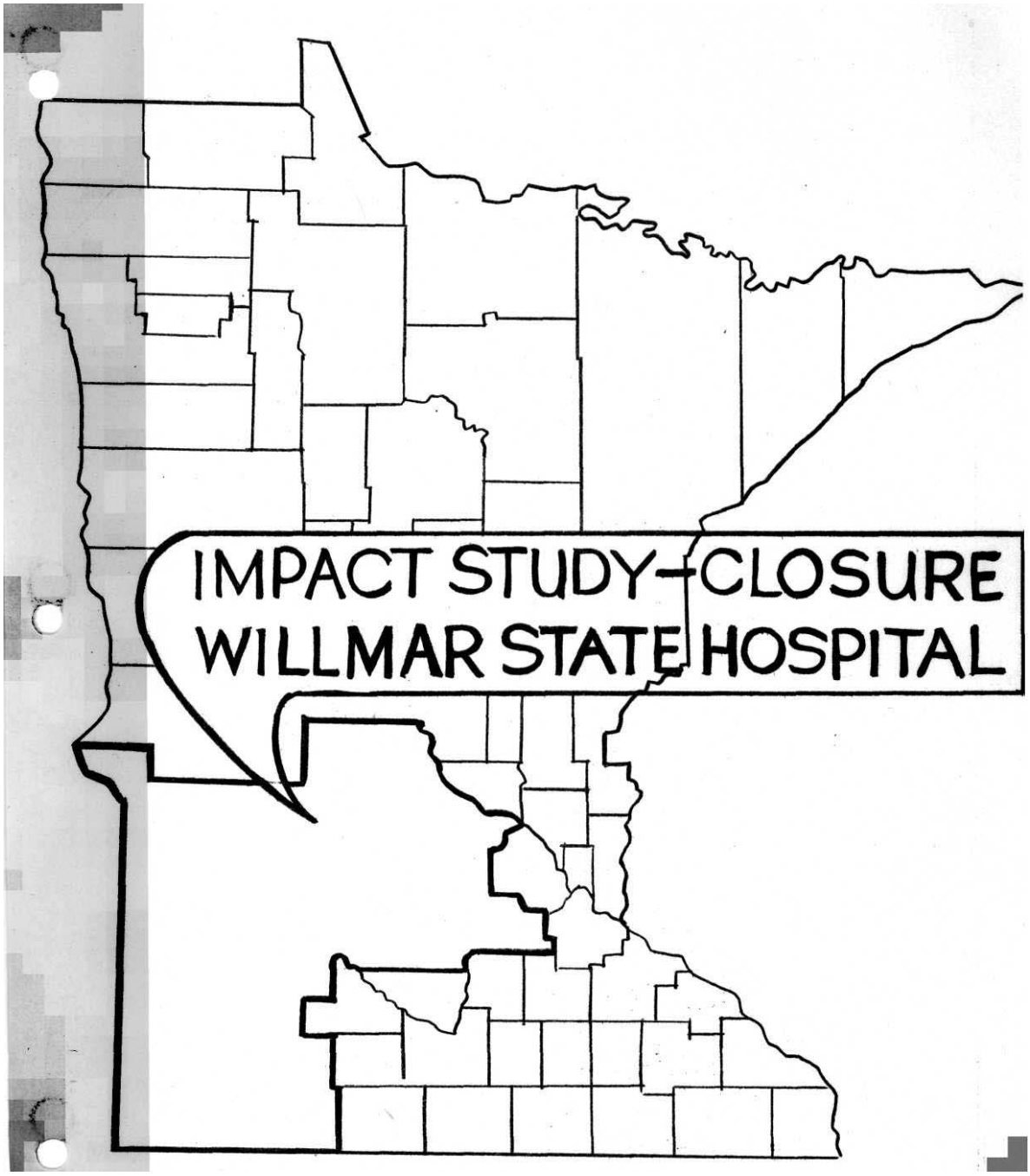

IMPACT STUDY-CLOSURE
WILLMAR STATE HOSPITAL

LIST OF APPENDICES

INTRODUCTION

Willmar State Hospital, established by enabling legislation seventy-five years ago, has served all of Minnesota at one time for care and treatment of inebriate persons. For over 30 years prior to 1951, it served all of Minnesota as a "transfer hospital" for the mentally ill. Since then it has served, with variation as it does today, more than 20 counties (about 13% of the state's population) for citizens needing care for psychiatric, addictive and developmental disabling problems and conditions. Typical of the role of state hospitals, it has been a leader and demonstrator of clinical services that could and should be available to the public at attractive conservative costs. To illustrate, Willmar State Hospital served as a prototype for all the United States and Canadian alcohol treatment programs we know today. It operates the longest sustained publicly owned adolescent treatment service in our state with a non-faltering future before it. It has recently demonstrated the positive role state government can play in the care of the dangerous, mentally ill adolescent by establishing a protective secure program in 1979 to meet these state-wide needs. Established in 1973, the Glacial Ridge Training Center serving severely and profoundly retarded citizens illustrates a contemporary prototype of service in this field. The hospital is seldom without a "future role" project underway. The hospital has a long tradition of displaying an attitude of leadership, technical know-how, and compassion while serving a clientele not uncommonly selectively rejected by other providers.

The issue of closure to be addressed in this report comes at a time when we anticipate greater demands for service as a result of regional population growth of 11.8% (see Appendix A), decreasing federal financial assistance, and a decreasing ability by the community to support programs for the types of clients served by the State Hospital System. Until a publicly accepted idea of abandonment of these Minnesota citizens is in place, there are consequences and impacts that would follow if facilities such as Willmar State Hospital are forsaken.

A. Mental Illness-Program

Programs for the mentally ill at Willmar State Hospital have 281 beds, serving several distinctively different patients. There is an 84-bed Adult Psychiatric Admissions Unit, a 122-bed Psychiatric Rehabilitation Unit and a 75-bed Psycho-geriatric Program. This is the only facility serving more than 600,000 people of southwestern Minnesota that can handle the volume and complexity of psychiatric problems it does. Community interventions for these patients would severely tax local facilities. In most cases, immediate and direct care facilities are lacking. Currently, the mental illness programs are running at 96% occupancy as of May 1, 1982.

