12-17-65

M E M O R A N D U M

TO: David J. Vail, M.D.
Director, Medical Services Division

FROM: E. J. Engberg, M.D., Superintendent

SUBJECT: Unit Program System

This is to clarify some questions you posed about our unit system in a memo to me dated December 10, 1965.

The basic factors that determined our organization of buildings into units were:

a. Georgraphical proximity, as indicated in the accompanying map. We want to make it possible for team members to function effectively and also to work with patients that are most appropriate to their talents and experience. The fact that certain buildings are restricted as to use for certain types of patients also had to be taken into account.

b. Compatibility of programs within a unit.

c. Equalization of case load, based on the amount of intensive care or programming required as well as on numbers alone.

The accompanying chart indicates the case loads by building and unit and the predominant program(s) in each building and unit. The terms "New Infirmary Unit" and "New School Unit" were temporary ones which indicated the predominant programs that we expected to be carried out in them. These have since been given the names "Grandview Unit" and "Center Unit" respectively.

With respect to your inquiry regarding our intent to implement the program concept, I would like to indicate that we do have an analysis of the programs into which the patients of the various cottages fall. You will note from the chart that some buildings contain patients falling into two, and in one instance into three, programs, as they have been defined. While this is not the most desirable arrangement, we feel that because of age or developmental status, patients may not fall neatly into a specific program or may be in the process of changing from one program need to another. The necessity of keeping buildings occupied also introduces the problem of combining patients from different programs, although we try to select patients so as to minimis the differences between such groups. In those buildings which have more than one program, we believe the programs would be compatible. Mr. Krafve has discussed this with Dr. Bartman and he agreed that this is feasible.

One of the major intents in our adopting the unit system is to make the staff more aware of the individual program needs of patients, and it is our expectation that a major benefit will be the proper assessment of patient needs and the regrouping of patients when common needs are determined. Rather than concentrate on mass shifting of patients at

this time, we would much prefer to have the impetus for any needed changes arise from the functioning of the unit teams.

I hope that the foregoing, together with the accompanying material and original any additional questions or to receive suggestions from you.

/er

cc: Richard A. Bartman, M.D.

Building	Rated Capacity	Population	Programs
SUNNYSIDE UNIT (Male)			
Chippewa	120	162	5 and 6
Pawnee	97	120	5
HillCrest	50		6
West	42	84	6
Sioux	53	63	6
		66	
SKINNER UNIT (Female)			
Ivy	132	161	6
Holly	74	97	5
Iris	45	42	6
Oaks	90	110	6
		410	
EAST GROVE UNIT (Female)			
Poppy	61	94	5
Wi ern ow	126	171	4 and
Daisy	45	63	5
			5
GREENACRES UNIT (Male and Female)			
Cedar (female)	72	76	2 and 3
Maple (male)	72	97	2 and 3
Linden (male)	120		1 2 and 4
Birch (female)	100	126	4
		100	
		399	
GRANDVIEW UNIT (Male) - New Infirmary			
Elm	100	109	6
Dakota	85	104	5
Hickory	100	111	5
Seneca	10 0	100	M
Sdale	767	19	4
CENTER UNIT (Male and female) - New School			
Mohawk (male)	53	60	3
Osage (male)	74	85	3
Rose (female)	25	38	3
Laurel (female)	59	58	3
Pine (male)	67	106	1 and 2
Spruce (female)	67	66	1
			and 2
		433	
HOSPITAL (male and female)			
Institution Hospital	59	50	

Skinner
Eaet Grove
Green Ares
Grandview
Center