to salary ratio of 20 percent that allows for the overall savings in direct care staff costs. This scenario shows that a private entity could "reinvest" the savings found in the direct care costs into an additional 29 hours of treatment to each patient per month, yet still shows expenditures at the baseline level for the Forensic Unit.

While cost savings may be realized through the scenarios above, PCG's discussions with stakeholders across the state and experience with privatization efforts across the country show that one of the biggest concerns with privatization revolves around the adverse effects on staffing. Recruiting and retaining quality staff is a critical component in maintaining the continuum of care and quality of care, and any privatization effort must take this into account.

3. UTAH STATE DEVELOPMENTAL CENTER TLC AND WOODLAND UNITS

A. Utah State Developmental Center Financial Baseline Model (TLC & Woodland)

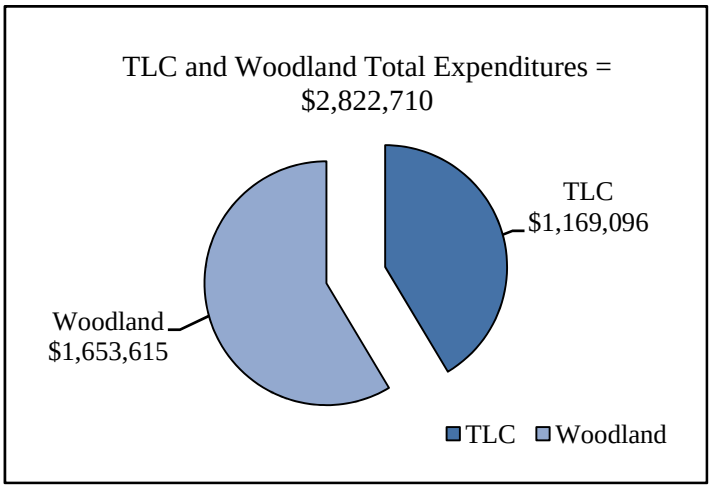
Scope and Methodology

PCG was tasked with identifying the cost of providing services and a way to measure service delivery in the Semi-secure Units at USDC (the Transitional Living Center (TLC) and Woodland), as well as subsequently determine the feasibility of privatizing these units. To do this, PCG worked with staff at USDC to obtain the financial and service information necessary to show an accurate picture of how these units operate today. The resulting baseline model reflects the costs and current service delivery within the TLC and Woodland for fiscal year 2009. Furthermore, PCG's subsequent peer facility analysis and privatization scenarios help answer the questions surrounding the feasibility of a private entity operating these units.

TLC and Woodland Financials

The first step in completing the financial analysis of the TLC and Woodland units was to create a baseline model against which peer facilities and privatization options could be compared. PCG obtained discrete unit level financial expenditure information including both direct and indirect/overhead expenditures from USDC for both TLC and Woodland. The total expenditures in fiscal year 2009 for TLC and Woodland are $2,822,710 with TLC accounting for $1,169,096, and Woodland accounting for $1,653,615, or 41.4 percent and 58.6 percent of the total expenditures, respectively.[42]

Figure 23: FY 2009 Total Expenditures[43]



[42] Please see Appendix F for additional detail on financial data for USDC.
[43] USDC, FY 2009 Financial Expenditures.

Total direct expenditures for the TLC and Woodland units were $1,911,922 and indirect expenditures totaled $910,718. The direct expenditures include the salary, benefits, and other expenses directly attributable to both TLC and Woodland. The indirect expenditures include the overhead expenses of administration, support services, maintenance, depreciation, non-direct medical services, etc. Salary and benefits at TLC and Woodland accounted for $1,812,622 of the direct expenditures, with TLC accounting for $741,135 and Woodland accounting for $1,071,486.[44] Salary and benefit expenditures account for 64.2 percent of the total costs at TLC and Woodland.

TLC and Woodland also generate significant Medicaid and other revenue over the course of a fiscal year. TLC and Woodland both generate $2,032,351 in program revenue, with Medicaid accounting for $1,862,989. The table below shows the net impact of this revenue on state resources. The revenue generated by the TLC and Woodland units is used to reduce the net impact on state expenditures.

Table 24: Net Expenditures for TLC and Woodland Units Fiscal Year 2009[45]

Expenditure/Revenue	Amount
Full Cost (TLC & Woodland)	$ 2,822,710
Total Revenue	$ (2,032,351)
Total Net Cost to State	$ 790,359

PCG also examined the following statistics as part of our financial baseline model.

Table 25: Financial Metrics – TLC and Woodland FY 2009[46]

Metric	TLC	Woodland	Total
Total Patient Days	1,824	2,565	**4,389**
Average Census	4.83	6.83	**11.66**
Total Beds	7	9	**16**
Direct Care FTEs	20	21	**41**

As the table above shows, total patient days at TLC and Woodland totaled 4,389 with an average daily census of 12 for both units combined. Total bed capacity within the two units is 16 with 41 full-time direct care staff taking care of the patients within TLC and Woodland across all shifts.

Based on the expenditure and statistical information from USDC, PCG calculated the following baseline financial metrics for TLC and Woodland.

[44] USDC, FY 2009 Financial Expenditures.
[45] USDC, FY 2009 Program Revenues
[46] USDC, FY 2009 Financial Statistics

Table 26: Financial Metrics – TLC and Woodland FY 2009[47]

Financial Metric	Total
Total Direct Cost per Patient Day (Direct Cost of Care/Total Patient Days)	$435.63
Total Full Cost per Patient Day(Direct plus Indirect Expenses/Total Patient Days)	$643.13
Total Net Full Cost per Patient Day (Net Full Cost/Total Patient Days)	$180.11
Occupancy Rate (Occupied Beds/Total Beds)	72.9%
Total Direct Care FTE per Patient per Shift (Direct Care FTEs/Occupied Beds/3 shifts)	1.17:1
Direct Staff Care Costs per Patient Day(Salary & Benefits/Total Patient Days)	$412.99
Direct Operating Costs per Patient Day (Direct Operating/Total Patient Days)	$22.64
Administration Costs per Patient Day (Administration/Total Patient Days)	$15.58
Depreciation Costs per Patient Day (Depreciation/Total Patient Days)	$10.32
Central Services and Supplies Costs per Patient Day (CS&S/Total Patient Days)	$142.94
Medical Services Costs per Patient Day (Medical/Total Patient Days)	$38.66

The financial metrics above show that it costs $435.63 per patient day to provide the direct/residential treatment services to each patient within the TLC and Woodland units. When overhead and support service expenditures are taken into consideration, the full cost per patient day of providing services to each patient within the TLC and Woodland units is $643.13. When accounting for the revenue that is generated by the TLC and Woodland units, the net cost per patient day of providing services to the patients within these units equals $180.11. In terms of staffing, the data shows that TLC and Woodland provide 1.17 staff per patient, per shift.

B. Utah State Developmental Center Programmatic Baseline Model (TLC & Woodland)

Scope and Methodology

In creating the programmatic baseline model for TLC and Woodland, PCG used the same methodology as we employed in creating the baseline model for the Forensic Unit at USH. This process required that our team develop a method by which to quantify the services currently available. PCG examined four ways of defining the level of service at TLC and Woodland:

1. Description of services.
2. Staffing ratios.
3. Hours of service reported.
4. Outcome descriptions.

[47] Generated from USDC FY 2009 Financial Statistics, Expenditures, and Revenues

TLC serves as the intake unit for USDC. In 2009, the average patient stayed between 285 and 305 days at TLC.[48] After a period of treatment and observation, individuals may be moved to different, less secure units within USDC to continue their treatment plans. Other individuals, however, may remain in TLC for a longer period of time based on diagnoses and behavioral patterns.

The table below shows the movement of persons in and out of TLC during a three year period from 2007to 2009.[49] Each new patient placed in TLC undergoes an evaluation to determine the level and type of services needed. Typically, when patients transition out of TLC, they are placed in either Oakridge or Quailrun. This placement is dependent upon the individual's needs and the space available in the units.

Table 27: Movement of Persons to and From the Transitional Living Center 2007-2009[50]

	Woodland	Oakridge	Quailrun	Twin Home	Outside USDC
Originating Unit	2	6	2	0	9
New Unit	3	7	3	1	2

The next table shows comparable data for Woodland. The pattern of movement at Woodland is noticeably different. Only one new admission came to Woodland from outside USDC in this period compared with nine new admissions at TLC. Most of those admitted to Woodland during this period resided there prior to 2007. Typically, when patients were transitioned out of Woodland, they were placed in the Oakridge unit. Just as with patients from TLC, placement in a different unit is dependent upon the individual's needs and the space available in the units.

Table 28: Movement of Persons to and From the Woodland Unit 2007-2009[51]

	Woodland prior to 2007	TLC	Oakridge	Quailrun	Town Home	Jail	Outside USDC
Originating Unit	9	3	0	1	0	0	1
New Unit	0	1	7	2	0	1	3

[48] Solicitation NO2009-02 - Posting for Utah State Legislature, Consultant - Feasibility Study to Privatize State Hospital and Dev. Center.
[49] Please see Appendix F for additional detail on programmatic data for USDC.
[50] Data Source: Utah State Developmental Center, 2010.
[51] Solicitation NO2009-02 - Posting for Utah State Legislature, Consultant - Feasibility Study to Privatize State Hospital and Dev. Center.

Description of Services

The statutory purpose of USDC is substantially different from the statutory mandates of USH as are the persons served and the services provided. The Utah Human Service Code at 62A-5-201 defines the role and function of USDC as a facility to,

"a) provide care, services, and treatment to:

- Persons with mental retardation, and
- Persons who require at least one of the following services from the developmental center:
    - Continuous medical care,
    - Intervention for conduct that is dangerous to self or others, or
    - Temporary residential assessment and evaluation, and…"

"b) provide the following services and supports to persons with disabilities who do not reside at the developmental center:

- Psychiatric testing,
- Specialized medical and dental treatment and evaluation,
- Family and client special intervention,
- Crisis management,
- Occupational, physical, speech, and audiology services, and
- Professional services, such as education, evaluation, and consultation, for families, public organizations, providers of community and family support services, and courts."

The methods of access to the USDC are different from the adjudicated requirements of access to USH. A committee called the Emergency Services Management Committee (ESMC) makes determinations on all requests for admission to the Developmental Center. The ESMC's fiscal year 2010 referral criteria included:

- Individual must be homeless or in immediate jeopardy of being homeless.
- Individual's parents are deceased and there is no other family member or friend able or willing to provide supports.
- Individual must have severe behavioral needs which jeopardize their or their family's health and safety.
- Individual must have severe medical needs which jeopardize their health and safety; He/she does not require a skilled nursing level of care but requires an enhanced level of nursing and medical follow up. Typically these individuals have medical disabilities such as seizures, severe burns, severe diabetes, and obesity.
- Individual must have documented physical/sexual abuse.
- Individual (self or others) must be at risk for permanent injury or death.
- Individual has been court ordered into the Division of Services for People with Disabilities (DSPD).

- The individual has a dual diagnosis of intellectual disabilities and has a serious mental health problem that the community mental health programs are not able to get under control during a short admission.

Individuals admitted to USDC usually have three characteristics: a degree of intellectual disability, mental health issues, and medical issues. These individuals are often difficult to serve in other placements and often have a history with the criminal justice system.

This is a different population than that served by the Forensic Unit at USH, which serves persons who will receive focused services with the intent of achieving a level of competency that will enable patients to understand and participate in their defense during a court trial. USDC serves individuals with inherited cognitive and physical disabilities that have developed both mental health and behavioral health issues manifesting themselves in socially inappropriate behaviors such as self injury and aggressiveness towards others. The difficulties of working with this population are seen in the incident reporting statistics. For example, during the period July 1, 2008 through June 30, 2009, the ten total patients who lived on the TLC unit during this period had 688 behavior incidents, 73 injury incidents, and 78 incidents in which restraints were used. These behaviors often times prevent patients from being transitioned to less secure units as doing so would put the patient and others in danger. Therefore, to better address individual patients' needs, USDC designs and provides multi-year residential services during which these physical, mental, and behavioral issues are gradually worked on until the patient can safely function in a safer and socially appropriate manner.

Staffing Ratios

The following table shows the number and kind of staff assigned to the TLC and Woodland units. As the table shows, there were 21 full time equivalent (FTE) assigned to each unit.

Table 29: Types and Number of Staff at Woodland and the Transitional Living Center June 2010[52]

Job Classifications	Woodland	TLC
Case Worker Specialist	1	1
Developmentalist	1	1
Lead Developmentalist	2	2
Licensed Clinical Therapist	1	0
Psychiatric Developmental Technician	15	16
Supervising Psychologist	1	0
Custodian	0	1
Total Staff	**21**	**21**

[52] Data Source: Utah State Developmental Center, 2010.

The next table below shows the number of patients in the TLC and Woodland units at USDC for fiscal year 2009.

Table 30: Average Number of Patients in Units at the Developmental Center in FY 2009[53]

FY 2009	TLC	Woodland
July	5	8
August	5	8
September	5	8
October	6	8
November	5	8
December	5	8
January	5	8
February	4	6
March	4	5
April	4	5
May	5	5
June	5	5
Average	**4.83**	**6.83**

Given the number of patients in each unit, and assuming that the staff have to be spread across three 24-hour per day seven days per week shifts, TLC and Woodland have a direct care staff to patient ratio of 1.17 staff to 1 patient[54].

Federal regulations at 42 CFR 483.430 specify staffing standards for ICF/MRs 42 CFR 483.430(d)(3)(i) and states the following:

> (i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2

Section 483.430 puts a financial limit on the operation of the semi-secure units in that a private entity or nonprofit agency cannot use a staffing ratio less than one staff to every 3.2 residents and still get Medicaid reimbursement for its services.

[53] Data Source: Utah State Developmental Center, 2010.
[54] This calculation does not take into consideration the custodian.

Hours of Services Reported

PCG examined the number of hours of services that were reported and/or provided as an additional way to build the baseline model. USDC supplied data on the number of estimated service hours per week that are provided to patients of TLC and Woodland, and this was converted to hours per month in the table below. Both groups of patients have similar characteristics and receive the same level of services regardless of unit of residence.

Table 31: Monthly Number of Hours of Service Provided to Patients in TLC and Woodland from July 2008 to June 2009[55]

Position	Monthly Hours of Service
Social Worker	160
Mental Retardation Professional	320
Secretary	40
Building Coordinator	40
Behavior Specialist	160
Registered Nurse	160
Audiologist	40
Dietitian	40
Medical Doctor	16
Music Therapist	4
Occupational Therapist	24
Physical Therapist	16
Psychologist	160
Recreational Therapist	160
Speech Habilitation Technician	20
Unit Director	104
Total	**1,463**

In 2009, the TLC and Woodland units served approximately 12 patients per month and provided approximately 1,463 hours of service per month to the patients for an average of 122 hours per month per patient.

Outcome Descriptions

The difference in the populations served by the Forensic Unit at USH, and TLC and Woodland create different concepts of how outcomes are described. In the context of the Forensic Unit, test outcomes occur when the same tests are given over time and changes to responses can be studied. The tests can show the improvement the patient is making and are evidence to indicate

[55] Data Source: Utah State Developmental Center, 2010.

that competency has been improved. This concept of testing and outcomes, from a competency restoration standpoint, however, is not relevant to the operation at TLC and Woodland.

The clinical history of patients in developmental centers typically shows repeated tests such as tests of mental functioning. The examination of the tests is useful in reviewing the level and types of services needed. For example, if several tests of mental functioning were conducted over a period of years and the results were generally the same, then it can be concluded that the level of mental functioning has been accurately determined and the treatment plan should be designed accordingly.

The tests given at USDC are primarily diagnostic to determine the medical status, level of intellectual functioning, and the social and behavioral supports and impairments of the person.[56] Thus, test results at USDC are a listing of the medical issues and diagnoses that the person currently has which is in line with other developmental centers around the country. Progress for USDC patients is measured by the control of medical problems and the slow modification of behavior which takes place over months and years with the results recorded in case notes.

The table below shows the diagnostic listing for a randomly selected patient at TLC in 2008.

Table 32: Typical Diagnostic Test Results at Developmental Center[57]

Diagnoses
Axis I 298.9 Psychotic Disorder, NOS
r/o 299.00 Autistic Disorder
302.91 Fetishism
Axis II 317. Mild Mental Retardation
Axis III medication induced thickening of the heart walls
Axis IV lack of family and social support
Axis V GAF: 20 (current)

Lists of medical and behavioral issues are also included in a patient's case history. The purpose of such listings is to be sure that staff members have identified all significant issues and have plans for ensuring these issues are addressed.

[56] The Developmental Center supplied a page listing all the assessment tools used at the Center and the specialist who used each. For example, approximately 17 different assessment tools were listed as being used by the psychologist and behavioral specialists.
[57] Solicitation NO2009-02 - Posting for Utah State Legislature, Consultant - Feasibility Study to Privatize State Hospital and Dev. Center.

Table 33: Typical List of Medical and Behavioral Issues at Developmental Center[58]

Medical and Behavioral Issues
Adult Antisocial Behaviors
Constipation
Fetal Alcohol Syndrome
Rule Out Mood Disorder
Insomnia
Mental Retardation
Traumatic Brain Injury
Borderline intellectual functioning versus Normal IQ

Programmatic Metrics

Just as with USH, quantifying programs and services is more complex than examining total costs. Using the same methodology as for USH, we examined staffing ratios and hours of service per patient per month to develop the baseline model. While these ratios are useful, they do not necessarily account for the quality of service provided. They do, however, provide measurements of the quantitative level of service within the facility.

As shown in the table below and based on fiscal year 2009 data, TLC and Woodland have a staffing ratio of 1.17 staff per patient per shift. PCG assumes that staff members work on a three-shift schedule (day, evening, and night). Throughout the course of a month, patients typically receive 122 hours of service while living in either TLC or Woodland. These services comprise individually designed treatment plans. USDC offers a wide array of services including physical therapy, occupational therapy, speech therapy, and psychological services.

Table 34: TLC and Woodland Programmatic Metrics[59]

Utah State Developmental Center (TLC and Woodland)	
Total Direct Staff	41
Total Hours of Services reported per Month	1463
Total Patients	11.66
Direct Staff Ratio	1.17:1
Hours of Services per Patient per Month	122

[58] Ibid.
[59] Data Source: Utah State Developmental Center, 2010.

C. Utah State Developmental Center Comparative Models (TLC & Woodland)

Scope and Methodology

PCG leveraged its experience with state intellectual and developmental disability programs and conducted research to prepare comparative models for peer facilities of TLC and Woodland units. Given the complex nature of the patient diagnoses at TLC and Woodland and the semi-secure nature of the units, identifying peer facilities that could discretely identify costs and services for similar units to TLC and Woodland was a difficult process.[60] PCG reviewed 150 developmental centers and focused closely on 22 facilities to identify comparative cost and service information for our study. PCG relied heavily on the staff within each facility that we contacted to report financial and census data. PCG identified the four peer facilities in this section that have similar patient diagnoses, a degree of security and/or a forensic unit, and were able to provide appropriate unit cost and staffing information.

The peer facilities selected include state-operated facilities with like unit structures and populations to those within TLC and Woodland. Because the comparable developmental centers vary in unit structure and reporting requirements, an "apples-to-apples" comparison on all metrics is not possible, but PCG believes that the facilities selected and information provided below provide for a good comparison with TLC and Woodland. For our comparative analysis, PCG focused on public providers, as we were unable to identify a comparable private entity that served populations with complex diagnoses and behavioral issues, housed in a semi-secure or secure environment similar to that of the TLC and Woodland units.

The following peer facilities have been identified as similar in structure, patient population, and as having a unit(s) that has similar security protocols to the semi-secure nature of TLC and Woodland:

California Department of Developmental Services – Canyon Springs Facility[61]
Canyon Springs is designed to serve adults with developmental disabilities who have moderate to mild mental retardation. It has a current annual census of 54 patients. Individuals at the facility have mental health needs in addition to their developmental disability. Individuals live and work at Canyon Springs while they undergo focused training and treatment to help them learn to manage their lives and gain control over impulsive and inappropriate behaviors.

The highly structured and semi-secure program provided by Canyon Springs is intended to help the patients improve their abilities and personal conduct. As individuals demonstrate acceptable behavioral control and personal responsibility, as well as appropriate work, social, and living skills, they are assisted in returning to their original home communities or other less restrictive living arrangements.

[60] Please see Appendix H for more information.
[61] Information obtained from the California Department of Developmental Services and Canyon Springs Facility.

The treatment program at Canyon Springs is designed to provide its patients with work/job training including formal educational opportunities and new home life and living skills. Referrals for admission are made by regional centers in the California Department of Developmental Services system and admissions are primarily for those who cannot be adequately treated in other facilities due to the complex diagnoses.

Minnesota Department of Human Services – Minnesota Extended Treatment Options – METO[62]

Minnesota developed a unit in Cambridge, Minnesota for persons with developmental disabilities and challenging behaviors that present a public safety risk. Unlike previous state institutions for people with developmental disabilities in Minnesota, METO currently serves a small number of people with a developmental disability who are considered mentally ill and dangerous.

To be admitted to the METO program, an individual must have mental retardation or related condition, be of adult age, exhibit behaviors that present a risk to public safety, be under an appropriate legal status identified in Minnesota statute, and not require hospital level care for psychiatric illness. METO does not accept admission of individuals civilly committed as Sexually Dangerous Persons or Sexual Psychopathic Personalities. The program makes use of intense levels of staff supervision and internal client management procedures to maintain security. Residential units have been constructed to be as homelike as possible, permitting clients to maintain or improve daily living skills that facilitate development of self-esteem, acceptance of personal responsibility, and eventual reintegration into the community.