Patients, not previously known to the state hospital, are regularly admitted along with a corresponding population who have previous histories in state hospitals. Appendix B reflects the mean number of admissions for each of the disabilities. It should be noted that 50% of the mental illness admissions are first time admissions. A general reduction in length of stay has been noted. Appendix C reflects current length of stay by disability. Noteworthy is the fact that 61% of all patients admitted to Willmar State Hospital are discharged within 60 days. Specifically, on the mental illness program, 48% of this population leaves within 30 days of admission. These figures tend to refute a stereotype of state hospital patients which suggests extremely long periods of hospitalization.

Effects of closure:

1. Population Served

The programs serve 23 southwestern Minnesota counties with characteristics of the hospital population served varying according to which treatment program the patient is admitted.

a. Adult Psychiatric Admissions Unit

Typical admissions include individuals who are neurotic, psychotic, who are having adjustment reactions of various types, personality disorders, and those having psychotic episodes which may have been precipitated by illicit drug use or organic brain disease. Age range is between 18 and 70 with the mean admission age becoming decidedly younger. Current mean age is 32 years (see Appendix D).

b. Psychiatric Rehabilitation Unit

Serves approximately 130 patients who are fairly long term in nature and difficult to place (primarily problem schizophrenics). Approximately 15% of this population is from outside of our current catchment area; a residual from periods when the hospital was a transfer hospital for other facilities. This group of patients over the years has experienced multi-treatment failures at a variety of treatment facilities, including this hospital. Out placement is increasingly difficult.

c. Psycho-geriatric Unit

This unit consists of two program areas: one having a geriatric orientation and the other a medical orientation. The geriatric service cares for 50 patients who are referred by programs within the hospital. The types of problems dealt with include various degenerative brain diseases, Korsakoff's psychosis, dementias, and post lobotomy patients. This population requires a high level of physical care and supervision. Many of the patients require bathing, shaving, dressing, toileting, feeding, activation and other related cares. The medical service provides care for 25 patients and complements the Psycho-geriatric Unit with additional care provided in treating the acute disease processes,

the chronic disease process, the post surgical care and the post fracture care. Patients may be admitted directly to the unit or be transferred in from other hospital programs.

2. Capacity Lost/Placement of Patients

Campus mental illness programs admit and discharge approximately 500 patients annually. Approximately 400 of these actions take place on the Psychiatric Admissions Unit with the remainder occurring primarily on the Psycho-geriatrics Program. (See Appendix E). The ability to place these patients within alternate mental illness programs is dismal. See Appendix F for a listing of alternate facilities within our region.