Ohio Department of Developmental Disabilities – Warrensville Developmental Center[63]

The Warrensville Developmental Center (WDC) has a small, unlocked forensic unit of five beds which opened in September 2009. The center as a whole serves 136 individuals who reside at the facility and provides housing and training to people who are diagnosed with severe and profound mental retardation and extensive supports in the areas of daily living, health care, and social skills development. WDC patients attend nine different worksites/activity centers and five different retirement centers operated by Cuyahoga County Board of the Department of Developmental Disabilities. There are also opportunities to work in supported employment in the community. WDC provides opportunities for individuals to create artwork and various craft projects, participate in gardening, and attend local recreational and educational events both on site and in the community. In addition to this vocational training, the center provides a full array of health services, including physician, specialists, nursing, psychiatrist, occupational therapists/physical therapists, and specialists in psychology, social work, and speech therapy.

[62] Information obtained from the Minnesota Department of Human Services and the METO program.
[63] Information obtained from the Ohio Department of Developmental Disabilities.

Tennessee Division of Intellectual Disabilities Services - Harold Jordan Habilitation Center

The Harold Jordan Center, located on the Clover Bottom Developmental Center (CBDC) campus, is a 32-bed facility for persons with intellectual disabilities that have been charged with a crime. Patients are evaluated every six months to assure they meet admittance requirements. If a person is deemed competent to stand trial, that person is returned to incarceration. Services include, in part:

- Assisting a person in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings.
- Providing individually tailored services and supports enabling a person to live in his or her own home and to access the community.
- Encouraging behaviors that help the individual attain his or her desired quality of life. Support strategies may include teaching the person to better communicate with others, expanding the opportunities for developing relationships, or improving the quality of living environments.
- Behavior analyses to assess, design, implement, and evaluate systematic environmental modifications for producing changes in behavior.

Other State Facilities

In addition to the four programs cited above, Appendix H contains a list of all state programs that have a specialized unit with a degree of security and/or a forensic unit. All of these were contacted and PCG gathered financial and census information to help narrow our list to the four identified above.

Peer Facility Comparison

PCG performed an analysis of each facility's cost structure by creating a side-by-side comparison of reported data. PCG converted the data to cost per patient day-based values to facilitate a better comparison between facilities. The table below shows this comparison, with reported expenditure information from fiscal year 2009 used in the analysis.

Table 35: Peer Facility Comparison[64]

Metric	USDC – TLC and Woodland	CA DDS - Canyon Springs	Minnesota Extended Treatment Options – METO	Warrensville Developmental Center	Harold Jordan Center
Gross Direct Cost (Direct cost of Care)	$1,911,992	N/A	$1,024,728	$621,896	N/A
Gross Full Cost (Direct plus Indirect)	$2,822,710	$15,114,232	N/A	N/A	$6,843,750
Total Revenue	$2,032,351	$8,161,685	$586,419	N/A	N/A
Total Patient Days	4,389	19,528	2,190	1,254	9,125
Gross Direct Cost/Patient Day	**$ 435.63**	**N/A**	**$ 467.91**	**$ 495.93**	**N/A**
Gross Full Cost/Patient Day	**$ 643.13**	**$ 774.00**	**N/A**	**N/A**	**$ 750.00**
Avg. Daily Census	12	54	6	4	25
Total Available Beds	16	63	8	5	32
Occupancy	**72.88%**	**84.92%**	**75.00%**	**72.00%**	**78.13%**
Direct Care FTE	40	58	21	13	65
Total Direct Care FTE per Patient per Shift	**1.17:1**	**1.08:1**	**1.17:1**	**1.20:1**	**.87:1**

The TLC and Woodland units gross direct cost per patient day of $435.63 is the lowest of the comparable facilities and is 6.9 percent less than the next lowest cost per patient day at METO. The TLC and Woodland gross full cost per patient day is also the lowest of the comparables at $643.13 and is 16.9 percent lower than the next lowest cost per patient day at Canyon Springs. The data show that the TLC and Woodland units are providing services to patients at a low cost per patient day as compared to peer facilities.

Looking at the size of the programs, TLC and Woodland are in the middle of the range of the peer facilities, with the largest facility reporting 19,528 days and the smallest reporting 1,254 days. The occupancy ratio at TLC and Woodland of 72.88 percent falls slightly above the Warrensville Developmental Center, which has the lowest ratio at 72.00 percent. PCG's analysis shows that the TLC and Woodland units are maintaining a comparable level of occupancy as compared to like facilities. The TLC and Woodland direct care staff per patient ratio of 1.17:1 is in the middle of the range of the peer facilities and well above the required minimum for developmental centers (1 staff per 3.2 patients). This information shows that the TLC and Woodland units are providing an adequate level of staffing, which falls towards the higher end of the peer facilities reviewed.

[64] Please see Appendix F for additional detail on included costs.

D. Utah State Developmental Center Privatization Scenarios (TLC & Woodland)

This section details the scenarios that PCG developed to show options available to the state regarding the privatization of the Semi-secure Units at USDC. These scenarios also help to analyze the feasibility of privatizing these units. Below are the assumptions that PCG is using in the scenarios.

Using Existing Facilities on the USDC Campus

PCG is assuming that a private entity would want to provide services to the patients of the TLC and Woodland units on the USDC campus, given the characteristics of units and the population. Based on PCG's previous privatization experience and interviews with private entities, it would be difficult and expensive for a private entity to construct a separate facility, or modify an existing one, to accommodate the TLC and Woodland population outside of the USDC campus. Private entities may come up against public opposition to constructing a new, or modifying an existing, facility to accommodate the TLC and Woodland patients as they have more complex conditions and/or may not be considered ready to enter the community.

The cost associated with constructing a new, or modifying an existing, facility would be significant to make sure that it could provide for the level of service needed for patients with the complex conditions exhibited by those at TLC and Woodland. For example, this may require single room occupancy and public areas that are separate from other populations at the facility. In addition, the facility would need to be built in a way to maintain the semi-secure nature. Given the small number of patients currently at TLC and Woodland, constructing a new, or modifying an existing, facility is something that PCG is assuming would be prohibitive to a private entity unless negotiated with the state.

Profit

Just as with the USH Forensic Unit, PCG assumes that a private entity taking over any portion of the units at USDC would be operating those units at a profit. This implies that privatization proposals would be expected to use overall costs per patient day that have a built-in profit percentage. Based on our research and analysis of available proposals for privatization, particularly those responses to the Louisiana privatization RFP, PCG determined that profits budgeted are typically 8.17 percent of the entity's overall budget. It is assumed that private entities in Utah would look for a similar level of profit if they were to consider taking over portions of USDC and that profit level is implicit in our calculations. For modeling purposes, PCG assumes that the profit percentage is included as part of the ratios or fees applied in the scenarios below, and it is not identified separately in our analysis.

Revenue

For the scenarios in this section, PCG is assuming that the revenue generated by patient care billing/claiming within the TLC and Woodland units will be retained by the state.

Limitations to Private Sector Cost Savings Analysis

PCG's research and analysis identified that a private entity would be able to find cost savings to operate the TLC and Woodland units through reduced overall compensation for direct care employees. This, however, was the only category of cost in which PCG could definitively identify potential cost savings. PCG's analysis into private sector cost savings was influenced by the following factors:

- The lack of cost data for pricing comparison from privately operated developmental centers serving populations with similar complex diagnoses.
- The small population size being served at TLC and Woodland reducing the potential for savings from volume discounts or limiting economies of scale usually seen in larger facilities related to operational equipment, supplies, and ancillary services.
- The relative purchasing power of the state of Utah to obtain favorable pricing for operational equipment and supplies.
- The lack of definitive empirical evidence supporting or contradicting the hypothesis that a private entity could realize operating (non-employee compensation related expenses) and ancillary/indirect (day training, medical services, support services, and administration) expense savings from the TLC and Woodland baseline.

These factors limited the number of privatization scenarios modeled for TLC and Woodland. For example, the inconclusive findings related to whether a private entity could realize cost savings over the state for operational supplies and equipment led PCG to concentrate on the scenario related to direct care compensation related savings. Likewise, a scenario related to cost savings associated with the ancillary day training and medical services expenses at TLC and Woodland resulted in inconclusive findings surrounding the ability of a private entity to realize savings in those cost centers. PCG's analysis and modeling in these areas, combined with the limiting factors identified above made it clear that it cannot be determined with empirical certainty whether a private entity would pay more or less for operating and ancillary/indirect expenses than the current baseline for TLC and Woodland.

Below are descriptions of two potential scenarios modeled by PCG with each including a table showing the difference in cost or service structure between the described scenario and the current condition at TLC and Woodland.

Scenario One: Privatize Entire TLC and Woodland Units

The first scenario looks at privatizing the entire TLC and Woodland operations. This includes privatizing the direct care staff related to TLC and Woodland service delivery, the direct operating costs, and all indirect, ancillary, and overhead costs. This scenario includes examining the direct care salary and benefit costs of those staff identified as being full-time employees of the units. Even though this scenario looks at privatizing the staff, staffing levels and patient ratios are assumed to remain the same in order to maintain the same level of services to patients. Because the determination of cost savings for non-direct care employee compensation cost

categories in the TLC and Woodland units is inconclusive, PCG is modeling this scenario with the same operating, support services, day training, medical, administration, and depreciation costs as in the TLC and Woodland baseline.

As identified above in the baseline cost analysis, direct care salary and benefit expenses are the most significant single source of cost for the units, accounting for 64.2 percent of total costs. In analyzing the data from TLC and Woodland, PCG's privatization experience, and what PCG has learned from other recent state facility privatization efforts, the benefit to salary ratio is one place where a private entity would be able to realize costs savings in operating the TLC and Woodland units. Currently, the benefits, which included health, dental, and life insurance; state retirement; FICA/Medicare tax; unemployment and workers compensation; and incentive payments, paid to direct care employees at TLC and Woodland as a percentage of overall salary equals 64 percent. In this scenario, PCG is assuming that there is no reduction in staff salaries; however, a reduction in the benefit to salary ratio is included to reflect the benefits packages offered by private entities in Utah. PCG is assuming a 35 percent benefit to salary ratio for this scenario.[65]

For this scenario, USDC's administration costs identified in the TLC and Woodland baseline, including costs such as those for the director's office, human resources, billing, and legal, would likely not be significantly reduced through the introduction of a private entity operating the TLC and Woodland units, as the units represent less than five percent of USDC's population. These administrative functions would still exist as they currently do, and staff would perform the same

[65] Bureau of Labor Statistics, 2009 Average Compensation, Dollars per Hour Worked, June 2009. The Bureau of Labor Statistics shows that Average private hourly compensation in the region that includes Utah is $26.18. This includes $19.63 per hour for salaries and wages, and $6.55 per hour for benefits, and equals a 33.4% benefits to salary ratio. Census-based, and employer-based human resources salary comparisons show that private the median total compensation including benefits for a typical Mental Health Technicians in Salt Lake City, is $43,387 (Human Resources, Inc. 2010). This includes the salary component of compensation totaling $32,270 (74% of total compensation) and benefits totaling $11,117 (24% of total compensation), for a benefits to salary ratio of 34.4%. Benefits as a percent of salaries include social security (6.8%); 401(k) (3.4%); disability (0.9%); healthcare (18.9%); and pension (4.5%).
(http://swz.salary.com/salarywizard/layoutscripts/swzl_salaryresults.asp?hdSearchByOption=0&hdLocationOption=0&hdKeyword=mental+health+technician&hdJobCategory=HC02&hdNarrowDesc=Healthcare+--+Technicians&hdZipCode=84101&hdStateMetro=&hdGeoLocation=Salt+Lake+City%2C+UT+84101&hdCurrentPage=&hdViewAllRecords=&hdJobCode=HC07000176&hdJobTitle=Mental+Health+Technician&hdCurrentTab=3&hdZipCodePosted=&hdPaycheckCalc=&hdpageName=&hdOmniJobTitle=Mental+Health+Technician&hdOmniNarrowDesc=Healthcare+--+Technicians&op=salswz_psr&pagefrom=selectjob&hdOmniState=Utah&hdOmniGeoLocation=Salt+Lake+City%2C+UT+84101&d50th=28681.8347&jobcounter=1&countertype=0&totaljoblistnum=&wsrcode=SW1&educationcode1=&geo=Salt+Lake+City%2C+UT+84101&metrocode=152&geometrocode=152&zipcode=84101&jobcode=HC07000176&narrowcode=HC02&state=Utah&statecode=UT&r=salswz_salresnxt_psr&joblevelcode=1&jobfamilycode=13&IsGoCreateProfile=0&cmbEducation=&hdNarrowDesc=&rdbSearchByOption=0&txtKeyword=mental+health+technician
The Technicians job classification at the TLC and Woodland units represents 76% of the overall direct care staffing. This job classification at TLC and Woodland has an average total compensation of $41,042. Salaries total $23,534 (57% of total compensation) and benefits total $17,508 (43% of total compensation). Applying the 35% benefits to salary ratio reduces the benefits amount to $8,237.

tasks they currently perform on behalf of TLC and Woodland. Therefore, USDC would still incur the same administrative costs as in the baseline model, but there would be an additional management fee from the private company to cover the oversight of the employees within the units. For this analysis, PCG estimated this additional management fee at 13 percent of direct care costs.[66]

This scenario results in all direct staff being employed by a private entity with the assumption that the salary structure would remain the same, the benefit to salary ratio would be reduced, and a private management fee would be included. The table below shows a comparison of the TLC and Woodland current cost summary and the scenario as described. Lines showing privatized costs are highlighted in green.

Table 36: Scenario 1: Privatize TLC and Woodland Units[67]

	TLC and Woodland Baseline	Scenario One
Direct Care Staff Costs per Patient Day (Salary & Benefits)	$412.99	N/A
Private Direct Care Staff Costs per Patient Day	N/A	$339.23
Direct Operating Costs per Patient Day	$22.64	$22.64
Administration Costs per Patient Day	$15.58	$15.58
Private 13% Management Fee per Patient Day	N/A	$47.04
Depreciation Costs per Patient Day	$10.32	$10.32
Central Services and Supplies Costs per Patient Day	$142.94	$142.94
Medical Services Costs per Patient Day	$38.66	$38.66
Total Cost Per Patient Day	**$643.13**	**$616.42**
Total Cost	**$ 2,822,710**	**$2,705,450**

By applying the 35 percent benefit to salary ratio to the TLC and Woodland total direct care salaries, the direct care staff costs per patient day are reduced from $412.99 to $339.23. Calculating a management fee of 13 percent of total direct care costs equals $206,474, or $47.04 per patient day. The total cost per patient day in this scenario equals $616.42 as compared to the TLC and Woodland baseline of $643.13. This equates to a cost per patient day savings of $26.72, and a total cost savings from the baseline of $117,260, or 4.2 percent of the baseline cost of TLC and Woodland.

While there is a potential for cost savings through the privatization of the direct care staff at TLC and Woodland, there are potential risks associated with such a change. The greatest risk would be that it may be difficult to retain the same staff currently working in the unit with a proposed reduction in their benefit structure. Furthermore, it may become difficult to recruit and retain

[66] American Health Insurance Plans, (2008, May) .A Shared Responsibility: Advancing Toward a More Accessible, Safe, and Affordable Health Care, System for America, Washington, D.C.
http://www.americanhealthsolution.org/assets/Uploads/ahipaffordability.pdf
The AHIP report states that 13% is the national average administrative cost in its study of health plans.
[67] Please see Appendix F for details on the calculations.

new staff with the lower benefits to salary ratio. The difficulty in retaining current staff and recruiting new staff may pose a risk to the current level of services, continuity of service delivery to patients, or the overall quality of care that is provided at TLC and Woodland. Any privatization proposals that the state solicits should be required to explain how such risks would be mitigated.

Scenario Two: Increasing Service Hours at the TLC and Woodland Units

The second scenario examines a private entity providing additional service hours at TLC and Woodland than are currently provided. As is described previously in this report, PCG's analysis focuses on only the quantitative side to "higher" by examining changes in the volume of services provided through increased staff hours or ratios, due to the limitations in modeling the qualitative components of service delivery. This one-dimensional view of "higher level of services" is only intended to show if it is possible for additional service hours to be provided, and it should not be interpreted as an increase in the quality of those services.

For this scenario, PCG assumes that the direct care staff at TLC and Woodland are fully utilized, and therefore do not have any excess capacity to provide additional services to patients. Because of that, one way that a private entity would be able to provide additional services would be to provide additional treatment hours to patients (e.g. behavioral modification, habilitation, vocational rehabilitation, or other therapy services). For modeling purposes, PCG identifies the point at which a private entity could increase the service hours for the same amount of cost as is currently incurred by the TLC and Woodland units. This "breakeven" analysis will identify the total number of additional hours that could be provided by a private entity before it would cost them more than what it currently costs TLC and Woodland to provide services.

Under this scenario, to increase the treatment hours to patients for fully utilized direct care staff means that a private entity would need to increase staff costs either through overtime or by hiring additional staff. PCG is assuming that a private entity will incur the cost of hiring additional staff to provide additional service hours at the TLC and Woodland units. In addition, PCG is assuming that the increase in staff would need to take place at the direct service clinician level (e.g. psychologist, case worker, and licensed clinical therapist, or other qualified mental retardation professional) as they are the kind of certified staff that must be available to provide additional behavioral modification, habilitation, vocational rehabilitation, or therapy services.

USDC provided PCG with salary information by staff position that shows that there are four full-time direct service clinical staff members in the TLC and Woodland units. That includes one psychologist, two caseworker specialists, and one licensed clinical therapist. Total salaries for these positions equals $241,874, or $29.07 per hour. This scenario also includes the 13 percent additional management fee and the 35 percent benefit to salary ratio as identified in scenario one above. The table below shows a comparison of the TLC and Woodland current cost summary and the scenario as described. Lines showing privatized costs are highlighted in green.

Table 37: Scenario 2: Increasing Services by Private Entity at TLC and Woodland[68]

	TLC and Woodland Baseline	Scenario Two
Direct Staff Care Costs per Patient Day(Salary & Benefits)	$412.99	N/A
Additional Private Direct Care Staff Treatment Hours per Month	N/A	220.35
Hourly Rate for Direct Care Clinical Staff	N/A	$29.07
Additional Private Direct Care Salary Costs per Year	N/A	$76,866
Private Direct Care Staff Costs per Patient Day	N/A	$362.87
Direct Operating Costs per Patient Day	$22.64	$22.64
Administration Costs per Patient Day	$15.58	$15.58
Private 13% Management Fee per Patient Day	N/A	$50.12
Depreciation Costs per Patient Day	$10.32	$10.32
Central Services and Supplies Costs per Patient Day	$142.94	$142.94
Medical Services Costs per Patient Day	$38.66	$38.66
Total Cost Per Patient Day	**$643.13**	**$643.13**
Total Cost	**$ 2,822,710**	**$2,822,710**

In this scenario, the breakeven number of additional treatment hours that a private entity could provide before it would cost them more than what it currently costs TLC and Woodland to provide services, is 220 hours per month, or 18.3 additional treatment hours per patient per month. This scenario shows that the direct care staff costs would decrease to $362.87 per patient day from $412.99 per patient day in the baseline, even though there is an additional $76,866 per year in additional direct care salary costs. As in scenario one above, the $362.87 cost per patient day realized in this scenario is a result of the private entity benefits to salary ratio of 35 percent that allows for the overall savings in direct care staff costs. This scenario shows that a private entity could "reinvest" the savings found in the direct care costs into an additional 220 hours of treatment to patients per month, yet still shows expenditures at the baseline level for TLC and Woodland.

The cost savings shown in both scenarios above are made possible by a reduction in the benefits to salary ratio. The first scenario shows the savings and the second assumes the savings are reinvested back into the program in the form of increased direct care therapy hours provided to patients in TLC and Woodland. Therefore, it appears that privatization may be financially feasible; however, it is PCG's point of view that privatization implemented for cost savings purposes through reductions in direct care staff compensation contains potential risks because of the adverse impact on staff. PCG's discussions with stakeholders and experience with privatization efforts show that one of the biggest concerns with privatization revolves around the adverse effects on staffing. Recruiting and retaining quality staff is a critical component in maintaining the continuum of care and quality of care, and any privatization effort must take this into account.

[68] Please see Appendix F for details on the calculations.

4. FINDINGS AND RECOMMENDATIONS

PCG's analysis detailed in the sections above for the Forensic Unit at USH and the Semi-secure Units at USDC provides insight into the three main objectives identified in the RFP for this engagement related to the feasibility of a private entity to:

1. Provide services that are currently provided at or for the facilities, at the same cost at which those services are currently provided at or for the facilities.
2. Realize a savings to the state while providing services at the same level or a higher level than is currently provided at or for the facilities.
3. Provide services at a higher level than is currently provided at or for the facilities, at the same cost at which current services are provided at or for the facilities.

The findings presented below have been categorized to address each of these objectives first for the Forensic Unit at USH and subsequently for the Semi-secure Units at USDC.

A. Utah State Hospital Forensic Unit

1. Private entity providing services that are currently provided at or for the facilities, at the same cost at which those services are currently provided at or for the facilities.

PCG's analysis suggests that it would be financially feasible for a private entity to provide the services that are currently provided in the USH Forensic Unit at the same cost at which they are currently being provided. While this may be feasible based solely on the analysis in Section 2 above, there are additional considerations that the state would need to take into consideration before making a move towards privatization of this unit, including the ability of the private entity to hire and retain the same staffing as is currently employed at USH. As noted, there is substantial national policy agreement that consistent staffing is directly correlated to positive outcomes. Further, USH has worked to develop relationships with the community, and more importantly for the Forensic Unit, with the court and corrections systems in the state. A move towards privatization of the unit would have to maintain the efficiency of these existing relationships.

2. Private entity realizing a savings to the state while providing services at the same level or a higher level than is currently provided at or for the facilities.

PCG has illustrated that there is the potential for a cost savings by privatizing the entire Forensic Unit or by privatizing different components of the unit. These costs savings are shown in privatization scenarios one through three in our analysis of the Forensic Unit. While these models show that there is the potential for cost savings, they do not show conclusively that services could be provided at the same or higher level than they are currently provided. Again, as

most of the cost savings is tied to a reduction in the direct costs, comprised largely of direct staff compensation, it could be stated that any cost savings would come as a result of a decrease in overall staff compensation. PCG has illustrated that the most likely way for a private entity to achieve savings would be through a reduction in employee benefits, which could have an adverse effect on staff retention and continuity of care. As such, it is PCG's belief that privatization resulting in reduced costs does not allow for services to be maintained at the existing level nor at a level greater than is currently provided.

3. Private entity providing services at a higher level than is currently provided at or for the facilities, at the same cost at which current services are provided at or for the facilities.

As stated in the findings for objective one, the analysis has illustrated that it would be feasible for a private entity to operate the Forensic Unit at USH at the same cost as it is currently operated. Privatization scenario four illustrates that it would be possible for a private entity to provide additional service hours while still remaining in line with the Forensic Unit current total cost. PCG's research and experience with privatization efforts show, however, that concerns with privatization efforts tend to focus on staffing. Recruiting and retaining quality staff is a critical component in maintaining the continuum of care and quality of care, and any privatization effort must take this into account. Further, if the state decides to pursue privatization, PCG would recommend that clear standards are set which define staffing ratios, minimum clinician licensure levels, and other metrics that ensure that at least the same level of service is provided by the prospective vendor as is currently provided by USH in the Forensic Unit.

B. Utah State Developmental Center (TLC & Woodland)

1. Private entity providing services that are currently provided at or for the facilities, at the same cost at which those services are currently provided at or for the facilities.

The analysis of the costs for the TLC and Woodland units at USDC and the privatization scenarios presented illustrate that it would be possible for the same level of services to be provided at the same costs. PCG's analysis in Section 3 above shows that a private entity may be able to provide the current level of services at a cost savings to the state, and as such, it would be reasonable to assume that a private entity could provide the same level of services at the same cost.

As was stated before, there are potential risks associated with privatizing these units that are not shown through an analysis of the costs alone. The main risk would be the potential for staff turnover from the state to private operations of the units. Any significant changes to the current staffing would pose a risk to the current level of services, continuity of service delivery, or overall quality of services provided to patients in the TLC and Woodland units.

2. **Private entity realizing a savings to the state while providing services at the same level or a higher level than is currently provided at or for the facilities.**

As the analysis of the TLC and Woodland privatization scenarios suggests, it may be financially feasible to provide services at a reduced cost from what the state currently incurs to provide services in the TLC and Woodland units. As identified in the scenarios in Section 3 above, the savings would be primarily driven by a reduction in the benefits to salary ratio, and thus a reduction to direct staff compensation. A reduction in staff compensation for current employees poses the risk of staff turnover and future difficulties in staff recruitment and retention that, as noted throughout the report, poses an additional risk to the level, continuity, and quality of services provided to patients.

3. **Private entity providing services at a higher level than is currently provided at or for the facilities, at the same cost at which current services are provided at or for the facilities.**

The final privatization scenario developed for TLC and Woodland illustrates that while it may be possible to provide a greater number of service hours than are currently provided, it would require an increase in staffing through an increase in direct care staff salary expenditures. To offset the increase in staff salary costs, the facility would need to reduce costs elsewhere to ensure that costs do not exceed current baseline levels. PCG's analysis showed that many private entities would find that cost savings in the benefits to salary ratio, thus reducing total employee compensation from the baseline case.

As stated throughout this report, one of the biggest concerns with privatization revolves around the adverse effects on staffing and how that can affect service delivery to patients. Recruiting and retaining quality staff is a critical component in maintaining the continuum of care and quality of care, and any privatization effort must take this into account. Further, if the state decides to pursue privatization, PCG would recommend that clear standards are set which define staffing ratios, minimum clinician licensure levels, and other metrics that ensure that at least the same level of service is provided by the prospective vendor as is currently provided by USDC in the TLC and Woodland units.

C. Stakeholder Findings

USH Forensic Unit Stakeholder Findings

As has been noted previously in this report, PCG conducted a number of interviews with stakeholders associated with the Forensic Unit at USH. Through these interviews, PCG gained insight into the current operations of the hospital and the perception of the hospital in the community and criminal justice system.

The most common feedback received during our interviews was that USH has become an important part of the continuum of care for those individuals in the Forensic Unit. These individuals were identified as a more difficult population that cannot adequately be served in a prison setting or treated safely in a community setting. It has also been noted that USH has worked extensively at developing greater interaction with the court systems throughout the state to ensure that the individuals are admitted to the hospital in a timely fashion and returned to the courts only after being restored to competency.

TLC and Woodland Stakeholder Findings

PCG conducted several TLC and Woodland stakeholder interviews as part of the data gathering for this report. PCG talked with advocates, family members of patients at USDC, state of Utah agency representatives, associations, and private providers. One of the recurring themes throughout the stakeholder information gathering was that many people had concerns related to quality of care if privatization were to occur. There were general opinions that the quality of care would decrease even if a private entity were to increase staffing levels. In conjunction with this, there were concerns related to staff turnover as a result of privatization and the impact that would have on services to patients. With staff turnover, stakeholders believed that there would be negative effects on the continuity of care and overall quality of care to patients.

There was also a general theme from private providers that privatizing the TLC and Woodland units would be difficult given the complex conditions exhibited by the population and the small number of patients in those units. In addition, there are potential liability issues, questions about using the existing buildings or whether new ones would need to be constructed, and questions about the difficulty of cost effectively paying for infrequently used skilled services such as. nurses, physicians, audiologists, and recreational therapists.

D. Recommendations

PCG has conducted a thorough analysis of the current costs and services provided at the Utah State Hospital Forensic Unit and the TLC and Woodland Semi-secure Units at the Utah State Developmental Center. In addition, PCG developed comparative models using peer facilities throughout the country to provide a broad picture of costs at other state operated forensic units and other developmental centers. PCG also conducted extensive stakeholder interviews to gather information and feedback on the feasibility of privatizing these units. Through the analysis of these baseline and comparative models, as well as stakeholder interviews, PCG has presented multiple privatization scenarios for the state to consider as it examines the feasibility of privatizing the selected units.

As the privatization models and findings illustrate, PCG believes it may be possible for a private entity to provide services in the USH Forensic Unit and the USDC Semi-secure Units at the same level and at the same cost at which they are currently provided. To do so would require the

acceptance of some risks associated with such a decision. The greatest risk would be the potential for increased staff turnover and difficulties in future staff recruitment and retention, which could directly impact the level, continuity, and quality of services currently furnished in these units. Furthermore, PCG's analysis suggests that it would be difficult for a private entity to provide services at the same level at which they are currently provided at a lower cost, or for services to be provided at a higher level for the same or reduced cost, given the potential risks of affecting service delivery to patients.

Based on our research and analysis, PCG does not believe privatizing the Forensic Unit at USH or the TLC and Woodland units at USDC would be in the best interest of the state. PCG's analysis shows that while it is possible and potentially financially feasible to privatize the units at a cost savings, it may result in a reduction in the quality and continuity of care provided to the patients within the units studied.

5. APPENDICES

A. Data from Solicitation NO2009-02 –Consultant for Feasibility Study on Privatization of Portions of the Utah State Hospital and the Utah State Developmental Center

The following pages contain the supplemental data provided as part of the Solicitation announcement from the state of Utah.

State of Utah Bid NO2009-02 - Posting for Utah State Legislature

Page: 1
Date: 9/18/09

Appropriation Category Report

Base Budget

		Act 09	App 10	Auth 10	Req 11	Fis Anal
KB						
KBF	**KBF State Hospital**					
Expenditures						
AA	PERSONAL SERVICES	43,528,400.00	44,366,400.00	43,986,500.00	44,011,000.00	0.00
BB	TRAVEL / IN STATE	4,200.00	5,000.00	4,200.00	4,200.00	0.00
CC	TRAVEL / OUT STATE	2,000.00	19,500.00	2,000.00	2,000.00	0.00
DD	Current Expense	8,792,900.00	9,533,800.00	9,195,200.00	9,937,000.00	0.00
EE	DATA PROC CURRENT EXPENSE	2,071,100.00	2,009,100.00	2,071,100.00	2,071,100.00	0.00
		54,398,600.00	55,933,800.00	55,259,000.00	56,025,300.00	0.00
Revenues						
AG	GENERAL FUND	39,657,000.00	39,204,300.00	39,204,300.00	40,620,600.00	0.00
DF	FEDERAL FUNDS	0.00	(6,000.00)	0.00	0.00	0.00
ED	DEDICATED CREDIT	3,305,100.00	3,015,100.00	3,280,800.00	3,280,800.00	0.00
LT	TRANSFERS	66,800.00	68,500.00	68,500.00	68,500.00	0.00
PL	LAPSING BALANCE	(113,500.00)	0.00	0.00	0.00	0.00
TN	TRANSFERS TITLE XIX	11,483,200.00	13,651,900.00	12,705,400.00	12,055,400.00	0.00
		54,398,600.00	55,933,800.00	55,259,000.00	56,025,300.00	0.00
Total	**KBF**					
	Expenditures	**54,398,600.00**	**55,933,800.00**	**55,259,000.00**	**56,025,300.00**	**0.00**
	Revenues	**54,398,600.00**	**55,933,800.00**	**55,259,000.00**	**56,025,300.00**	**0.00**
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
KB	**Totals**					
	Expenditures	**54,398,600.00**	**55,933,800.00**	**55,259,000.00**	**56,025,300.00**	**0.00**
	Revenues	**54,398,600.00**	**55,933,800.00**	**55,259,000.00**	**56,025,300.00**	**0.00**
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Grand Totals						
	Expenditures	**54,398,600.00**	**55,933,800.00**	**55,259,000.00**	**56,025,300.00**	**0.00**
	Revenues	**54,398,600.00**	**55,933,800.00**	**55,259,000.00**	**56,025,300.00**	**0.00**
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Appropriation Category Report

Base Budget

		Act 08	App 09	Auth 09	Req 10	Fis Anal
KB						
KBF	**KBF State Hospital**					
Expenditures						
AA	PERSONAL SERVICES	42,166,700.00	44,888,784.00	44,366,400.00	44,366,400.00	0.00
BB	TRAVEL / IN STATE	5,100.00	5,000.00	5,000.00	5,000.00	0.00
CC	TRAVEL / OUT STATE	19,000.00	19,500.00	19,500.00	19,500.00	0.00
DD	Current Expense	9,711,900.00	8,276,016.00	9,609,000.00	9,609,000.00	0.00
EE	DATA PROC CURRENT EXPENSE	2,230,700.00	1,605,800.00	2,009,100.00	2,009,100.00	0.00
GG	CAPITAL EXPEND (EXCEPT DP)	104,400.00	0.00	0.00	0.00	0.00
		54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	0.00
Revenues						
AG	GENERAL FUND	39,385,600.00	40,751,900.00	40,751,900.00	40,751,900.00	0.00
ED	DEDICATED CREDIT	3,359,900.00	2,350,500.00	3,011,500.00	3,011,500.00	0.00
LT	TRANSFERS	69,400.00	65,000.00	68,500.00	68,500.00	0.00
PL	LAPSING BALANCE	(739,400.00)	0.00	0.00	0.00	0.00
TN	TRANSFERS TITLE XIX	12,162,300.00	11,627,700.00	12,177,100.00	12,177,100.00	0.00
		54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	0.00
Total	**KBF**					
	Expenditures	54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	**0.00**
	Revenues	54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	**0.00**
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
KB	**Totals**					
	Expenditures	54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	**0.00**
	Revenues	54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	**0.00**
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**
Grand Totals						
	Expenditures	54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	**0.00**
	Revenues	54,237,800.00	54,795,100.00	56,009,000.00	56,009,000.00	**0.00**
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**

Page: 1
Date: 9/14/07

Appropriation Category Report

Base Budget

		Act 07	App 08	Auth 08	Req 09	Fis Anal
KB						
KBF	**KBF State Hospital**					
Expenditures						
AA	PERSONAL SERVICES	39,448,100.00	41,850,800.00	41,891,000.00	41,891,000.00	0.00
BB	TRAVEL / IN STATE	6,600.00	7,000.00	7,000.00	7,000.00	0.00
CC	TRAVEL / OUT STATE	20,100.00	21,300.00	21,500.00	21,500.00	0.00
DD	Current Expense	9,491,900.00	8,627,100.00	9,394,400.00	9,463,900.00	0.00
EE	DATA PROC CURRENT EXPENSE	1,596,700.00	1,417,000.00	1,596,600.00	1,596,600.00	0.00
FF	DATA PROC CAPITAL EXPEND	5,400.00	7,500.00	0.00	0.00	0.00
GG	CAPITAL EXPEND (EXCEPT DP)	16,600.00	0.00	69,500.00	0.00	0.00
		50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
Revenues						
AG	GENERAL FUND	38,082,200.00	39,385,600.00	39,385,600.00	39,385,600.00	0.00
ED	DEDICATED CREDIT	2,751,000.00	2,475,700.00	2,270,800.00	2,270,800.00	0.00
LT	TRANSFERS	87,000.00	65,000.00	65,000.00	65,000.00	0.00
PL	LAPSING BALANCE	(206,200.00)	0.00	0.00	0.00	0.00
TN	Transfers Title XIX	9,871,400.00	10,004,400.00	11,258,600.00	11,258,600.00	0.00
		50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
Total	**KBF**					
	Expenditures	50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
	Revenues	50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
	Difference	0.00	0.00	0.00	0.00	0.00
KB	**Totals**					
	Expenditures	50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
	Revenues	50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
	Difference	0.00	0.00	0.00	0.00	0.00
Grand Totals						
	Expenditures	50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
	Revenues	50,585,400.00	51,930,700.00	52,980,000.00	52,980,000.00	0.00
	Difference	0.00	0.00	0.00	0.00	0.00

Revenue Category by Appropriation Unit

9/29/2006 — 2000 DBS Division of Substance Abuse and Mental Health — Form 300C

KBF DBS STATE HOSPITAL

CODE	DESCRIPTION	ACTUAL FY 2006	APPROPRIATE FY 2007	AUTHORIZED FY 2007	REQUEST FY 2008
AB	GENERAL FUNDS	34,333,400.00	37,605,300	37,605,300	37,671,000
DC	DEDICATED CREDITS	1,912,800.00	3,009,100	2,353,900	2,353,800
TN	TRANSFERS TITLE XIX	9,549,000.00	8,729,500	9,416,700	9,416,700
TR	TRANSFERS OTHER	74,300.00	59,000	65,000	65,000
ZA	BEGIN FUND BAL	56,000.00			
ZC	LAPSING FUNDS	-240,700.00			
	TOTAL REVENUES	45,684,800.00	49,402,900	49,440,900	49,506,500

Expenditure Category by Appropriation Unit

9/29/2006 — 2000 DBS Division of Substance Abuse and Mental Health — Form 300C

KBF DBS STATE HOSPITAL

CODE	DESCRIPTION	ACTUAL FY 2006	APPROPRIATE FY 2007	AUTHORIZED FY 2007	REQUEST FY 2008
AA	PERSONAL SERVICES	36,729,600.00	41,026,500	39,714,500	39,843,100
BB	TRAVEL / IN STATE	6,700.00	9,500	9,600	9,600
CC	TRAVEL / OUT STATE	16,700.00	15,200	15,200	15,200
DD	CURRENT EXPENSE	7,971,300.00	7,689,300	8,347,600	8,284,600
EE	DATA PROC CURRENT EXPENSE	704,400.00	655,900	1,347,500	1,347,500
FF	DATA PROC CAPITAL EXPEND	41,000.00		0	0
GG	CAPITAL EXPEND (EXCEPT DP)	215,100.00	6,500	6,500	6,500
	TOTAL EXPENDITURE	45,684,800.00	49,402,900	49,440,900	49,506,500

Revenue Category by Appropriation Unit

10/12/2005 — 2000 DHS Division of Substance Abuse and Mental Health — Form 300C

KBF STATE HOSPITAL

CODE	DESCRIPTION	ACTUAL FY 2005	APPROPRIATE FY 2006	AUTHORIZED FY 2006	REQUEST FY 2007
AB	GENERAL FUNDS	31,961,500.00	33,974,700	33,974,700	33,899,100
DC	DEDICATED CREDITS	3,445,900.00	3,002,800	2,657,000	2,614,500
TN	TRANSFERS TITLE XIX	9,072,900.00	9,597,000	8,016,700	8,016,700
TR	TRANSFERS OTHER	64,000.00	59,000	59,000	59,000
ZA	BEGIN FUND BAL	10,400.00		56,000	
ZB	NON-LAPSE FUNDS	-56,000.00		0	
ZC	LAPSING FUNDS	-120,600.00			
	TOTAL REVENUES	44,378,100.00	46,633,500	44,763,400	44,589,300

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Expenditure Category by Appropriation Unit

10/12/2005 — 2000 DHS Division of Substance Abuse and Mental Health — Form 300C

KBF STATE HOSPITAL

CODE	DESCRIPTION	ACTUAL FY 2005	APPROPRIATE FY 2006	AUTHORIZED FY 2006	REQUEST FY 2007
AA	PERSONAL SERVICES	36,014,700.00	38,465,700	36,679,500	36,561,700
BB	TRAVEL / IN STATE	6,000.00	9,500	9,400	9,400
CC	TRAVEL / OUT STATE	16,300.00	15,200	15,200	15,200
DD	CURRENT EXPENSE	7,382,700.00	7,341,400	7,247,200	7,246,900
EE	DATA PROC CURRENT EXPENSE	838,700.00	750,000	805,900	749,900
FF	DATA PROC CAPITAL EXPEND	22,800.00	45,500	0	0
GG	CAPITAL EXPEND (EXCEPT DP)	96,900.00	6,200	6,200	6,200
	TOTAL EXPENDITURE	44,378,100.00	46,633,500	44,763,400	44,589,300

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Appropriation Category Report

Base Budget

		Act 09	App 10	Auth 10	Req 11	Fis Anal
KF						
KFC KFC State Developmental Center						
Expenditures						
AA	PERSONAL SERVICES	30,899,100.00	32,138,300.00	32,138,700.00	32,138,700.00	0.00
BB	TRAVEL / IN STATE	1,000.00	6,700.00	6,700.00	6,700.00	0.00
CC	TRAVEL / OUT STATE	0.00	7,200.00	0.00	0.00	0.00
DD	Current Expense	6,625,400.00	6,480,500.00	6,487,300.00	6,487,300.00	0.00
EE	DATA PROC CURRENT EXPENSE	830,500.00	841,100.00	841,100.00	841,100.00	0.00
FF	DATA PROC CAPITAL EXPEND	0.00	6,000.00	6,000.00	6,000.00	0.00
GG	CAPITAL EXPEND (EXCEPT DP)	55,500.00	50,000.00	50,000.00	50,000.00	0.00
HH	OTHER CHARGES/PASS THROUGH	120,900.00	0.00	0.00	0.00	0.00
		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Revenues						
AG	GENERAL FUND	8,529,600.00	7,493,900.00	7,493,900.00	10,661,400.00	0.00
ED	DEDICATED CREDIT	2,517,500.00	2,534,600.00	2,534,600.00	2,534,600.00	0.00
KC	CLOSEING BALANCE	(1,285,300.00)	0.00	0.00	0.00	0.00
LT	TRANSFERS	0.00	75,000.00	75,000.00	75,000.00	0.00
PL	LAPSING BALANCE	(500,000.00)	0.00	0.00	0.00	0.00
TN	TRANSFERS TITLE XIX	29,270,600.00	29,426,300.00	29,426,300.00	26,258,800.00	0.00
		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Total KFC						
Expenditures		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Revenues		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Difference		0.00	0.00	0.00	0.00	0.00
KF Totals						
Expenditures		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Revenues		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Difference		0.00	0.00	0.00	0.00	0.00
Grand Totals						
Expenditures		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Revenues		38,532,400.00	39,529,800.00	39,529,800.00	39,529,800.00	0.00
Difference		0.00	0.00	0.00	0.00	0.00

Appropriation Category Report

Base Budget

		Act 08	App 09	Auth 09	Req 10	Fis Anal
KF						
KFC	**KFC State Developmental Center**					
Expenditures						
AA	PERSONAL SERVICES	29,999,300.00	32,186,500.00	32,186,200.00	32,186,200.00	0.00
BB	TRAVEL / IN STATE	1,000.00	6,700.00	6,700.00	6,700.00	0.00
CC	TRAVEL / OUT STATE	0.00	7,200.00	7,200.00	7,200.00	0.00
DD	Current Expense	6,403,000.00	6,357,300.00	6,357,600.00	6,357,600.00	0.00
EE	DATA PROC CURRENT EXPENSE	835,900.00	889,000.00	889,000.00	889,000.00	0.00
FF	DATA PROC CAPITAL EXPEND	0.00	6,000.00	6,000.00	6,000.00	0.00
GG	CAPITAL EXPEND (EXCEPT DP)	241,800.00	50,000.00	0.00	0.00	0.00
HH	OTHER CHARGES/PASS THROUGH	106,000.00	0.00	50,000.00	50,000.00	0.00
		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Revenues						
AG	GENERAL FUND	10,763,800.00	10,842,800.00	10,842,800.00	10,842,800.00	0.00
ED	DEDICATED CREDIT	2,493,200.00	2,263,400.00	2,533,000.00	2,533,000.00	0.00
KC	CLOSEING BALANCE	(531,700.00)	0.00	0.00	0.00	0.00
LT	TRANSFERS	1,900.00	155,000.00	75,000.00	75,000.00	0.00
TN	TRANSFERS TITLE XIX	24,859,800.00	26,241,500.00	26,051,900.00	26,051,900.00	0.00
		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Total	**KFC**					
Expenditures		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Revenues		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Difference		0.00	0.00	0.00	0.00	0.00
KF	**Totals**					
Expenditures		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Revenues		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Difference		0.00	0.00	0.00	0.00	0.00
Grand Totals						
Expenditures		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Revenues		37,587,000.00	39,502,700.00	39,502,700.00	39,502,700.00	0.00
Difference		0.00	0.00	0.00	0.00	0.00

Appropriation Category Report

		Act 07	App 08	Auth 08	Req 09	Fis Anal	Base Budget
KF							
KFC	**KFC State Developmental Center**						
Expenditures							
AA	PERSONAL SERVICES	28,500,700.00	32,989,400.00	31,777,600.00	31,777,600.00	0.00	
BB	TRAVEL / IN STATE	1,700.00	6,700.00	6,700.00	6,700.00	0.00	
CC	TRAVEL / OUT STATE	0.00	7,200.00	7,200.00	7,200.00	0.00	
DD	Current Expense	6,398,600.00	5,812,700.00	6,860,500.00	6,860,500.00	0.00	
EE	DATA PROC CURRENT EXPENSE	688,500.00	573,000.00	737,000.00	737,000.00	0.00	
FF	DATA PROC CAPITAL EXPEND	0.00	6,000.00	6,000.00	6,000.00	0.00	
GG	CAPITAL EXPEND (EXCEPT DP)	52,200.00	100,000.00	100,000.00	100,000.00	0.00	
		35,641,700.00	39,495,000.00	39,495,000.00	39,495,000.00	0.00	
Revenues							
AG	GENERAL FUND	10,406,500.00	10,763,800.00	10,763,800.00	10,763,800.00	0.00	
ED	DEDICATED CREDIT	2,264,400.00	2,183,100.00	2,183,100.00	2,183,100.00	0.00	
KC	CLOSEING BALANCE	(24,600.00)	0.00	0.00	0.00	0.00	
LT	TRANSFERS	33,200.00	0.00	155,000.00	155,000.00	0.00	
TN	Transfers Title XIX	22,962,200.00	26,548,100.00	26,393,100.00	26,393,100.00	0.00	
		35,641,700.00	39,495,000.00	39,495,000.00	39,495,000.00	0.00	
Total KFC							
	Expenditures	**35,641,700.00**	**39,495,000.00**	**39,495,000.00**	**39,495,000.00**	**0.00**	
	Revenues	**35,641,700.00**	**39,495,000.00**	**39,495,000.00**	**39,495,000.00**	**0.00**	
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	
KF	**Totals**						
	Expenditures	**35,641,700.00**	**39,495,000.00**	**39,495,000.00**	**39,495,000.00**	**0.00**	
	Revenues	**35,641,700.00**	**39,495,000.00**	**39,495,000.00**	**39,495,000.00**	**0.00**	
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	
Grand Totals							
	Expenditures	**35,641,700.00**	**39,495,000.00**	**39,495,000.00**	**39,495,000.00**	**0.00**	
	Revenues	**35,641,700.00**	**39,495,000.00**	**39,495,000.00**	**39,495,000.00**	**0.00**	
	Difference	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	

Revenue Category by Appropriation Unit

9/29/2006 — Form 300C

4000 DHS Div of Services for People with Disabilities

KFC DHS STATE DEVELOPMENTAL CNTR

CODE	DESCRIPTION	ACTUAL FY 2006	APPROPRIATE FY 2007	AUTHORIZED FY 2007	REQUEST FY 2008
AB	GENERAL FUNDS	9,481,800.00	10,398,300	10,543,000	10,570,100
DC	DEDICATED CREDITS	1,719,600.00	1,493,000	2,070,000	2,070,000
TN	TRANSFERS TITLE XIX	23,200,500.00	25,294,100	24,724,800	24,808,500
TR	TRANSFERS OTHER	56,900.00	141,000	144,000	155,000
ZB	NON-LAPSE FUNDS	-162,200.00			
	TOTAL REVENUES	34,296,600.00	37,326,400	37,481,800	37,603,600

Expenditure Category by Appropriation Unit

9/29/2006 — Form 300C

4000 DHS Div of Services for People with Disabilities

KFC DHS STATE DEVELOPMENTAL CNTR

CODE	DESCRIPTION	ACTUAL FY 2006	APPROPRIATE FY 2007	AUTHORIZED FY 2007	REQUEST FY 2008
AA	PERSONAL SERVICES	27,806,200.00	31,032,800	30,395,100	30,486,900
BB	TRAVEL / IN STATE	2,700.00	6,700	6,700	6,700
CC	TRAVEL / OUT STATE		7,200	7,200	7,200
DD	CURRENT EXPENSE	5,713,600.00	5,673,700	6,306,200	6,336,200
EE	DATA PROC CURRENT EXPENSE	476,100.00	500,000	660,600	660,600
FF	DATA PROC CAPITAL EXPEND	0.00	6,000	6,000	6,000
GG	CAPITAL EXPEND (EXCEPT DP)	286,600.00	100,000	50,000	50,000
HH	OTHER CHARGES/PASS THROUGH	11,400.00		50,000	50,000
	TOTAL EXPENDITURE	34,296,600.00	37,326,400	37,481,800	37,603,600

Revenue Category by Appropriation Unit

9/19/2005 — 4000 DHS Div of Services for People with Disabilities — Form 300C

KFC STATE DEVELOPMENTAL CENTER

CODE	DESCRIPTION	ACTUAL FY 2005	APPROPRIATE FY 2006	AUTHORIZED FY 2006	REQUEST FY 2007
AB	GENERAL FUNDS	8,933,500.00	9,353,000	9,481,800	9,541,900
DC	DEDICATED CREDITS	1,448,500.00	1,445,400	1,407,000	1,407,000
TN	TRANSFERS TITLE XIX	23,230,500.00	23,268,400	24,225,900	24,098,500
TR	TRANSFERS OTHER	189,200.00	336,300	144,400	119,000
ZB	NON-LAPSE FUNDS	-14,700.00			
	TOTAL REVENUES	33,787,000.00	34,403,100	35,259,100	35,166,400

Expenditure Category by Appropriation Unit

9/19/2005 — 4000 DHS Div of Services for People with Disabilities — Form 300C

KFC STATE DEVELOPMENTAL CENTER

CODE	DESCRIPTION	ACTUAL FY 2005	APPROPRIATE FY 2006	AUTHORIZED FY 2006	REQUEST FY 2007
AA	PERSONAL SERVICES	27,919,100.00	28,483,200	29,019,500	28,931,500
BB	TRAVEL / IN STATE	2,800.00	6,700	6,700	6,700
CC	TRAVEL / OUT STATE	100.00	7,200	7,200	7,200
DD	CURRENT EXPENSE	5,223,800.00	5,300,000	5,550,000	5,545,300
EE	DATA PROC CURRENT EXPENSE	442,200.00	500,000	500,000	500,000
FF	DATA PROC CAPITAL EXPEND		6,000	6,000	6,000
GG	CAPITAL EXPEND (EXCEPT DP)	129,300.00	100,000	100,000	100,000
HH	OTHER CHARGES/PASS THROUGH	69,700.00		69,700	69,700
	TOTAL EXPENDITURE	33,787,000.00	34,403,100	35,259,100	35,166,400

REQUEST FOR PROPOSALS to the Utah State Legislature
Consultant for Feasibility Study on Privatization of Portions of the Utah State Hospital and the Utah State Developmental Center, 2009-02

ADDENDUM 3

Addendum Date: January 4, 2010

Note: The information in this addendum is provided in response to questions posed by potential RFP responders. Much of this information is more applicable to conducting the actual study requested in the RFP than it is to the initial RFP response itself. However, the information is provided in order to assist potential responders in providing the best RFP response possible. It is requested that questions regarding this RFP focus on information needed to respond to the RFP itself. The successful RFP responder will be provided additional information on the FACILITIES in order to enable the responder to complete the study and the report described in this RFP.

Item 1:

UTAH STATE HOSPITAL
FORENSIC FACILITY PERSONNEL & OPERATIONAL COSTS- FY 2010

The Forensic Mental Health Facility at Utah State Hospital has a capacity of 100 patients. The facility provides court ordered inpatient psychiatric services in a secure setting to the citizens of Utah 18 years and older who suffer from a serious mental illness and who have been convicted or have been charged with a crime in the State of Utah.

The facility is divided into 4 units with populations of 22, 26, 26, and 26. One unit of 26 admits both males and females. The other 3 units are male units. The core staff for the entire facility is 155.5 FTE's with a cost in FY 2010 of $9,247,000.

In FY 2010, $7,694,013 in indirect costs for the Forensic Mental Health Facility is provided by Utah State Hospital. These indirect costs include hospital personnel as well as hospital wide services that are contracted privately. Personnel from Medical Clinics, Physical Therapy, Transportation, Information Technology, Medical Records, Substance Abuse Day treatment, Pharmacy, Food Services, Custodial Services, Maintenance and Fleet, Swimming Pool, Patient Library, Volunteer Services, Chaplain, Business Office/Purchasing/Warehouse, Switchboard, Medical Staff Coordinator, Human Resources, Hospital Executive Staff, Risk Management, Nursing Education, Nursing Administration, Scheduling, Security, Infection Control, Occupational Therapy, Vocational Therapy, Director of Social Work Services, Director of Recreation Therapy, Medicare/Medicaid Eligibility, Psychology, Legal Services/Civil Court, Consumer Advocates, Beautician, Medical Services, and Quality Resources provide services to the Forensic facility. Many of these departments consist of 1 or 2 FTE's and could not be downsized without a significant negative impact to the entire hospital.

Hospital wide contracted services for this facility are Dental, Optometry, Podiatry, Neurology, EEG's, EKG's, Audiology, Laboratory, Radiology, Adult Education, Utah State Department of Technical Services, Laundry, Window Washing, Pest Control, Grounds-lawns, and a Patient Attorney. The cost effectiveness of these services would be diminished if the contract was not hospital wide.

The budget for support staff and contracted services in the Forensic Facility is 45% of the total Forensic budget. The total budget for the Forensic Mental Health Facility for FY 2010 is $16,941,013.

Item 2:

Procedure/protocol for placement in TLC and Woodland and for moving residents from there to a less secure environment:

The Emergency Services Management Committee (ESMC) makes determinations on all requests for admission to the Utah State Developmental Center. Determinations can result in a recommendation for admission, a referral to another resource, or suggestions regarding other interventions or supports that should be tried before an admission decision is considered.

Typically, individuals referred to the Developmental Center meet the following ESMC Criteria:

- Individual must have severe behavioral needs which jeopardizes their or the families health and Safety.
- Individual must have severe medical needs which jeopardizes their health and safety
- Individual (self or others) must be at risk for permanent injury or death.

Other criteria typically considered by the Committee include:

- The Community Provider has exhausted the available resources and still has not been able to stabilize the individual's behavioral, mental health or health issues.
- The ability of alternative community placements to provide the necessary support for the individual. Frequently admissions to the Developmental Center are at the request of the provider who has been given a 30 days notice to continue services. No other community provider is willing to provide services until the behavioral or medical issues are resolved.
- The individual is a sex offender and is unable to be supported in a community setting. Typically the individual is found not competent to stand trial and is referred to us by the courts with a request for a secure setting.
- The individual has severe behavioral issues that have not been able to be brought under control in a community provider setting. The individuals may require a semi-secure setting to assure the communities safety while behaviors are being addressed.
- The individual has a dual diagnosis of Intellectual Disabilities and has a serious Mental Health problem that the Community Mental Health Hospitals are not able to get under control during a short admission. The individual does not meet the criteria for the State Hospital, yet requires intensive mental health supports in order to address their treatment

needs.

- The individual has severe medical issues. He/she does not require a skilled nursing level of care but requires an enhanced level of nursing and medical follow up. Typically these individuals have medical disabilities such as seizures, severe burns, severe diabetes and obesity.

The ESMC has historically referred only the most difficult individuals for placement. Admission requests are quite individualized and are typically based on clinical observations and the clinical decision of the ESMC team.

Item 3:

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES
EMERGENCY SERVICES MANAGEMENT COMMITTEE
Guidelines July 2009 to June 2010

PURPOSE:

- Consider requests from the Regions for emergency funding for individuals on the Waiting List, Court Ordered referrals, individuals who are currently in service and are Requesting Additional Funding (RAS) for existing services over $3,000 in state funds, new services (ex. residential, day supports), and individuals who meet the ESMC criteria for Emergency Waiting List One-Time crisis funding criteria.
- Allocate Committee funds based on decisions about each case, after ascertaining that the Region has considered all possible alternatives and has used all available funding resources. The Regions must have exhausted all their options with available Waiting List and RAS allocations prior to coming to the committee.
- Provide professional and clinical recommendations on difficult cases on which the regions request assistance.
- Make determinations on all requests for admission to the Utah State Developmental Center. These can include recommendation for admission, referral to other resources or suggestions regarding other interventions/supports that might help before an admission decision should be considered.
- When considering funding priorities for Waiting List consumers, the ESMC will typically fund the most critical cases primarily based upon the individual's Needs Assessment ranking. However, the ESMC may override the Needs Assessment ranking order based upon a clinical review by the Committee that indicates a crisis situation that is not clearly identified by the Needs Assessment Score document that shows an immediate need for funding.
- Review Court Ordered placements for appropriateness of referrals, necessity for funding, proposed treatment planning, and approval of suggested Regional funding level.

COMPOSITION:

A State Office professional will chair the Committee, appointed by the Division Director. One staff member appointed by the Region Director will represent each Region. Other State Office staff with expertise in behavioral issues, medical and available community resources will also be asked to serve. The Utah Health Care Association may provide a representative from the private ICF/MR system to participate as a member of the committee. A consumer and /or parent may be appointed to attend but can not receive a stipend for their attendance. Terms of membership for division staff are not time limited but can change if job duties so necessitate. Terms of membership for members not employed by the division should be reviewed every four years. These members can be re-appointed for additional terms if they are so willing and the approval of the Division Director.

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MEETINGS and REFERRALS:

- Regular meetings will be held monthly on the first Thursday of the month, with emergency meetings being called as necessary. Access / referral to the Committee should go through the Region Administrative Program Managers for initial review and recommendations.
- Support coordinators may attend by phone or in person to provide necessary information to support their request, when invited by the Committee Chair.
- Families and other involved persons may attend via phone in order to provide information to the committee, when invited by the Committee Chair.
- Prior to screening an individual at ESMC, all community, natural and family resources must be documented, explored and/or exhausted.
- Referrals to the ESMC Committee must be received by Tuesday afternoon of the first week of the month to be considered for the Thursday meeting. Administrative Program Mangers should review the ESMC Request for New / Additional Services (RAS requests over $3000 & Waiting List) document to assure that they meet the funding criteria and request the appropriate level of funding. They should enter their comments and approval on the ESMC referral form.
- Support Coordinators should submit an electronic version of the ESMC referral form for New / Additional RAS services over $3,000 and Waiting lit request prior to the meeting. The referral form should be filled out completely, including the proposed services / supports requested and the projected costs for the current and coming fiscal years. A Worksheet should be attached showing how funding was developed for residential and day programs. A referral should be made for Court Ordered funding requests for review and approval of the committee.
- The Committee meetings will be closed for final decision-making and funding determinations. The Regional Administrative Program Managers will inform the support coordinator of the committee's decision upon receiving the ESMC minutes. A copy of the minutes, regarding the consumer, should be emailed to the support coordinator for inclusion in the Log notes.
- Decisions will normally be made by consensus, but if agreement cannot be reached, the Division Director will have the final say. If there is a difference of opinion on the final funding in terms of what the person needs between the Committee, Region and / or support coordinator, for either community or court ordered funding requests, the final approved funding amount will be determined between the Division Director and his /her designee.

CRITERIA FOR PRIORITIZING ESMC REFERRALS - <u>CAN INCLUDE BUT ARE NOT LIMITED TO:</u>

- Immediate threat to health and safety of the individual or their family.
- Immediate risk of becoming homeless
- Children who can no longer be maintained in their family residence due to sever behavioral or medical issues
- Immediate threat of causing injury to others or property destruction

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- Immediate risk of loss of caregiver and/or deterioration of family

FY 2010 Referral Criteria for Ongoing (base) Funding:
Individuals requesting ESMC funding must meet one of the following:

- Individual must be homeless or in immediate jeopardy of being homeless Individual's parents are deceased and there is no other family member or friend able or willing to provide supports.
- Individual must have severe behavioral needs which jeopardizes their or the families health and safety
- Individual must have severe medical needs which jeopardizes their health and safety
- Individual must have documented physical/sexual abuse
- Individual (self or others) must be at risk for permanent injury or death
- Individual has been court ordered into DSPD service

FY 2010 Criteria for Distribution of One-Time ESMC Waiting List Funding:

- The ESMC Committee will establish criteria to determining who is eligible for distribution of One-Time Waiting List Crisis State Funding.
- This document will be revised annually based upon the Division's budgets and available One – Time State funds.

Item 4:

TLC Building Guidelines for Staff (5-19-09)

Phone protocol:

Individuals are allowed to use the phone in the med room with staff supervision on Level 1 or 2. If an individual is escalated, then staff will allow them time (15 minute minimum) to calm before the call is made. Staff will dial the number and the individual will be given the handset to use in the hallway with the med room door closed. The cordless phone in the kitchen and downstairs are not to be used by individuals.

- Phone calls are not allowed during workshop, meal times, or other scheduled activities.
- Lawyers and clergy can be called at any available time throughout the day as long as the individuals is not escalated.
- Guardians, immediate family, and caseworkers can be contacted with the assistance of the social worker or QMRP when the individual is on Level 1 or 2.
- Other phone calls can be made at the following times:
  - 6:00 8:00 pm daily
  - 12:00 -2:00 pm on Weekends

Keys:

Each individual will be assigned a key to their room unless the right is restricted. Once it is lost, they will require staff to open their door or they can purchase a new key for $2.00.

Visitors:

All visitors should be accompanied in the building by staff at all times. This includes nurses and other USDC staff, unless the nurse/staff tell TLC staff they do not need an escort.

QMRP/Program Lead office:

Individuals are not to be in the office due to confidential information that is on the desks at times. The QMRP or Program Lead may invite an individual into the office, but only one should enter at a time. Individuals should not knock on the door and disturb anyone working in the office, but should get with staff and call from the building phone to make an appointment.

Social Work office:

Individuals should not knock on the door and disturb anyone working in the office, but should get with staff and call from the building phone to make an appointment.

Nurses Office:

Individuals should not knock on the door and disturb anyone working in the office, but should get with staff and call from the building phone to make an appointment.

Downstairs:

Downstairs access is limited to individuals who have taken their medications, made their bed, cleaned their room, attended work, and done any chores assigned. Anyone who appears escalated to staff can be denied access until 2 staff can interact with them and agree that the individual is no longer escalated. When individuals are downstairs, they are responsible for cleaning up before leaving. Staff need to make certain that the individuals clean up or the staff will clean up any mess before the end of shift.

Med room:

Individuals are not to enter the med room unless invited. Only one individual is to be in the room at any time. Individuals are not to stay in the Med room while talking on the phone.

Kitchen:

The TLC kitchen is kept locked. There is an automatic lock on the back door and the door leading to the dining room is locked except when serving meals or cooking. Sharps are kept in the kitchen which is locked. This means the knives and food are restricted. Individuals are not to enter the kitchen unless invited by staff. Staff need to monitor potential weapons and knives

before they invite an individual into the kitchen and continue monitoring during the time the individual is in the kitchen. Some individuals may not be allowed access to the kitchen at all by the team or they may not be allowed to use knives or other specified kitchen utensils.

Bedrooms:

Individuals are not allowed to go in each others' rooms. No exceptions!

Hallways:

Staff should be monitoring hallways at all times when individuals are using them. Staff should observe and watch for individuals trying to go in offices or other individual's rooms. They should also observe interactions and monitor conversations between individuals.

Dayroom:

When behaviors occur, staff may need to remove furniture and objects that could be used to cause further damage or be used to climb on to reach wires, speakers, etc. Individuals can disable the magnetic door by ripping out the wires above the door and this must be monitored or prevented.

Laundry Room:

Individuals should not be left unaccompanied in the laundry room.

Building Van/vehicles:

Individuals will be restricted from use of vehicles until they can be effectively assessed and proven safe to ride. (Conditional—will be an Interdisciplinary Team decision).

Media:

Movies. No R-rated or NC-17 movies are allowed to be viewed in TLC. PG-13 movies need to be Okayed by the team before viewing. Any PG or G rated movies do not need any prior approval.

Games hat have an ESRB rating of Teen, Mature, Adults Only, or Rating Pending need to be approved by the team before use by the individual. ESRB Ratings of Early Childhood, Everyone, and Everyone 10+ have no restrictions.

Music that has a "Parental Advisory Explicit content" logo or warning on the album is not allowed. Any music with profanity, drug references, violent themes, or sexual content should not be played by individuals and may be restricted.

Paychecks:

Individuals will get up to $10 every two weeks from their paychecks. Money will be kept in the lock box in the program lead office to help assist them to manage their money. At no time will the individuals be allowed to keep more than $20 on their person. Since the money must be accounted for, the individuals are only given enough for the purchase they want to make during that shift.

Lock Box:

The lock box will only be available once in the AM (11:00 am) for TIMS payment and once in the PM (4:00 pm) for TIMS payment. Individuals will need to arrange to get any of their personal money at those times. The program leads or a charge person with a key are the only ones who will disperse money. Individuals will sign off on their ledger sheet when money is deposited or withdrawn. If they are unable to sign, then the program lead or charge person will sign off on the transaction.

Work:

Individuals are expected to go to work Monday through Friday from 9:00 am to 11:00 am and 2:00 pm to 4:00 pm. Times may differ slightly, but are still expected to meet the standard of 2 hours in the morning and 2 hours in the afternoon. If an individual does not go to work, they do not earn that part of their TIMS money and their pay check will have 50 cents deducted for each time they miss work or work less than half of the scheduled time from the $10 they are given each two weeks. If the individual misses work 2 mornings and 3 afternoons and come back from work after only 15 minutes of work 3 times, they would get $4 less that pay period and would get $6 instead of $10.

Item 5:

TLC Level System (Revised 5-19-09)

Level 1: The individual enjoys all privileges. The individual may participate in all on-campus and off-campus activities scheduled unless personal restrictions apply.

Level 2: The individual enjoys privileges strictly related to and located on the USDC campus. The individual may participate in riding horses at the farm, going to dances, working, swimming, riding bikes, etc. The individual may not go on any activity off the USDC campus.

Level 3: The individual is restricted to the TLC building and work only. They may go out back in the fenced area. They cannot go downstairs. They cannot walk anywhere else outside the building except directly to work and back. They are restricted from going on the van for on hill box runs. Individuals on Level 3 do not attend school. All Phone privileges are restricted while on Level 3. An incident form must be filled out Documenting the behavior that warranted a drop in each Level.

Level Procedure:

- An individual will drop a level when he refuses to take his medications during the appropriate time frame (med pass), refuses to go to work, or threatens physical harm to staff, self or another individual. If an individual refuses the second med pass, they will drop from Level 2 to Level 3. An incident form must be filled out documenting the behavior that warranted a drop in each Level.
- A person will be placed on Level 3 if they become physically aggressive with another individual or staff member, and/or when he deliberately attempts to destroy property. One does not go to Level 3 for swearing or SIB, unless it escalates to physical aggression or property destruction. Threatening staff or other individuals with harm will also lead to a Level 3 if the individual is given a warning, has already dropped to Level 2, and continues to make threats of harm.
- An incident form must be filled out documenting the behavior that warranted a drop in Level.
- Once a level drop occurs, the staff must indicate this on the white board in the kitchen. This needs to be initialed and the starting date and time must be noted. After 24 hours, the individual will start on Level 2. Should he do well the entire day, he will then rise to Level 1 after another 24 hours. Should the individual regress and experience challenges, he will go back to the previous level, and will restart working toward a Level 1 starting from the time in incident ended. If they are on Level 3 due to refusing meds, they will be raised a level 24 hours from the end of the last med pass refused (8:30 am, 1:00 pm, 17:30 pm, and 20:30 pm).
- It is critical that staff document all changes of levels and the dates of these changes. It is also critical that all staff check the board and follow the Level Program in order to provide consistency and best support the individuals.

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- Any exceptions to these guidelines should be discussed in consultation with the team leader (QMRP, Professional in charge, or program lead/charge person on the weekend). For example, it may be felt that the individual who was put on Level 3 the previous day would benefit therapeutically from a walk with therapist outside the fenced area and the individual has been appropriate and working toward raising his level.

Item 6:

Budget Breakdown:

Transitional Living Center (TLC)

- Cost per client (average daily rate): $635.
- FY 2009 average census: 5
- FY 2009 total TLC cost : $1,158,872

Woodland

- Cost per client: $664.
- FY 2009 average census: 7
- FY 2009 total Woodland Cost: $1,697,503

Item 7:

Woodland & Transitional Living Center (TLC) Census
December, 2009

Number of individuals enrolled in TLC & Woodland at the end of the month

2007	TLC	Woodland	TLC Females
January	7	9	3
February	5	9	5
March	5	9	5
April	5	9	5
May	6	9	5
June	6	9	5
July	6	8	3
August	5	8	4
September	6	9	5
October	6	10	4
November	6	9	4
December	6	9	4

2008	TLC	Woodland	TLC Females
January	4	7	4
February	4	7	4
March	5	7	4
April	5	7	4
May	6	7	4
June	6	7	4
July	5	8	3
August	5	8	3
September	5	8	3
October	6	8	3
November	5	8	3
December	5	8	3

2009	TLC	Woodland	TLC Females
January	5	8	3
February	4	6	3
March	4	5	3
April	4	5	4
May	5	5	4
June	5	5	4
July	5	5	4
August	6	5	4
September	6	4	3
October	6	5	3
November	6	4	3
December	5	4	3

Item 8:

Woodland Movement of Population 2007-2009

Name	Moved In	Moved Out
23945	Before 1/1/2007	7/16/2007 to Oakridge #3
4083	Before 1/1/2007 TEMP 4/24/2008	11/13/07 to Oakridge #5 TEMP 5/20/2008 to Oak #5
14757	Before 1/1/2007	1/22/2008 to Oakridge #7
22393	Before 1/1/2007	9/29/2009 to Quailrun #7
4075	Before 1/1/2007	10/29/2007 to Oakridge #4
10201	Before 1/1/2007	
4085 TEMP=temporary	Before 1/1/2007 TEMP 10/28/2009 TEMP 12/1/2009	9/1/2007 to Quailrun #7 TEMP 11/16/2009 Quailrun #7 TEMP 12/2/2009 Quailrun #7
23744	Before 1/1/2007	7/16/2007 to Oakridge #3
23931	Before 1/1/2007 6/11/2008 – return from jail 10/10/2009 from Oakridge #1	5/21/2008 –Jail 11/20/2008 to Oakridge #1 10/12/2009 Twin Home 4B
3480	10/26/2007 from TLC	1/3/2008 – Jail 1/31/2008 – Discharged to State Hospital
24802	7/23/2007 new admission	3/26/2009 to TLC
22844	9/25/2007 from Quailrun #6	
24895	6/18/2008 from Woodland	2/2/2009 to Oakridge #5
3957	11/24/2008 new admission	2/2/2009 to Oakridge #2
24721	10/28/2009 from TLC	
25205	9/24/2009 from TLC	10/28/2009 to TLC

Item 9:

Transitional Living Center Movement of Population 2007-2009

Name	Moved In	Moved Out
22360	Before 1/1/2007	2/8/2007 to Oakridge #2
24145	Before 1/1/2007 8/26/2009 from Quailrun #7	6/24/2009 to Quailrun #7
24085	Before 1/1/2007	
22871	Before 1/1/2007	2/27/2007 to Quailrun
22649	Before 1/1/2007	1/22/2008 to Oakridge #7
13443	Before 1/1/2007	
23931	Before 1/1/2007 10/6/2008	9/10/2008 to Oakridge #1
24895	9/19/2007 new admission	6/18/2007 to Woodland
3480	10/24/2007 new admission	10/26/2007 to Woodland 1/3/2008 – Jail 1/31/2008 – Discharged to State Hospital
15085	5/3/2007 new admission	8/27/2007 to Oakridge #8
24721	5/30/2007 new admission 9/24/2009 Oakridge #5	3/18/2009 to Oakridge #5 10/28/2009 to Woodland
25087	3/12/2008 new admission	2/2/2009 to Quailrun #7
25205	5/28/2008 new admission 6/23/2009 from Quailrun #7 10/28/2009 from Woodland	2/2/2009 to Quailrun #7 9/24/2009 to Woodland
25398	9/30/2009 new admission	11/1/2008 Discharged
24802	3/26/2009 from Woodland	
25678	3/20/2009 new admission	12/7/2009 to Oakridge #2
25710	5/28/2009 new admission	

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Item 10:

Transitional Center for Females (Quailrun #4) Movement of Population 2007-2009

23631	Before 1/1/2007	4/13/2009 Twin Home 2A
22940	Before 1/1/2007	7/9/2007 Quailrun #1
21680	Before 1/1/2007	10/24/2007 Quailrun #3
20496	2/16/2007 re-admission 4/2/2009 Raintree #8	5/5/2008 to Raintree #8 9/28/2009 Twin Home 2A
24313	2/20/2007 new admission	7/12/2007 Discharged
24908	9/26/2007	7/11/2008 Quailrun #1
25649	4/29/2009	
25172	5/5/2008	
24851	8/28/2007	

Item 11:

USDC funding sources

General state funding: 30%
Title XIX: 65%
Social Security, Earned Income, and Insurance Collections: 5%

Item 12:

FY 2010 "Staffing Data Report" for Quailrun Apartment #4

Staffing (Full-time):

Developmentalist (8)
Lead Developmentalist (1)

Staffing (Part-time - ranging from .5 hrs daily to 30 hrs weekly):

Accounting Technician
Archive Technician
Audiaulogist
Building Coordinator
Center Attendant
Clinical Director
Custodian
Dental Assistant
Dentist
DHS Administrator III
Diet Tech
Executive Secretary
Financial Manager
Food Service Manager
Food Service Worker
Liability Prevention Specialist
Living Skills Atttendant
LPN
Maintenance Supervisor
Maintenance Worker
Nurse Practitioner
Occupational Therapist
Office Clerk
Office Technician
OT Tech
Physical Therapist
Program Administrator
Project Aide
Psychologist
PT Tech
Purchasing Agent
QMRP
Records Manager
Recreation Therapist

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RN II
RN III
Secretary
Social Worker
Superintendent
Support Service Coordinator
Support Staff Supervisor
Trainer III
Unit Director
Warehouse Worker

Item 13:

FY 2010 "Staffing Data Report" for Transitional Living Center

Staffing (Full-time):

Developmentalist (16)
Lead Developmentalist (2)

Staffing (Part-time - ranging from .5 hrs daily to 30 hrs weekly):

Accounting Technician
Archive Technician
Audiaulogist
Building Coordinator
Center Attendant
Clinical Director
Custodian
Dental Assistant
Dentist
DHS Administrator III
Diet Tech
Executive Secretary
Financial Manager
Food Service Manager
Food Service Worker
Liability Prevention Specialist
Living Skills Atttendant
LPN
Maintenance Supervisor
Maintenance Worker
Nurse Practitioner
Occupational Therapist
Office Clerk
Office Technician
OT Tech
Physical Therapist
Program Administrator
Project Aide
Psychologist
PT Tech
Purchasing Agent
QMRP
Records Manager
Recreation Therapist

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RN II
RN III
Secretary
Social Worker
Superintendent
Support Service Coordinator
Support Staff Supervisor
Trainer III
Unit Director
Warehouse Worker

Item 14:

FY 2010 "Staffing Data Report" for Woodland

Staffing (Full-time):

Developmentalist (19)
Lead Developmentalist (2)

Staffing (Part-time - ranging from .5 hrs daily to 30 hrs weekly):

Accounting Technician
Archive Technician
Audiaulogist
Building Coordinator
Center Attendant
Clinical Director
Custodian
Dental Assistant
Dentist
DHS Administrator III
Diet Tech
Executive Secretary
Financial Manager
Food Service Manager
Food Service Worker
Liability Prevention Specialist
Living Skills Atttendant
LPN
Maintenance Supervisor
Maintenance Worker
Nurse Practitioner
Occupational Therapist
Office Clerk
Office Technician
OT Tech
Physical Therapist
Program Administrator
Project Aide
Psychologist
PT Tech
Purchasing Agent
QMRP
Records Manager
Recreation Therapist

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RN II
RN III
Secretary
Social Worker
Superintendent
Support Service Coordinator
Support Staff Supervisor
Trainer III
Unit Director
Warehouse Worker

Item 15:

FY 2009 "Patient Days" Report

Quailrun Apartment #4

Patient #	Patient Days
4168	63
4165	365
4162	365
4137	289

Total: 1082

Transitional Living Center

Patient #	Patient Days
4156	365
4159	365
4170	34
4166	365
4135	365
4150	330

Total: 1824

Transitional Living Center

Patient #	Patient Days
4146	365
4158	365
3957	219
10201	365
4155	65
4143	365
4085	365
9926	365
2367	91

Total: 2565

Item 16:

USDC Census Data (Number of individuals enrolled at the end of the month)

2007	TLC	Woodland	Quailrun Apartment #4	Oakridge	Quailrun	Town Home 4
January	7	9	3	35	37	0
February	5	9	5	36	40	0
March	5	9	5	35	40	0
April	5	9	5	35	40	0
May	6	9	5	36	40	0
June	6	9	5	35	40	0
July	6	8	3	35	40	0
August	5	8	4	31	41	0
September	6	9	5	31	41	0
October	6	10	4	30	40	0
November	6	9	4	31	40	0
December	6	9	4	30	40	0

2008	TLC	Woodland	Quailrun Apartment #4	Oakridge	Quailrun	Town Home 4
January	4	7	4	33	39	0
February	4	7	4	33	40	0
March	5	7	4	33	40	0
April	5	7	4	33	40	0
May	6	7	4	33	40	0
June	6	7	4	33	40	0
July	5	8	3	34	40	0
August	5	8	3	34	39	0
September	5	8	3	34	37	0
October	6	8	3	33	37	0
November	5	8	3	34	37	0
December	5	8	3	33	37	0

2009	TLC	Woodland	Quailrun Apartment #4	Oakridge	Quailrun	Town Home 4
January	5	8	3	33	36	0
February	4	6	3	34	33	0
March	4	5	3	33	33	0
April	4	5	4	21	33	8
May	5	5	4	20	33	9
June	5	5	4	19	33	9
July	5	5	4	19	33	9
August	6	5	4	19	32	9
September	6	4	3	19	33	8
October	6	5	3	20	30	8
November	6	4	3	20	31	8
December	5	4	3	21	31	8

Item 17:

USDC Census Data (Number of individuals enrolled at the end of the month)

Transitional Living Center (TLC) Movement of Population 2007-2009

Name	Moved In	Moved Out
22360	Before 1/1/2007	2/8/2007 to Oakridge
24145	Before 1/1/2007 8/26/2009 from Quailrun	6/24/2009 to Quailrun
24085	Before 1/1/2007	
22871	Before 1/1/2007	2/27/2007 to Quailrun
22649	Before 1/1/2007	1/22/2008 to Oakridge
13443	Before 1/1/2007	
23931	Before 1/1/2007 10/6/2008	9/10/2008 to Oakridge
24895	9/19/2007 new admission	6/18/2007 to Woodland
3480	10/24/2007 new admission	10/26/2007 to Woodland 1/3/2008 – Jail 1/31/2008 – Discharged
15085	5/3/2007 new admission	8/27/2007 to Oakridge
24721	5/30/2007 new admission 9/24/2009 Oakridge	3/18/2009 to Oakridge 10/28/2009 to Woodland
25087	3/12/2008 new admission	2/2/2009 to Quailrun
25205	5/28/2008 new admission 6/23/2009 from Quailrun 10/28/2009 from Woodland	2/2/2009 to Quailrun 9/24/2009 to Woodland
25398	9/30/2009 new admission	11/1/2008 Discharged
24802	3/26/2009 from Woodland	
25678	3/20/2009 new admission	12/7/2009 to Oakridge
25710	5/28/2009 new admission	

Woodland Movement of Population 2007-2009

Name	Moved In	Moved Out
23945	Before 1/1/2007	7/16/2007 to Oakridge
4083	Before 1/1/2007 TEMP 4/24/2008	11/13/07 to Oakridge TEMP 5/20/2008 to Oakridge
14757	Before 1/1/2007	1/22/2008 to Oakridge
22393	Before 1/1/2007	9/29/2009 to Quailrun
4075	Before 1/1/2007	10/29/2007 to Oakridge
10201	Before 1/1/2007	
4085 TEMP=temporary	Before 1/1/2007 TEMP 10/28/2009 TEMP 12/1/2009	9/1/2007 to Quailrun TEMP 11/16/2009 Quailrun TEMP 12/2/2009 Quailrun
23744	Before 1/1/2007	7/16/2007 to Oakridge
23931	Before 1/1/2007	5/21/2008 –Jail

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	6/11/2008 – return from jail 10/10/2009 from Oakridge	11/20/2008 to Oakridge 10/12/2009 Twin Home 4
3480	10/26/2007 from TLC	1/3/2008 – Jail 1/31/2008 – Discharged to State Hospital
24802	7/23/2007 new admission	3/26/2009 to TLC
22844	9/25/2007 from Quailrun	
24895	6/18/2008 from Woodland	2/2/2009 to Oakridge
3957	11/24/2008 new admission	2/2/2009 to Oakridge
24721	10/28/2009 from TLC	
25205	9/24/2009 from TLC	10/28/2009 to TLC

Quailrun Apartment #4 Movement of Population 2007-2009

23631	Before 1/1/2007	4/13/2009 Twin Home 2
22940	Before 1/1/2007	7/9/2007 Quailrun #1
21680	Before 1/1/2007	10/24/2007 Quailrun
20496	2/16/2007 re-admission 4/2/2009 Raintree	5/5/2008 to Raintree 9/28/2009 Twin Home 2
24313	2/20/2007 new admission	7/12/2007 Discharged
24908	9/26/2007	7/11/2008 Quailrun
25649	4/29/2009	
25172	5/5/2008	
24851	8/28/2007	

Oakridge Movement of Population 2007-2009

Name	Moved In	Moved Out
22360	2/8/2007 from TLC	
21288		3/14/2007 Discharged
24085	5/30/2007 from TLC	9/4/2009 Discharged
18022		6/19/2007 Discharged
23744	7/16/2007 From Woodland	3/13/2009 Discharged
23945	7/16/2007 from Woodland	4/13/2009 Twin Home 4
	8/10/2009 from Twin Home 4	
3931	7/16/2007 from Quailrun	9/30/2008 Discharged
4038		7/17/2007 to Sunset
15085	8/27/2007 from TLC	
22393	10/29/2009 from Quailrun	8/27/2007 to Sunset
14779	7/14/2008	8/27/2007 to Sunset
3342		8/27/2007 to Sunset
15578		8/27/2007 to Sunset
3484		8/27/2007 to Sunset
22844		9/25/2007 to Woodland
21676		10/5/2007 Discharged
4083	11/13/2007 from Woodland	4/13/2009 to Twin Home 3
14740		12/20/2007 Discharged
14757	1/22/2007 from Woodland	
23360	1/22/2007 from Woodland	
22649	1/22/2007 from TLC	
23931	9/10/2008 from TLC	10/6/2008 to TLC
22941	11/20/2008 from Woodland	4/13/2009 to Twin Home 4
21714	1/6/2009 from Quailrun	4/13/2009 to Twin Home 3
20799		1/23/2009 Discharged
24895	2/2/2009 from Woodland	4/10/2009 Discharged
3957	2/2/2009 from Woodland	4/13/2009 to Woodland
23021		2/5/2009 to TLC
24721	3/18/2009 from TLC	9/24/2009 to TLC
15656		3/24/2009 Discharged
14750		4/13/2009 to Twin Home 3
14807		4/13/2009 to Twin Home 3
4071		4/13/2009 to Twin Home 3
15560		4/13/2009 to Twin Home 3
3377		4/13/2009 to Twin Home 3
14780		4/13/2009 to Twin Home 3
14825		4/13/2009 to Twin Home 3
15215		4/13/2009 to Twin Home 3
4065		4/13/2009 to Twin Home 4
4075		4/13/2009 to Twin Home 4
14822		4/13/2009 to Twin Home 4
13443		4/13/2009 to Twin Home 4

15317	4/16/2009 from Sunset	
3927	4/16/2009 from Willow Creek	6/17/2009 Discharged
15268	4/16/2009 from Willow Creek	
14743	4/16/2009 from Willow Creek	
15217	4/16/2009 from Willow Creek	
15344	4/16/2009 from Willow Creek	
15280		5/28/2009 to Willow Creek
3939		6/23/20009 Discharged

Quailrun Movement of Population 2007-2009

Name	Moved In	Moved Out
20496		1/29/2007 DISCHARGED
	2/16/2007 re-admission	5/5/2008 to Raintree
	4/2/2009 from Raintree	9/28/2009 Twin Home 2
24313	2/20/2007 new admission	4/4/2007 Discharged Home
	4/5/2007 Re-admitted	7/12/2007 Discharged DSPD
22871	2/27/2007 from TLC	9/30/2008 Discharged
3931		7/16/2007 to Oakridge
		9/30/2008 Discharged
24851	8/28/2007 New admission	
24908	9/26/2007 New admission	7/11/2008 Quailrun
		4/13/2009 to Twin Home 2
22940		10/10/2007 Discharged
15360		1/7/2008 Deceased
24943	2/22/2008 from Pleasant View	
3617		8/4/2008 to Sunset
21714		1/6/2009 moved to Oakridge
25205	2/2/2009 from TLC	
25087	2/2/2009 from TLC	
14758		2/17/2009 to Sunset
14840		2/17/2009 to Sunset
3459		2/17/2009 to Sunset
3467		2/17/2009 to Sunset
21860		2/17/2009 to Sunset
22830		4/13/2009 to Twin Home 4
3456		4/13/2009 to Twin Home 1
14767		4/13/2009 to Twin Home 2
14801		4/13/2009 to Twin Home 2
23631		4/13/2009 to Twin Home 2
15285		4/13/2009 to Sunset
15289	4/14/2009 from Willow Creek	9/15/2009 Discharged
3623	4/16/2009 from Raintree	
15329	4/16/2009 from Raintree	
4076	4/16/2009 from Raintree	
4047	4/16/2009 from Raintree	
25649	4/29/2009	
24145		8/26/2009 to TLC
4085	9/1/2009 from Woodland	
	11/16/2009 from Woodland	
22393	9/29/2009 from Woodland	10/29/2009 To Oakridge
25172	5/5/2008	

Twin Home 4 Movement of Population 2009

Name	Moved In	Moved Out
13443	4/13/2009 from Oakridge	
14822	4/13/2009 from Oakridge	
4065	4/13/2009 form Oakridge	
4075	4/13/2009 from Oakridge	
22830	4/13/2009 from Oakridge	
22941	4/13/2009 from Oakridge	
23945	4/13/2009 from Oakridge	8/7/2009 to Oakridge
9926	4/13/2009 from Woodland	
23021	5/27/2009 from TLC	

Item 18:

USDC Diagnoses Data

TLC Diagnoses 2007

1.	**Axis I**	299.00	Autistic Disorder
	Axis II	318.1	Severe Mental Retardation
	Axis III	343.9	Cerebral Palsy
		345.10	Epilepsy
2.	**Axis I**	299.00	Autistic Disorder
	Axis II	317	Mild Mental Retardation
	Axis III		recurrent ear infections, PE tubes
	Axis IV		none identified at this time
	Axis V		GAF: 15 (current)
3.	**Axis I**	296.32	Major Depressive Disorder, Recurrent, Moderate
		313.01	Attention-Deficit/Hyperactivity Disorder, Combined Type
	Axis II	317.	Mild Mental Retardation (Provisional)
		R/O	Antisocial Personality Disorder
	Axis III		reported history of brain trauma
	Axis IV		Problems with primary support and legal systems
	Axis V		Current GAF: 45
4.	**Axis I**	296.24	Major Depressive Disorder-single episode severe with psychotic features
	Axis II	317.0	Mild Mental Retardation
5.	**Axis I**	299.00	Autistic Disorder
		300.3	Obsessive Compulsive Disorder
		307.52	Pica
	Axis II	319.	Mental Retardation, Severity Unspecified
	Axis III		seizure disorder (controlled)
	Axis IV		multiple and ongoing changes in living environment (both in staff and individuals)
	Axis V		GAF = 15 (current)
6.	**Axis I**		Bipolar Disorder, most recent episode mania, attention. Deficit Hyperactivity Disorder, combined type.
	Axis II		Severe Mental Retardation
	Axis III		MRI evidence of frontal lobe changes
7.	**Axis I**	314.00	Attention Deficit / Hyperactivity Disorder, Predominantly Inattentive
		300.4	Dysthymic Disorder
	Axis II	317.	Mild Mental Retardation
	Axis III		Hypothyroidism by history, obesity
	Axis IV		Lack of support system
	Axis V		GAF: 55 (current)

TLC Diagnoses 2008

1.	**Axis I**	299.00	Autistic Disorder
	Axis II	317	Mild Mental Retardation
	Axis III		recurrent ear infections, PE tubes
	Axis IV		none identified at this time
	Axis V		GAF: 15 (current)
2.	**Axis I**	299.00	Autistic Disorder
		r/o	Mood Disorder NOS
		r/o	Anxiety Disorder NOS
	Axis II	319.00	Mental Retardation, Severity Unspecified
	Axis III		Deferred to Physician
	Axis IV		Poor communication skills
	Axis V		GAF = 40 (Current)
3.	**Axis I**	302.2	Pedophilia, Sexually attracted to males
	Axis II	317.	Mild Mental Retardation
	Axis III		asthma, orthostasis
	Axis IV		death of his grandmother, reintroduction of his mother into his life, placement in Woodland Unit of USDC
	Axis V		GAF = 50
4.	**Axis I**	299.00	Autistic Disorder
		300.3	Obsessive Compulsive Disorder
		307.52	Pica
	Axis II	319.	Mental Retardation, Severity Unspecified
	Axis III		seizure disorder (controlled)
	Axis IV		multiple and ongoing changes in living environment (both in staff and individuals)
	Axis V		GAF = 15 (current)
5.	**Axis I**		Bipolar Disorder, most recent episode mania, attention. Deficit Hyperactivity Disorder, combined type.
	Axis II		Severe Mental Retardation.
	Axis III		MRI evidence of frontal lobe changes.
6.	**Axis I**	314.00	Attention Deficit / Hyperactivity Disorder, Predominantly Inattentive
		300.4	Dysthymic Disorder
	Axis II	317.	Mild Mental Retardation
	Axis III		Hypothyroidism by history, obesity
	Axis IV		Lack of support system
	Axis V		GAF: 55 (current)

TLC Diagnoses 2009

1.	**Axis I**	299.00	Autistic Disorder
	Axis II	317	Mild Mental Retardation
	Axis III		recurrent ear infections, PE tubes
	Axis IV		none identified at this time
	Axis V		GAF: 15 (current)
2.	**Axis I**	299.00	Autistic Disorder
		r/o	Mood Disorder NOS
		r/o	Anxiety Disorder NOS
	Axis II	319.00	Mental Retardation, Severity Unspecified
	Axis III		Deferred to Physician
	Axis IV		Poor communication skills
	Axis V		GAF = 40 (Current)
3.	**Axis I**	296.43	Bipolar Disorder, most recent episode manic, severe, by history
		299.00	Autistic Disorder
		300.00	Anxiety Disorder Not Otherwise Specified, with Obsessive Compulsive Features
	Axis II	318.1	Severe Mental Retardation
	Axis III		hypothyroidism, possible seizure disorder
4.	**Axis I**	299.00	Autistic Disorder
		r/o	Bipolar Disorder
		r/o	Obsessive Compulsive Disorder
	Axis II	319	Mental Retardation, Severity Unspecified
5.	**Axis I**	314.00	Attention Deficit / Hyperactivity Disorder, Predominantly Inattentive
		300.4	Dysthymic Disorder
	Axis II	317.	Mild Mental Retardation
	Axis III		Hypothyroidism by history, obesity
	Axis IV		Lack of support system
	Axis V		GAF: 55 (current)

Woodland Diagnoses 2007

1.	**Axis I**	296.32	Major Depressive Disorder, Recurrent, Moderate
		R/O	Intermittent Explosive Disorder
	Axis II	317	Mild Mental Retardation
		R/O	Moderate Mental Retardation
	Axis III	none	
2.	**Axis I**	312.34	Intermittent Explosive Disorder
	Axis II	317	Mild Mental Retardation
	Axis III		seizure disorder
3.	**Axis I**	296.64	Bipolar Disorder, mixed with psychotic features
	Axis II	317.00	Mild Mental Retardation
4.	**Axis I**	314.01	Attention-Deficit/Hyperactivity Disorder
	Axis II	317.00	Mild Mental Retardation
	Axis III		Fetal Alcohol Effects
	Axis IV		Early history of exposure to domestic violence and sexual abuse, major physical injury resulting in the partial severing of three fingers on his right hand, multiple foster care placements, termination of his mother's parental rights
	Axis V		GAF: 65 (current)
5.	**Axis I**	299.80	Pervasive Developmental Disorder, NOS
		302.2	Pedophilia, Sexually Attracted to Females, Exclusive type
		r/o	Eating Disorder, NOS
	Axis II	317.00	Mild Mental Retardation
		r/o	Borderline Intellectual Functioning
6.	**Axis I**	298.9	Psychotic Disorder, NOS
	r/o	299.00	Autistic Disorder
		302.91	Fetishism
	Axis II	317.	Mild Mental Retardation
	Axis III		medication induced thickening of the heart walls
	Axis IV		lack of family and social support
	Axis V		GAF: 20 (current)
7.	**Axis I**	v71.09	No Diagnosis on Axis I
	Axis II	317.	Mild Mental Retardation
		300.7	Antisocial Personality Disorder
	Axis III		none
	Axis IV		conflict with peers and staff, court commitment, possible victim of child sexual abuse
	Axis V		GAF = 55 (current)
8.	**Axis I**	V62.83	Sexual Abuse of Adult (provisionary).
	Axis II	317.00	Mild Mental retardation.
	Axis III		Deferred to Medical
9.	**Axis I**	313.81	Oppositional Defiant Disorder, Childhood Onset (provisional)
	Axis II	317	Mild Mental Retardation

Woodland Diagnoses 2008

1.	**Axis I**	312.8	Conduct Disorder
		313.01	Attention-Deficit/Hyperactivity Disorder, combined type.
		r/o	Reactive Attachment Disorder
		r/o	Generalized Anxiety Disorder
		r/o	Mood Disorder NOS
	Axis II	318.0	Moderate Mental Retardation
	Axis III		Fetal Alcohol Syndrome
	Axis IV		recent incarceration, history of physical, emotional, and medical abuse/neglect, multiple failed placements
	Axis V		Current GAF: 10
2.	**Axis I**	299.00	Autism
		311.34	Intermittent Explosive Disorder
		311	Depressive Disorder, Not Otherwise Specified
		r/o	Psychotic Disorder
	Axis II	318.0	Moderate Mental Retardation
	Axis III		Seizure Disorder
	Axis IV		separation from parents
	Axis V		GAF: 45 (current)
3.	**Axis I**	296.64	Bipolar Disorder, mixed with psychotic features
	Axis II	317.00	Mild Mental Retardation
4.	**Axis I**	310.1	Personality change due to Traumatic Brain Injury, Disinhibited Type
	Axis II	301.7	Antisocial Personality Disorder
	Axis III		history of severe traumatic brain injury with left hemiparesis; spastic hemiplegia; cerebellar ataxia; dysphonia and dysarthria, severe with partial vocal cord paralysis; dysconjugate gaze with anasocoria, OS; and acquired Organic Brain Syndrome, secondary to Traumatic Brain Injury
5.	**Axis I**	314.01	Attention-Deficit/Hyperactivity Disorder
	Axis II	317.00	Mild Mental Retardation
	Axis III		Fetal Alcohol Effects
	Axis IV		Early history of exposure to domestic violence and sexual abuse, major physical injury resulting in the partial severing of three fingers on his right hand, multiple foster care placements, termination of his mother's parental rights
	Axis V		GAF: 65 (current)
6.	**Axis I**	298.9	Psychotic Disorder, NOS
		r/o 299.00	Autistic Disorder
		302.91	Fetishism
	Axis II	317.	Mild Mental Retardation
	Axis III		medication induced thickening of the heart walls
	Axis IV		lack of family and social support
	Axis V		GAF: 20 (current)
7.	**Axis I**	v71.09	No Diagnosis on Axis I

	Axis II	317.	Mild Mental Retardation
		301.8	Antisocial Personality Disorder
	Axis III		none
	Axis IV		conflict with peers and staff, court commitment, possible victim of child sexual abuse
	Axis V		GAF = 55 (current)
8.	**Axis I**	302.2	Pedophilia, Sexually attracted to Males
		302.81	Fetishism
	Axis II	317.	Mild Mental Retardation
	Axis III		Neurofibromatosis, seizure disorder
9.	**Axis I**	313.81	Oppositional Defiant Disorder, Childhood Onset (provisional)
	Axis II	317	Mild Mental Retardation

Woodland Diagnoses 2009

1.	**Axis I**	312.8	Conduct Disorder
		314.01	Attention-Deficit/Hyperactivity Disorder, combined type
		r/o	Reactive Attachment Disorder
		r/o	Generalized Anxiety Disorder
		r/o	Mood Disorder NOS
	Axis II	318.0	Moderate Mental Retardation
	Axis III		Fetal Alcohol Syndrome
	Axis IV		recent incarceration, history of physical, emotional, and medical abuse/neglect, multiple failed placements
	Axis V		Current GAF: 10
2.	**Axis I**	299.00	Autism
		311.35	Intermittent Explosive Disorder
		311	Depressive Disorder, Not Otherwise Specified
		r/o	Psychotic Disorder
	Axis II	318.0	Moderate Mental Retardation
	Axis III		Seizure Disorder
	Axis IV		separation from parents
	Axis V		GAF: 45 (current)
3.	**Axis I**	300.00	Anxiety Disorder, NOS
		293.0	Mental Disorder NOS, Due to a Medical Condition
	Axis II	318.1	Moderate Mental Retardation
	Axis III		Seizure Disorder (L side focus, R parietal/temporal, focal motor, complex partial)
4.	**Axis I**	302.2	Pedophilia, Sexually attracted to males
	Axis II	317.	Mild Mental Retardation
	Axis III		asthma, orthostasis,
	Axis IV		death of his grandmother, reintroduction of his mother into his life, placement in Woodland Unit of USDC
	Axis V		GAF = 50
5.	**Axis I**	314.01	Attention-Deficit/Hyperactivity Disorder
	Axis II	317.00	Mild Mental Retardation
	Axis III		Fetal Alcohol Effects
	Axis IV		Early history of exposure to domestic violence and sexual abuse, major physical injury resulting in the partial severing of three fingers on his right hand, multiple foster care placements, termination of his mother's parental rights
	Axis V		GAF: 65 (current)
6.	**Axis I**	298.9	Psychotic Disorder, NOS
		r/o 299.00	Autistic Disorder
		302.91	Fetishism
	Axis II	317.	Mild Mental Retardation
	Axis III		medication induced thickening of the heart walls
	Axis IV		lack of family and social support
	Axis V		GAF: 20 (current)
7.	**Axis I**	v71.09	No Diagnosis on Axis I
	Axis II	317.	Mild Mental Retardation
		301.8	Antisocial Personality Disorder

	Axis III		none
	Axis IV		conflict with peers and staff, court commitment, possible victim of child sexual abuse
	Axis V		GAF = 55 (current)
8.	**Axis I**	302.2	Pedophilia, Sexually attracted to Males
		302.81	Fetishism
	Axis II	317.	Mild Mental Retardation
	Axis III		Neurofibromatosis, seizure disorder

Quailrun Apartment #4 Diagnoses 2007

1.	**Axis I**	r/o	Bipolar I Disorder
	Axis II	317	Mild Mental Retardation
		r/o	Borderline Personality Disorder
2.	**Axis I**	299.00	Autistic Disorder
	Axis II	318.1	Severe Mental Retardation
3.	**Axis I**	400.00	Bipolar Disorder NOS (Dr. Yau)
			ADHD by history
	Axis II	317.00	Mild Mental Retardation
	Axis III		Obesity
	Axis IV		Residential Placement, victim of multiple rapes
	Axis V		GAF = 35 (on admission)
			GAF = 60 (at discharge)
4.	**Axis I**	310.1	Personality Change Secondary to CNS abnormality
	Axis II	318.1	Severe Mental Retardation

Quailrun Apartment #4 Diagnoses 2008

1.	**Axis I**	r/o	Bipolar I Disorder
	Axis II	317	Mild Mental Retardation
		r/o	Borderline Personality Disorder
2.	**Axis I**	296.80	Bipolar Disorder NOS
	Axis II	301.9	Personality Disorder NOS
			Mental Retardation - Mild
3.	**Axis I**	299.00	Autistic Disorder
	Axis II	318.1	Severe Mental Retardation
4.	**Axis I**	312.34	Intermittent Explosive Disorder
		295.70	Schizoaffective Disorder, Bipolar Type
		297.1	Delusional Disorder, Erotomanic Type (by history)
		309.81	Posttraumatic Stress Disorder (by history)
	Axis II	317.00	Mild Mental Retardation
		r/o	Borderline Personality Disorder
	Axis III		Deferred to Physician
	Axis IV		history of sexual abuse
	Axis V		GAF = 35 (Current)

Quailrun Apartment #4 2009

1.	**Axis I**	296.90	Mood Disorder NOS
		299.00	Autistic Disorder
	Axis II	318.10	Severe Mental Retardation
	Axis III		Seizure Disorder
2.	**Axis I**	296.80	Bipolar Disorder NOS
	Axis II	301.9	Personality Disorder NOS
			Mental Retardation - Mild
3.	**Axis I**	299.00	Autistic Disorder
	Axis II	318.1	Severe Mental Retardation

B. Kick-Off Presentation

PCG used the presentation provided on the following pages during both our project kick-off meeting and our stakeholder sessions held in May 2010. The presentation provides an overview on PCG's approach and work plan, as well as provides details on the timeline and deliverables for the project.

Slide 1

PCGHealth & Human Services™

Feasibility Study on Privatization of Portions of the Utah State Hospital and the Utah State Developmental Center

May 2010

PUBLIC CONSULTING GROUP

Public Focus. Proven Results. ™

Slide 2

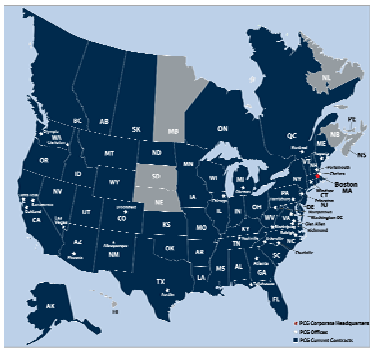
Topics for Today

1. Welcome and Introductions
2. Review PCG's Work Plan and Approach
   a). Financial Analysis
   b). Programmatic Analysis
3. Timelines and Deliverables

Slide 3

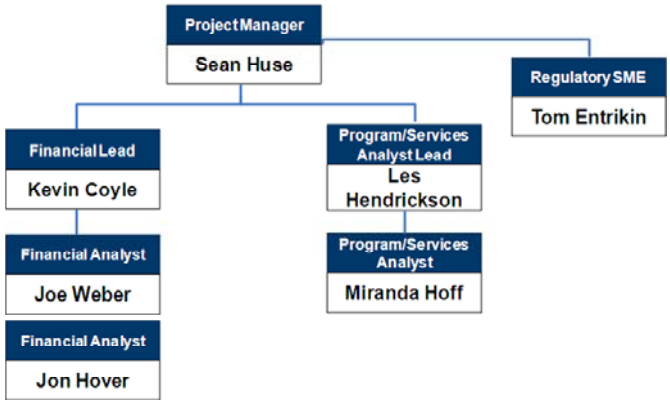
PCG's National & International Public Sector Experience

- Boston-based firm with offices in 32 cities across the US and Canada.
- Since 1986, providing management consulting to help public sector clients achieve their performance goals and better serve populations in need.
- Over 700 employees providing state of the art consulting and business process outsourcing management to improve service outcomes and associated business functions while reducing or containing costs.

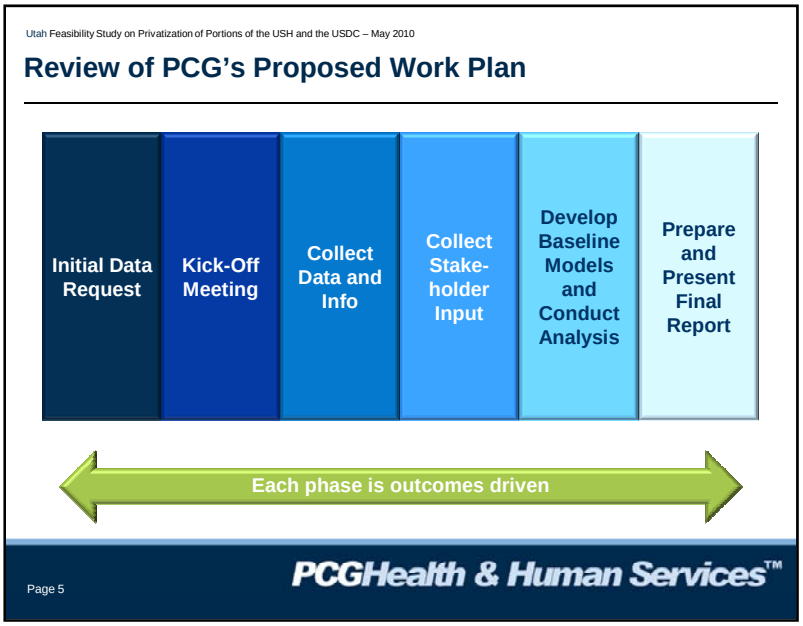


Slide 4

PCG's Project Team



Slide 5



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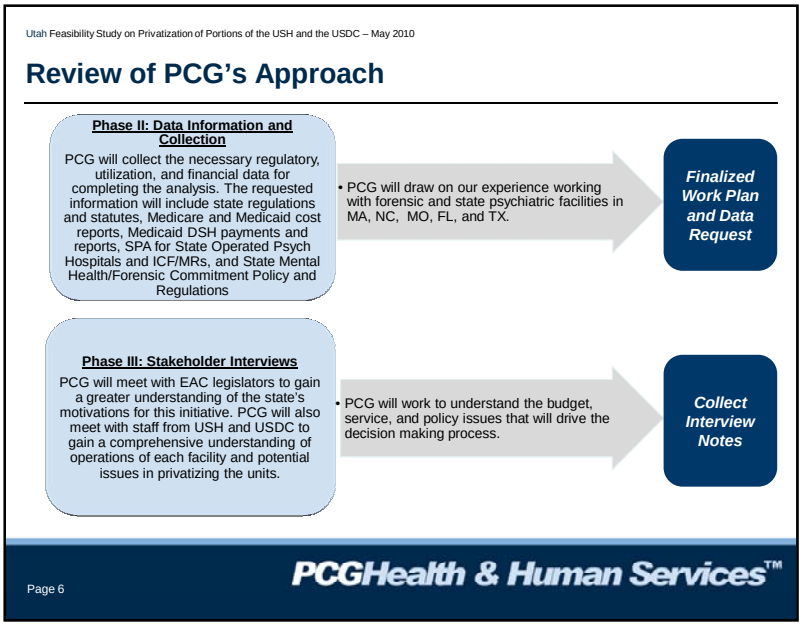


Slide 7

Review of PCG's Approach

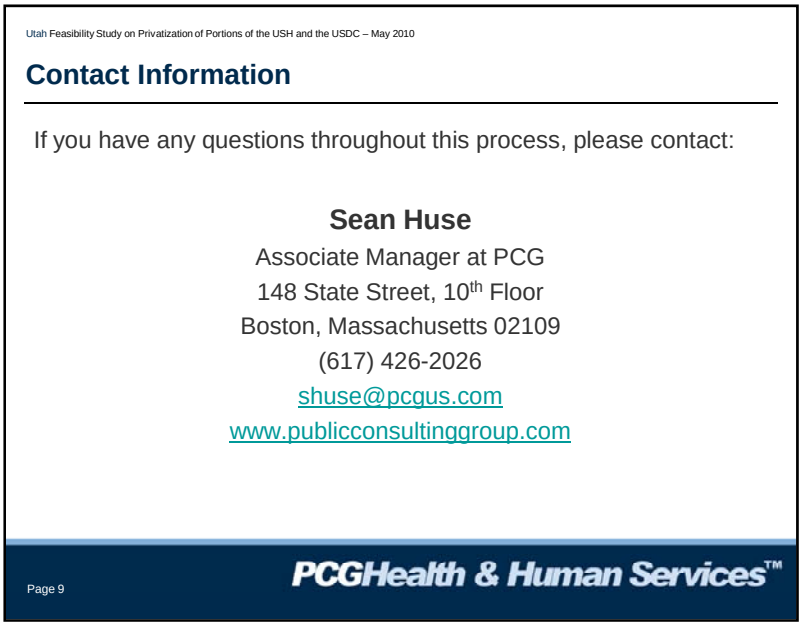
- Stakeholder sessions held this week will focus primarily in two areas:
  - Financial
    - Budgeting and Cost Structure
    - Eligibility Process
    - Cost reporting
    - Cost containment activities
  - Programmatic
    - Outcomes management practices
    - Data collection, analysis, and reporting capabilities
    - Treatment protocols
    - Quality assurance protocols

Slide 8

Timeline and Deliverables

- Data Collection / Stakeholder Interviews – May
- Baseline Model Development – May/June
- Private Comparative Model Development – May/June
- Final Report to be submitted August

Slide 9


Utah Feasibility Study on Privatization of Portions of the USH and the USDC – May 2010
Contact Information
If you have any questions throughout this process, please contact:
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PCGHealth & Human Services™

C. Stakeholder Sessions Handout

The document on the following pages was used in conjunction with the previous presentation during our stakeholder sessions. It provides a project overview and lists general questions that our team discussed with the attendees.

About PCG

Public Consulting Group, Inc. (PCG) is a privately-owned independent management consulting firm offering strategic planning and implementation, organizational development, financial management and operations improvement, systems development and other advisory services to government health and human service and education providers. PCG is a company of 700 employees that is headquartered in Boston with offices throughout the country.

Purpose of the Study

The purpose of this engagement is to complete a feasibility study to determine whether the forensic units at Utah State Hospital (USH) and/or the semi-secure units at the Utah State Developmental Center (USDC) can be operated by a private (non-governmental) entity in a manner that will result in one of the following:

a. The provision of services that are currently provided at or for the USH and USDC, at the same cost at which those services are currently provided at or for the USH and USDC;
b. A savings to the state while providing services at the same level or a higher level than is currently provided at or for the USH and USDC; or
c. The provision of services at a higher level than is currently provided at or for the USH and USDC, at the same cost at which current services are provided at or for the USH and USDC.

Study Goals

1. Conduct on-site interviews to gather information and obtain stakeholder input concerning the forensic units at USH and the semi-secure units at USDC.
2. Provide a baseline model of the costs and services for the forensic units at USH and the semi-secure units at USDC.
3. Provide projected models for the costs and services of various privatization options for the forensic units at USH and the semi-secure units at USDC.
4. Detail cost savings, cost increases, and cost avoidance for each of the privatization option.
5. Advise the Executive Appropriations Committee (EAC) of the best options and methods to obtain a result described above and the benefits and drawbacks of each option and method.
6. Provide the EAC with a detailed report of the data, assumptions, financial analysis, and other criteria considered in making the determinations and rendering the advice.
7. Complete a final written report by August 6, 2010.
8. Provide a formal presentation of the final report to the Utah State Legislature, Executive Appropriations Committee on August 17, 2010.

Project Teams

Management Team

Marc Staubley, Manager, PCG

Sean Huse, Associate Manager, PC

Programmatic Team
Les Hendrickson, Independent Consultant
Miranda Hoff, Business Analyst, PCG

Fiscal Team
Kevin Coyle, Senior Consultant, PCG
Joe Weber, Consultant, PCG
Jon Hover, Business Analyst, PCG

Questions

Fiscal Interview Team

1. What is the current eligibility process for entering an institution?
2. Does the state have any transitional living facilities available? If so, describe them.
3. Are there any differences within the populations of USH and USDC? For example, are there different levels of Forensic clients within the units at USH?
4. How is the state's budget structured? Separate appropriations for USH and USDC, same agency/different agency. Any relationship between the two?
5. What is the age of the physical plant of USH and USDC, specifically the forensic and semi-secure units? Have there been any capital improvements at either facility?
6. Are the Direct Care Service staffs unionized? If so, please describe.
7. What is the fixed vs. variable cost structure of USH? Of USDC?
8. Do you have a provider tax for Psychiatric Facilities or ICF/MRs? Describe amount, use of revenue?
9. What is the Psychiatric Facility Medicaid rate? ICF/MR Medicaid rate?
10. Have there been any discussions on the impact on Medicaid DSH due to the change in the cost structure with privatizing the forensic unit?
11. Are Medicare Part D (Rx) and/or Medicare Part B (Professional) revenue generated for the forensic unit of USH? For the semi-secure unit of USDC? If so, how much?

Programmatic Interview Team

1. What are your expectations of this project?
2. What do you think are key components of the current operation of forensic units at USH and the semi-secure units at USDC that are working well?
3. What do you think are major gaps in the current operation of these facilities?
4. How do you think shifting responsibilities for the operation of these facilities from the state to private entities will affect services?
5. What is the history of the privatization project in Utah?
6. How has your organization/agency/group been involved with the discussion of privatization?
7. What is your organization/agency/group's stance on privatization of forensic units at USH and the semi-secure units at USDC?
8. Has your group conducted any studies or released any reports related to the privatization of the forensic and semi-secure units?
9. What do you think advantages of privatization are?
10. What do you think disadvantages of privatization are?

D. Stakeholders

Through the course of the project, PCG contacted and received information from a wide variety of stakeholders. The list below outlines those we contacted and interviewed during the course of our project.

Contact	Agency/Organization	Response
Adam Trupp	Utah Association of Counties	Yes
Alicia Cook	Salt Lake District Attorney's Office	Yes
Andrew Riggle	Disability Law	Yes
Brock Belnap	Washington County Attorney's Office	No
Carola Zitzmann	MRAU/parent	Yes
Charles Goodman	Utah State Developmental Center	Yes
Cheryl Smith	Autism Council of Utah	Yes
Craig Barlow	Attorney General's Office	Yes
Dale Schippanboord	Utah State Prison	Yes
Dallas Earnshaw	Utah State Hospital	Yes
Don Rosenbaum	Utah State Hospital	Yes
James Lex	MRAU	Yes
Janice Coleman	Legislative Auditor General's Office	Yes
Jason Riddell	Family Council USDC	Yes
Jerry Provencal	MORC	Yes
Joyce Dolcourt	LCPD	Yes
Juergen Korbanka	Wasatch Mental Health/Utah Behavioral Healthcare Committee	Yes
Justin Naylor	Rise	Yes
Karen Clarke	Utah State Developmental Center	Yes
Keith Davis	Human Services Bureau of Administrative Support	Yes
Kris Fawson	Independent Living Council	Yes
Kristina Swickard	Salt Lake Legal Defender	No

Contact	Agency/Organization	Response
Lana Stohl	Mental Health Utah State Division of Substance	Yes
Laura Anderson	Autism Council of Utah	Yes
Marc Christensen	Chrysalis	Yes
Mark Ward	Department of Human Services	Yes
Marsha Colegrove	Danville	Yes
Mel Sowerby	Facilities	Yes
Michael Hales	Utah Medicaid	Yes
Paul Parker	Salt Lake District Attorney's Office	Yes
Paul Whitehead	Utah State Hospital	Yes
Rebecca Glathar	NAMI Utah	Yes
Robert Burton	Utah State Hospital	Yes
Rodney Riddell	Family Council USDC	Yes
Ron Gordon	Utah Commission on Criminal and Juvenile Justice	No
Ron Sromberg	Davis Behavioral Health	Yes
Scott Garrett/David Allred	Iron County Attorney's Office	No
Scott Kline/Steve Bradford	Department of Human Services Division of Services for People with Disabilities	Yes
Sherri Wittwer	NAMI Utah	Yes
Stephen Coleman	GOPB	Yes
Steve Kesler	Guardianship Provider	Yes
Susan Eisenman	Assistant Attorney General	Yes
Tony Baird	Cache County Attorney's Office	Yes

E. Utah State Hospital Reports and Data

Through our data collection and stakeholder interviews phase, PCG collected a significant number of reports and data from USH regarding the current financial and programmatic structures of the Forensic Unit. The following list summarizes the information we requested, reviewed, and/or used within to help conduct the analysis:

- A revised Medicare 2552 cost report was developed for the Utah State Hospital Forensic Unit baseline model using the following data provided by the hospital:
  - Original FY 2009 Medicare 2552 cost report.
  - Census statistics, including admissions, discharges, beds, and patient days, with the Forensic Unit broken out from the other inpatient statistics.
  - Personnel and operating expenses by object code specific to the Forensic Unit.
  - FTE totals and average hourly pay by job title specific to the Forensic Unit.
  - Revised allocation statistics, including square footage, nursing hours, and meals served, with the Forensic Unit broken out from other inpatient statistics.
- FY 2009 Medicare 2552 cost reports and supporting documentation were used for the following hospitals to complete the peer facility and scenario analyses:
  - Fulton State Hospital.
  - Florida State Hospital.
  - East Louisiana State Hospital.
  - South Florida State Hospital.
- FY 2009 Medicare 2552 cost reports were researched but deemed not usable for the following hospitals:
  - Alaska Psychiatric Institute.
  - Bryce Hospital.
  - Arizona State Hospital.
  - Wyoming State Hospital.
  - Patton State Hospital.
  - Hawaii State Hospital.
- The Legislature's Posting for the Feasibility Study contained the following data about the operations of the Forensic Units at USH.
- Additional data on the operation of USH Forensic Unit acquired during the report development included:
  - Assessment Statistic.
  - USH Forensic Manual.
  - Forensic Mental Health Facility Description of Services.
  - Forensic Programming and Services Totals.

- Average Length of Stay.
- Census.
- Admission data.
- Elopement data.
- Violent Incidents Reports.
- Hours of restraints and/or seclusion.
- Nurse Acuity Report.
- USH Patient Care Manual.
- USH Behavioral Support Manual.

On the following pages, PCG has included additional data and tables used for the analysis within this report.

Detailed USH Forensic Unit Baseline Model FY 2009

Cost Category	Fixed/Variable	Statistic	FTE	Avg. Hourly Salary	Cost
Medical Administrator	N/A	N/A	1.00	$ 86.34	$ 179,587
Medical Doctor	N/A	N/A	3.00	$ 84.02	$ 524,285
Registered Nurse III	N/A	N/A	4.00	$ 26.17	$ 217,734
Program Administrator II	N/A	N/A	4.00	$ 25.47	$ 211,910
Registered Nurse II	N/A	N/A	21.00	$ 24.13	$ 1,053,998
Licensed Clinical Therapist	N/A	N/A	6.00	$ 21.06	$ 262,829
Social Worker	N/A	N/A	2.00	$ 18.38	$ 76,461
Recreational Therapist II	N/A	N/A	4.00	$ 16.07	$ 133,702
Licensed Practical Nurse	N/A	N/A	12.00	$ 15.22	$ 379,891
Caseworker I	N/A	N/A	1.00	$ 14.81	$ 30,805
Senior Psychiatric Technician	N/A	N/A	14.00	$ 13.65	$ 397,488
Therapeutic Recreation Technician	N/A	N/A	2.00	$ 13.28	$ 55,245
Office Specialist II	N/A	N/A	1.00	$ 12.58	$ 26,166
Office Specialist II	N/A	N/A	4.00	$ 10.99	$ 91,437
Psychiatric/Developmental Technician	N/A	N/A	77.00	$ 10.99	$ 1,760,158
Total Direct Patient Care (Salary) Cost					**$ 5,401,698**
Overtime	N/A	N/A	N/A	N/A	$ 464,270
Fringe Benefits	N/A	N/A	N/A	N/A	$ 2,863,772
Total Direct Patient Care (OT & Fringe) Cost					**$ 3,328,042**
Direct Non-Salary	N/A	N/A	N/A	N/A	$ 142,459.17
Total Direct Other Cost					**$ 142,459**
New Buildings & Fixtures	Fixed	Patient Days	N/A	N/A	$ 234,839
New MME	Fixed	Patient Days	N/A	N/A	$ 12,104
Administration Group	Fixed	Patient Days	N/A	N/A	$ 1,701,048
Maintenance	Fixed	Patient Days	N/A	N/A	$ 6,479
Plant	Fixed	Patient Days	N/A	N/A	$ 617,509
Laundry	Variable	Patient Days	N/A	N/A	$ 65,090
Housekeeping	Fixed	Patient Days	N/A	N/A	$ 293,348
Dietary	Variable	Patient Days	N/A	N/A	$ 1,093,941
Nursing Administration	Fixed	Patient Days	N/A	N/A	$ 369,450
Central Service & Supplies	Variable	Patient Days	N/A	N/A	$ 124,674
Medical Records	Variable	Patient Days	N/A	N/A	$ 202,326
Total Overhead Cost					**$ 4,720,808**
Radiology	N/A	N/A	N/A	N/A	$ 21,543
Physical Therapy	N/A	N/A	N/A	N/A	$ 47,622
Drugs	N/A	N/A	N/A	N/A	$ 1,315,102
Total Ancillary Cost					**$ 1,384,266**
Total Forensic Unit Cost					**$ 14,977,273**
Patient Days					36,282
Total Cost per Patient Day					**$ 412.80**

USH Forensic Unit Expenses FY 2009

Object Code	Object Name	Amount
6055	Out State Meal	$ 59.00
6056	Out State Lodging	$ 95.33
6057	Out State Trans	$ 105.56
6122	Client Support (Food)	$ 3,298.83
6123	Client Support	$ 197.92
6126	Wireless	$ 404.99
6132	Telephone Reimb	$ (10.46)
6136	Postage/Mailing	$ 360.09
6155	Med Prof/Tech Srvcs	$ 2,000.00
6166	Buss Passes/Parking Rent	$ 120.60
6171	Bldg/Grounds O&M	$ 2,216.52
6175	Other Equip O&M	$ 413.20
6176	Laundry/Janitorial	$ 11,102.93
6177	Bldg/Grounds Security	$ 877.39
6181	Office Supplies	$ 8,341.50
6184	Ed/Rec Supplies	$ 1,102.03
6185	Bks/Subcriptions	$ 957.39
6186	Photocopy Exp	$ 3,564.13
6188	Office Furnishings <5,000	$ 1,695.45
6189	Other Sm Equip <5,000	$ 3,045.37
6213	Clothing/Uniforms	$ 12,259.89
6214	Food	$ 8,497.13
6219	Lab Supplies	$ 1,819.38
6233	Household Supplies	$ 15,498.87
6244	Patient Medical Cost	$ 1,547.64
6245	Patient Support Cost	$ 4,198.83
6246	Rehab Rec Costs	$ 261.96
6262	Claims/Damages	$ (147.26)
6263	Insurance/Bonds	$ 23,833.39
6283	OT Meal Allowance	$ 330.00
6300	Tele Charges	$ 29,941.28
6582	DP Supplies	$ 4,470.29
Total Operating Costs		**$ 142,459.17**
5101	Salary/Wages	$ 4,530,570.00
5110	Leave Paid	$ 692,888.11
5120	On-Call	$ 98,595.43
5130	Over-Time	$ 128,372.39
5135	Comp/Excess	$ 223,672.72
5140	Comp/Excess	$ 112,224.81
5150	Incentive	$ 63,770.00
5160	State Retirement	$ 861,500.30
5170	FICA/Medicare	$ 398,461.35
5180	Health/Dental/Life	$ 1,489,404.71
5190	Employer Insurance	$ 50,635.61
Total Personnel Costs		**$ 8,650,095.43**
Total Direct Costs		**$ 8,792,554.60**

USH Forensic Unit Staffing FY 2009

Job Title	Number in Position	Avg Hourly Pay Rate	Total Hours	Total Pay
MEDICAL ADMINISTRATOR	1	$86.34	2,080	$179,587
MEDICAL DOCTOR	3	$84.02	6,240	$524,285
REGISTERED NURSE III	4	$26.17	8,320	$217,734
PROGRAM ADMINISTRATOR II	4	$25.47	8,320	$211,910
REGISTERED NURSE II	21	$24.13	43,680	$1,053,998
LICENSED CLINICAL THERAPIST	6	$21.06	12,480	$262,829
SOCIAL WORKER	2	$18.38	4,160	$76,461
RECREATIONAL THERAPIST II	4	$16.07	8,320	$133,702
LICENSED PRACTICAL NURSE	12	$15.22	24,960	$379,891
CASEWORKER I	1	$14.81	2,080	$30,805
SENIOR PSYCHIATRIC TECHNICIAN	14	$13.65	29,120	$397,488
THERAPEUTIC RECREATION TECHNICIAN	2	$13.28	4,160	$55,245
OFFICE SPECIALIST II	1	$12.58	2,080	$26,166
OFFICE SPECIALIST I	4	$10.99	8,320	$91,437
PSYCHIATRIC/DEVELOPMENTAL TECHNICIAN	77	$10.99	160,160	$1,760,158
Total	**156**		**324,480**	**$5,401,698**

USH Forensic Unit Census FY 2009

Statistic	Amount
Beds	100
Patient Days	36,282
Admissions	105
Discharges	93

USH Square Footage Allocation Unit FY 2009

Cost Report Category	Square Footage Summary
ADMINISTRATIVE & GENERAL	44,953
MAINTENANCE & REPAIRS	8,868
OPERATION OF PLANT	46,478
LAUNDRY & LINEN SERVICE	9,918
ADULTS & PEDIATRICS	270,966
FORENSIC	70,908
TOTAL	**452,091**

Building	Cost Report Category	Square Footage Detail
Administration (Heninger)	ADMINISTRATIVE & GENERAL	37,000
Amphitheater (Castle)	OPERATION OF PLANT	8,300
Beesley Youth	ADULTS & PEDIATRICS	11,250
Castle Pavillion/ Rest Rooms	OPERATION OF PLANT	1,200
Castle Restrooms	OPERATION OF PLANT	1,110
Chapel	OPERATION OF PLANT	5,443
Cottage	OPERATION OF PLANT	3,327
Day Care Center Garage	OPERATION OF PLANT	504
Excel House	OPERATION OF PLANT	3,213
Excel House Garage #1	OPERATION OF PLANT	504
Excel House Garage #2	OPERATION OF PLANT	504
Forensic Building	FORENSIC	70,908
Support Services Building	ADMINISTRATIVE & GENERAL	7,953
Hazardous Waste Shed	OPERATION OF PLANT	80
Heating Plant	OPERATION OF PLANT	4,800
Kitchen Storage Shed	OPERATION OF PLANT	168
Laundry/Rec Therapy Storage	LAUNDRY & LINEN SERVICE	9,918
Rec Therapy Storage Shed	MAINTENANCE & REPAIRS	168
7 Peaks Maintenance Building	MAINTENANCE & REPAIRS	5,952
Medical Services Building	ADULTS & PEDIATRICS	57,006
Rampton I	ADULTS & PEDIATRICS	74,500
Rampton Cafe	ADULTS & PEDIATRICS	18,350
Lucy Beth Rampton II	ADULTS & PEDIATRICS	84,233
Rampton Pavillion	ADULTS & PEDIATRICS	528
Ropes Course	OPERATION OF PLANT	5,000
Paint Storage Shed	MAINTENANCE & REPAIRS	164
Grounds Storage Shed	MAINTENANCE & REPAIRS	164
Storage #4 (Pizza Hut)	MAINTENANCE & REPAIRS	1,820
Well Pumphouse #1	MAINTENANCE & REPAIRS	600
Youth Center North/South	ADULTS & PEDIATRICS	24,619
Youth Center Storage Shed	ADULTS & PEDIATRICS	480
New Warehouse	OPERATION OF PLANT	11,925
Chair Storage Shed	OPERATION OF PLANT	400
TOTAL		**452,091**

USH Nursing Statistics FY 2009

Nurse Title	Nursing Hours	Total FTE	Forensic FTE	Hospital FTE
LICENSED PRACTICAL NURSE II	67,696	33	12	21
REGISTERED NURSE II	150,808	73	21	52
REGISTERED NURSE III	45,614	22	4	18
ASSISTANT DIRECTOR OF NURSING	2,094	1	-	1
NURSE PRACTITIONER/CLINICAL NURSE S	15,438	7	-	7
NURSING DIRECTOR	2,096	1	-	1
TOTAL	**283,745**	**136**	**37**	**99**

USH Meal Allocation Statistics FY 2009

Program	Patient Days	% of Days	Meals Served
Youth	13,943	12.59%	41,829
State/Adult	61,590	55.61%	184,770
Forensic	35,223	31.80%	105,669
TOTAL	**110,756**	**100.00%**	**332,268**

USH Laundry Statistics FY 2009

Program	Patient Days	% of Days	Laundry Pounds
Youth	13,943	12.59%	22,950
State/Adult	61,590	55.61%	101,377
Forensic	35,223	31.80%	57,977
TOTAL	**110,756**	**100.00%**	**182,304**

F. Utah State Developmental Center Reports and Data

Through our data collection and stakeholder interviews phase, PCG collected reports and data from USDC regarding current financial and programmatic structures related to the TLC and Woodland units. The Posting for the Feasibility Study (see Appendix A above) contained information, and additional information was obtained from staff in a subsequent visit, as well as by phone calls and e-mails.

Collecting data on comparable programs in other states had to be done by contacting other states. With the exception of national health surveys, the major federal national data bases are those collecting data on federal programs. For example, the CMS-2552 reports used in the analysis of the Utah State Hospital were developed to be the Medicare cost report form for hospitals and the Federal Medicaid agency, the Centers of Medicare and Medicaid Services. CMS has accumulated these CMS 2552 cost reports into a national database. Since Medicaid is a state-federal program, national statistics on its operation can be difficult to obtain. This generalization is true for developmental centers. PCG identified a list of 150 licensed ICFs/MRs in 37 states. The remaining states have closed such institutions. All of these states were either researched on the internet, called, or emailed. A description of the results of this work is contained in Appendix H.

The following list summarizes the information we requested, reviewed, and/or used within to help conduct the analysis:

- The Legislature's Posting for the Feasibility Study contained the following data about the operations of the semi-secure units at USDC:
    - An "Appropriation Category Report" covering the period 2009-2011.
    - Descriptions of the operation of the Emergency Services Management Committee (ESMC).
    - Policy directions to staff regarding the operations of the TLC program.
    - Descriptions of the TLC level system.
    - The cost per client, total cost, and census for 2009 for both the TLC and Woodland units.
    - The monthly census for 2007 through 2009 for both the TLC and Woodland units.
    - The movement of persons to and from the TLC and Woodland programs showing where the persons came from and where they went during 2007-2009.
    - A list of staff titles showing all the staff types that provide service to the TLS, Woodland and Quailrun units.
    - A patient days report for the semi-secure units.
    - Census data for the months of 2007-2009 for the TLC, Woodland Quailrun, Oakridge and Town Home units.

  - The movement of persons to and from the Quailrun unit showing where the persons came from and where they went during 2007-2009.
  - A list of diagnoses for persons on the TLC and Woodland units for the period 2007-2009.
- Additional data on the operation of the TLC and Woodland units acquired during the report development included:
  - List of staff and salaries at both the TLC and Woodland units.
  - Expenditure data by category.
  - Estimates of the number of hours provided by specialized ancillary staff.
- Information was requested from the twenty-two potentially comparable programs:
  - Total cost of operating the program.
  - Current census.
  - Number of beds in the program.
  - Cost per patient day.
  - Number of staff FTE.
  - Number of Direct Care FTE.
  - Amount of revenue obtained from Medicaid.
- Some states included their unit in the cost reporting of a larger unit such as the developmental center and cost data could not be readily obtained. For example, these programs included:
  - Porterville Developmental Center in California.
  - North Dakota Developmental Center.
  - South Dakota Developmental Center.

TLC and Woodland Summary Information FY 2009

SUMMARY STATISTICS		
Gross Direct Cost (Direct cost of Care)	$	1,911,992
Gross Full Cost (Direct plus Indirect)	$	2,822,710
Total Revenue	$	2,032,351
Total Net Full Cost to State	$	790,359
Total Days		4,389
Avg. Daily Census		12
Total Available Beds		16
Gross Direct Cost/Patient Day	$	435.63
Gross Full Cost/Patient Day	$	643.13
Net Full Cost/Patient Day	$	180.08
Occupancy		72.9%
Non-Physician Direct Care FTE		40
Physician(Psychologist) FTE		1
Non Direct-Care FTE		1
Physician per Occupied Bed		0.09
Total Direct Care FTE per Occupied Bed		3.52
Total Direct Care FTE per Patient per Shift		1.17

TOTAL COSTS BY COST CENTER		
Total Direct (Salary, Benefits, and Other)	$	1,911,992
Physicians	*$*	*107,778*
Administration	$	68,362
Depreciation	$	45,312
Central Service & Supplies	$	627,380
Medical Services	$	169,664
COST PER PATIENT DAY		
Total Direct (Salary & Other)	$	435.63
Physicians	*$*	*24.56*
Administration	$	15.58
Maintenance	$	10.32
Depreciation	$	10.32
Central Service & Supplies	$	142.94
Medical Services	$	38.66

TOTAL COSTS BY CATEGORY		
Residential Costs	$	1,911,992
Day Training Costs	$	322,633
Support Services Costs	$	350,059
Medical Services Costs	$	169,664
Administration Costs	$	68,362
COST PER PATIENT DAY		
Residential Costs	$	435.63
Day Training Costs	$	73.51
Support Services Costs	$	79.76
Medical Services Costs	$	38.66
Administration Costs	$	15.58

TLC and Woodland Revenues FY 2009

Revenue Source	Amount
Medicaid	$ 1,862,989
Other	$ 169,363
Total	**$2,032,351**

TLC and Woodland Expense Baseline Model FY 2009

Cost Category	Cost
All Salaries	$ 1,096,813
Total Direct Patient Care (Salary)	**$1,096,813**
Overtime	$ 8,191
Fringe Benefits	$ 707,618
Total Direct Patient Care (OT & Fringe)	**$ 715,809**
Operating Costs	$ 92,133
EE Data Processing Current Expense	$ 7,238
Total Direct Other	**$ 99,371**
Support Services (DTS, HR, etc.)	$ 304,747
Day Training Costs	$ 322,633
Medical Services	$ 169,664
Administration Costs	$ 68,362
Depreciation	$ 45,312
Total Indirect	**$ 910,718**
Grand Total Direct	$ 1,911,992
Grand Total Indirect	$ 910,718
Total TLC and Woodland Cost	**$2,822,710**
Patient Days	*4,389*
Avg. Census	*12*
Total Cost per Patient Day	**$ 643.13**

TLC and Woodland Direct Patient Care Salary by Position (Non-Audited) FY 2009

Job Title	FTE	Avg. Hourly Salary	Cost
PSYCHIATRIC/DEVELOPMENTAL TECHNICIAN	31.00	$ 11.31	$ 729,547
SUPERVISING PSYCHOLOGIST	1.00	$ 37.39	$ 77,778
LEAD DEVELOPMENTALIST	4.00	$ 13.53	$ 112,585
CASEWORKER SPECIALIST II	2.00	$ 25.58	$ 106,404
LICENSED CLINICAL THERAPIST	1.00	$ 27.74	$ 57,691
DEVELOPMENTALIST	2.00	$ 10.74	$ 44,683
CUSTODIAN	1.00	$ 12.63	$ 26,267
TOTAL	**42.00**		**$1,154,956**

TLC Expense Baseline Model FY 2009

Object Code	Object Name	Total
5101	Salary/Wages	$ 352,881.02
5110	Leave Paid	$ 65,835.44
5130	Overtime Paid	$ 6,179.75
5135	Comp/Excess Used	$ 1,283.76
5140	Comp/Excess Earned	$ 9,618.97
5150	Incentive	$ 200.00
5160	State Retirement	$ 67,006.35
5170	FICA/Medicare	$ 32,160.63
5180	Health/Dental/Life	$ 196,770.18
5190	Unemploy and Workers Comp Insurance	$ 3,801.43
5199	Comp/Excess Benft	$ 5,397.83
Total AA Personnel Expense		**$ 741,135.36**
6171	Buildings and Grounds-Operating Supplies, Maint & Repairs	$ 36,324.72
6175	Other Equipment	$ 496.50
6184	Educational & Rec Supplies	$ 960.97
6186	Photocopy Expenses	$ 3,237.09
6188	Office Furnishings less than $5000	$ 540.00
6189	Other Small Equip and Supplies less than $5000	$ 2,844.78
6213	Clothing & Uniforms	$ 28.97
6214	Food	$ 10,994.35
6233	Household Supplies	$ 1,112.73
6241	Student or Inmate Training or Payroll Costs	$ 134.20
6244	Student & Inmate Medical Costs	$ 298.32
6245	Student & Inmate Support Costs	$ 218.81
6246	Rehabilitation Recreational Costs	$ 95.68
6287	Unclassified Other	$ 342.70
Total DD Current Expense		**$ 57,629.82**
6500	DTS - Data Processing Charges	$ 5,567.39
Total EE Data Processing Current Expense		**$ 5,567.39**
N/A	Day Training Costs	$ 97,630.00
N/A	Support Services (DTS, HR, etc.)	$ 126,978.00
N/A	Medical Services	$ 70,693.00
N/A	Administration Costs	$ 28,484.00
N/A	Depreciation	$ 40,978.00
Total Other Indirect Expense		**$ 364,763.00**
Grand Total Expense		**$ 1,169,095.57**
Patient Days		*1,824*
Avg. Census		*5*
Total Cost per Patient Day		**$ 640.95**

TLC Direct Patient Care Salary by Position (Non-Audited) FY 2009

Job Title	FTE	Total Hours	Average Full Hourly Pay Rate	Total Salary	Salary per FTE	Total Benefits	Benefits per FTE	Total Compensation	Total Comp per FTE
PSYCHIATRIC/DEVELOPMENTAL TECHNICIAN	16.00	33,280	$19.21	$366,360	$22,898	$272,896	$17,056	$639,257	$39,954
LEAD DEVELOPMENTALIST	2.00	4,160	$21.47	$56,292	$28,146	$33,005	$16,503	$89,298	$44,649
CASEWORKER SPECIALIST II	1.00	2,080	$35.29	$51,762	$51,762	$21,641	$21,641	$73,403	$73,403
CUSTODIAN	1.00	2,080	$23.07	$26,267	$26,267	$21,718	$21,718	$47,985	$47,985
DEVELOPMENTALIST	1.00	2,080	$20.58	$22,342	$22,342	$20,458	$20,458	$42,799	$42,799
TOTAL	**21.00**	**43,680**		**$523,023**		**$369,719**		**$892,742**	**$42,512**

Woodland Expense Baseline Model FY 2009

Object Code	Object Name	Total
5101	Salary/Wages	$ 558,469.57
5110	Leave Paid	$ 98,290.65
5120	Misc Earnings	$ 366.96
5130	Overtime Paid	$ 2,010.94
5135	Comp/Excess Used	$ 1,537.03
5140	Comp/Excess Earned	$ 8,529.34
5150	Incentive	$ 3,975.00
5160	State Retirement	$ 104,357.99
5170	FICA/Medicare	$ 50,638.33
5180	Health/Dental/Life	$ 232,654.83
5190	Unemploy and Workers Comp Insurance	$ 5,969.35
5199	Comp/Excess Benft	$ 4,686.38
Total AA Personnel Expense		**$ 1,071,486.37**
6171	Buildings and Grounds-Operating Supplies, Maint & Repairs	$ 5,964.00
6174	Repairs to Damaged Vehicles	$ 656.54
6175	Other Equipment	$ 51.25
6181	Office Supplies	$ 554.77
6184	Educational & Rec Supplies	$ 425.93
6186	Photocopy Expenses	$ 385.56
6188	Office Furnishings less than $5000	$ 1,120.00
6189	Other Small Equip and Supplies less than $5000	$ 144.99
6213	Clothing & Uniforms	$ 426.71
6214	Food	$ 21,063.16
6219	Medical/Testing & Lab Supplies	$ 61.87
6233	Household Supplies	$ 696.31
6241	Student or Inmate Training or Payroll Costs	$ 1,562.00
6244	Student & Inmate Medical Costs	$ 316.04
6245	Student & Inmate Support Costs	$ 663.75
6251	Library Books & Pamphlets	$ 20.13
6254	Library Audio-Visual Materials	$ 20.00
6287	Unclassified Other	$ 370.12
Total DD Current Expense		**$ 34,503.13**
6500	DTS - Data Processing Charges	$ 1,670.23
Total EE Data Processing Current Expense		**$ 1,670.23**
N/A	Day Training Costs	$ 225,003.00
N/A	Support Services (DTS, HR, etc.)	$ 177,769.00
N/A	Medical Services	$ 98,971.00
N/A	Administration Costs	$ 39,878.00
N/A	Depreciation	$ 4,333.95
Total Other Indirect Expense		**$ 545,954.95**
Grand Total		**$ 1,653,614.68**
Patient Days		*2,565*
Avg. Census		*7*
Total Cost per Patient Day		**$ 644.68**

Woodland Direct Patient Care Salary by Position (Non-Audited) FY 2009

Job Title	FTE	Total Hours	Average Full Hourly Pay Rate	Total Salary	Salary per FTE	Total Benefits	Benefits per FTE	Total Compensation	Total Comp per FTE
PSYCHIATRIC/DEVELOPMENTAL TECHNICIAN	15.00	31,200	$20.29	$363,187	$24,212	$269,853	$17,990	$633,040	$42,203
SUPERVISING PSYCHOLOGIST	1.00	2,080	$51.82	$77,778	$77,778	$30,000	$30,000	$107,778	$107,778
LEAD DEVELOPMENTALIST	2.00	4,160	$24.26	$56,292	$28,146	$44,643	$22,322	$100,936	$50,468
CASEWORKER SPECIALIST II	1.00	2,080	$41.09	$54,643	$54,643	$30,830	$30,830	$85,473	$85,473
LICENSED CLINICAL THERAPIST	1.00	2,080	$43.03	$57,691	$57,691	$31,809	$31,809	$89,500	$89,500
DEVELOPMENTALIST	1.00	2,080	$16.61	$22,342	$22,342	$12,200	$12,200	$34,541	$34,541
TOTAL	**21.00**	**43,680**		**$631,933**		**$419,334**		**$1,051,268**	**$50,060**

TLC and Woodland Scenario Detail

	USDC - TLC and Woodland FY 2009 BASELINE	USDC - TLC and Woodland FY 2009 SCENARIO 1	USDC - TLC and Woodland FY 2009 SCENARIO 2
All Salaries	$ 1,096,813	$ 1,096,813	$ 1,173,680
Total Direct Patient Care (Salary)	**$ 1,096,813**	**$ 1,096,813**	**$ 1,173,680**
Cost Per Patient Day	**$ 249.90**	**$ 249.90**	**$ 267.42**
Overtime	$ 8,191	$ 8,191	$ 8,191
Fringe Benefits	$ 707,618	$ 383,884	$ 410,788
Total Direct Patient Care (OT & Fringe)	**$ 715,809**	**$ 392,075**	**$ 418,979**
Cost Per Patient Day	**$ 163.09**	**$ 89.33**	**$ 95.46**
Operating Costs	$ 92,133	$ 92,133	$ 92,133
EE Data Processing Current Expense	$ 7,238	$ 7,238	$ 7,238
Total Direct Other	**$ 99,371**	**$ 99,371**	**$ 99,371**
Cost Per Patient Day	**$ 22.64**	**$ 22.64**	**$ 22.64**
Private Management Fee	$ -	$ 206,474	$ 219,964
Total Private 13% Management Fee	**$ -**	**$ 206,474**	**$ 219,964**
Cost Per Patient Day	**$ -**	**$ 47.04**	**$ 50.12**
Support Services (DTS, HR, etc.)	$ 304,747	$ 304,747	$ 304,747
Day Training Costs	$ 322,633	$ 322,633	$ 322,633
Medical Services	$ 169,664	$ 169,664	$ 169,664
Administration Costs	$ 68,362	$ 68,362	$ 68,362
Depreciation	$ 45,312	$ 45,312	$ 45,312
Total Indirect	**$ 910,718**	**$ 910,718**	**$ 910,718**
Cost Per Patient Day	**$ 207.50**	**$ 207.50**	**$ 207.50**
Total TLC and Woodland Cost	**$ 2,822,710**	**$ 2,705,450**	**$ 2,822,710**
Patient Days	*4,389*	*4,389*	*4,389*
Avg. Census	*12*	*12*	*12*
Cost Per Patient Day	**$ 643.13**	**$ 616.42**	**$ 643.13**

G. Discussions on Quality of Care

The following list identifies recent reports and papers regarding staffing levels, wages, and working conditions and the effects those each have on quality of care. PCG researched these reports in the development of our analysis.

- Schmitt, J. (2009, April), *Unions and Upward Mobility for Service-Sector Workers*, Center for Economic and Policy Research, Washington, D.C. Retrieved on June 21, 2010 from http://www.cepr.net/documents/publications/unions-service-2009-04.pdf

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- Lamberg, L. (2004, July 7) *Impact of Long Working Hours Explored*, JAMA, 292:1, pp. 25-26. Available by subscription only http://jama.ama-assn.org/cgi/content/extract/292/1/25

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H. Identifying Programs Comparable to the Semi-secure Units at USDC

There are no national lists of which states have semi-secure units in their developmental centers and there are no national associations of directors of semi-secure units. Given the absence of the usual resources to identify specific state programs, PCG undertook its own effort to create such a list.

PCG began by taking a list of 357 programs that were or had been licensed as Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) from Table 1.12 of the 2009 report titled "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2008" published by the University of Minnesota, retrieved on June 22, 2010 from http://rtc.umn.edu/docs/risp2008.pdf. All programs that were still open were contacted to inquire if they had any semi-secure units. Programs were contacted by either e-mailing or calling the particular program or by e-mailing or calling a central state office that supervised multiple state programs. We received excellent cooperation and all states responded to our requests for information.

This work established that there are no national standards or federal policy regulating how persons with an intellectual or developmental disability (ID/DD) are treated if their behavior involves a criminal offense. Not only are ICFs/MR known by different names such "developmental centers", "schools" and "habilitation centers", but there is substantial variation in the degree of security provided in specialized units and the degree to which competency restoration is stressed in their programming.

This work identified that currently there 150 open ICFs/MR and about twenty-three of them have a "secure", "semi-secure", "moderate security" or "locked" unit and sometimes these are called forensic units. The programs shown in the table below vary from a few beds in one developmental center, like USDC, to campuses with multiple buildings some of which are occupied by forensic residences, to stand alone centers that are either part of a larger developmental center campus or are unique buildings. The programs also vary considerably in their programming. Some stress competency restoration, others appear to emphasize traditional ID/DD programming, like USDC, while others claim to do both.

In addition to their differences in level of security and programming, the programs vary considerably in their ability to provide census and financial information about their operations. States, both large and small, with centers that have "forensic" beds do not usually allocate the direct and indirect costs of operating those beds, thus the costs of the forensic beds are not broken out separately from the costs of operating the larger centers. Large states with multiple programs present their own data collection problems, and states with stand alone programs in unique building often have good cost reporting. Finally, states vary in their responsiveness to requests for information and the degree to which internet research can find information specific to the operation of their specialized units.

Thus selecting comparable programs to study is a compromise among the competing factors of number of beds, degree of security, programming, availability of census and financial information, cooperation received in providing the information, and availability of public information about the specialized services.

State and name of secure, semi-secure or forensic unit	Short Description of Unit(s)
CA Canyon Springs (Cathedral City)	The facility at Canyon Springs (CS) is licensed as an ICF/DD and has a bed capacity of 63. The annual census averages 55 people given the physical infrastructure, and needs of the individuals who reside at CS. There are 4 separate areas/residences and the bedroom space is generally 2 people per room. The annual per resident cost is $282,509 based upon the projected budget.
CA Porterville Dev. Ctr. (Porterville)	The Porterville Secure Treatment Program (STP) has 11 separate residences licensed to serve anywhere from 16 – 40 people. In the areas that are licensed to serve up to 40 people it maintains its census at approximately 25 given the specific needs of the individuals and the physical infrastructure of the residence. The residences with 16 beds are intended to be at full capacity as the design includes individual bedroom areas. At Porterville the annual cost per resident (inclusive of the ICF/DD, Nursing Facility and STP) is $256,142 based upon the projected budget.
CT South Region ICF Campus	CT DDS has one secure (specialized security features and supervision) ICF/MR located on the campus of one of our regional centers (The unit is a stand alone home). There are 4 beds in this house and the average census is 4.
FL Mentally Retarded Defendant Program	The Mentally Retarded Defendant Program (MRDP) is a secure, 146-bed facility operated by the Florida Agency for Persons' with Disabilities (APD). MRDP is the only admissions facility in the State of Florida for residents with MR that have alleged offenses.
FL Seguin Unit-Alachua Retarded Defendant Ctr. (Gainesville)	Seguin has 21 beds and is a secure forensics unit. Persons are admitted to it after the MRDP program.
FL Sunland Ctr. (Marianna)	Sunland has 383 ID/DD beds of which 34 are forensic in a program called Pathways. Used after the MRDP program.
IL Choate Dev. Ctr. (Anna)	30 beds at the Clyde Choate Center. They occupy the entire second floor of a building. The program emphasizes both restoration to competency and transition to community living when the competency cannot be restored.
MN Ext. Treatment Options Program (Cambridge)	36 beds. Program is called METO.

State and name of secure, semi-secure or forensic unit	Short Description of Unit(s)
MO Marshall Habilitation Ctr. (Marshall)	24 beds. Only one in Missouri
MT Montana Developmental Ctr. (Boulder)	Has 12 bed secure unit
NJ New Lisbon Dev. Ctr. (New Lisbon)	At New Lisbon Development Center there is a 36-bed unit called the Modern Secure Unit. The Modern Secure Unit (MSU) is a specialized, institutional facility authorized and was established by the Director of the Division of Developmental Disabilities (DDD) which is characterized primarily by physical security for the confinement of individuals adjudicated to be dangerous to self, others or property and in need of a highly structured therapeutic program. The MSU is used as an alternative to incarceration in a correctional facility.
NY Brooklyn DDSO (Brooklyn)	Brooklyn's Regional Behavior Intensive Treatment Unit (RBITU) has 24 beds.
NY Broome DDSO (Binghamton)	Has 60 forensic beds
NY Finger Lakes DDSO (Rochester)	The Center for Intensive Treatment (CIT) is a comprehensive, secure treatment facility, located on the Sunmount campus in Tupper Lake, serving individuals who are developmentally disabled and who are involved with the criminal justice system, or have extremely challenging behaviors. The CIT is a one of a kind, self contained campus, consisting of four homes and a program building enclosed within an eight acre secure perimeter located on 37 acres of land.
NY Taconic DDSO (Wassaic)	Described as having forensic services
ND North Dakota Developmental Ctr. (Grafton)	12 beds in a residence where the doors are electronically locked where those residing there have different degrees of passing through doors with electronic key fobs. An additional 4 beds in a flexible living space where no one lives has been created for people who need short term freedom of movement limitations, both living at the Center and those admitted for short-term purposes.
OH Warrensville Dev. Ctr. (Warrensville)	The Warrensville Center has a small unlocked forensic unit of five beds which opened in September 2009.

State and name of secure, semi-secure or forensic unit	Short Description of Unit(s)
SD South Dakota Dev. Ctr. (Redfield)	Does not have any forensic units. May have someone who is admitted under voluntary admission that meets ICF-MR legibility and has conditions of court such as probation terms as a part of a suspended imposition of sentence. Although it does not have any forensic units it does have a few dorms/modules that are locked, 4 in adult program and 4 on youth program. People that reside on the locked modules require the limitation due to dangerous behavior to others. If a person did not require the locked module but that was the current place the person resided the person would be provided with a key and then the team would develop a plan that addressed responsibility with the key. All modules/dorms have awake staff at all times that provides access to and from the module/dorm for those people that do not have a key.
TN Clover Bottom Dev. Ctr. (Nashville)	Harold Jordan Center, 32 beds, located on the CBDC campus, is a facility for persons with intellectual disabilities that have been charged with a crime.
TX Corpus Christi State School (Corpus Christi)	2 homes with a 24 bed capacity
TX Mexia State School (Mexia)	4 homes with a 40 bed capacity
TX San Angelo State School (Carlsbad)	3 homes with a 39 bed capacity

Data Source: Public Consulting Group, 2010