The psycho-geriatric population needs special mention. If Willmar State Hospital was not available, it is unknown where this type of patient would receive care. There are two state nursing homes, usually filled to capacity. The majority of these patients would not be accepted in community nursing homes due to behaviors and level of care needed. There is a lack of community resources to meet the needs of the bulk of residents in the Psycho-geriatric Unit.

Approximately 80% of our population would have to be hospitalized at other state hospitals which are already being overtaxed with high occupancy rates (see Appendix G). The only alternative for many of these patients, as experienced in California, would be placement ultimately in penal facilities that are overcrowded and certainly not appropriate or equipped to treat mentally ill patients.

3. Impact on Patients

Impact on patients would be disruptive and unsettling. The Psychiatric Rehabilitation Unit's patients struggle towards a balance between behavior control and medication adjustment. This balance is affected easily and quickly. Certainly, closure would be a major environmental change affecting

stability. The impact on psycho-geriatric patients would be devastating. A majority of these people have failed several times in nursing homes and have had to return to this hospital. They have experienced repeated out placement failure. Many would deteriorate for lack of proper care.

Specifically, the impact of closure on patients could be reflected in:

a. Overtaxed mental health centers which are not equipped to deal with the severity, acuteness or problems our patients routinely present.
b. Mental health units that lack space and capability for treating the number of patients needing treatment, particularly over extended periods of time. Additionally, insurance will pay only for short stays at private facilities making treatment less available.
c. Trends suggest funding for mentally ill in the community are declining and community personnel are being laid off resulting in fewer professionals to deal with acutely mentally ill patients.
d. Medical doctors in the community are not experienced with the acutely psychotic individual.
e. Willmar State Hospital is more centrally located for its catchment area. Should the hospital close, distances would become formidable for patients, families and county social workers traveling to other facilities (see Appendix H).
f. Closure would mean county workers becoming less involved in patient treatment due to travel and distance which would affect discharge planning.
g. Patients would undoubtedly have lengthier hospitalizations because families would not visit as frequently ultimately affecting family therapy and discharge planning.
h. Additional cost for families and counties to travel would be realized.

i. Transition back to home communities would be difficult because of distances involved; i.e., home passes, looking for work, etc.

j. Volunteer support from local communities would be reduced.

k. Court systems in our area communicate with this hospital regarding treatment and alternatives. Unfamiliarity with distant treatment facilities would adversely affect patient treatment.

l. Availability of legal counsel for patients would become increasingly difficult.

4. Impact on Counties

The hospital mental illness units offer structured programs and supervision of patients simply not available in the private sector in southwestern Minnesota. Expense of replicating such programs in today's economic climate is prohibitive. Specifically, the impact of closure on counties could be:

a. Funding for transportation to distant hospitals would become formidable.

b. County participation in aftercare planning could be hindered due to the distance involved and the unfamiliarity with the distant alternate facility and their programs.

c. Involvement in a patient's treatment, planning and placement will be come increasingly difficult because of increased travel distances.

d. Patients on Hold Orders, Rule 20 evaluations, etc., would necessarily be placed in local hospitals or jails totally unequipped, both staff and space wise, to deal with this type of admission.

e. The cost of private care is formidable vs. the cost of state hospital care. Many of our present population would have to be given private care consideration if available.

f. Counties may be hesitant to transport patients long distances; consequently, these individuals would remain in the community. Increased

police service to confused, psychotic people as well as increased costs for the community in terms of fire protection, police protection, etc., ultimately would be realized.

g. Increasing the size of a state hospital to accommodate the closure of another hospital results in problems to the hospital community as a whole.

h. The further the distance from the community, families, natural support system, the more problems a hospital is likely to have with elopements, security, etc., affecting acceptance by that community.

i. Closure would result in an exodus of trained psychiatric personnel from the area impacting upon the area's professional resources and economic bases.

Impact to the counties in relation to the Psycho-geriatric Unit would be devastating. Many of the residents of the unit have unacceptable behaviors. Community facilities, such as nursing homes, will not deal with inappropriate or unpredictable behaviors which are characteristic of these patients. The community does not have the resources to care for these patients.

B. Mental Retardation Program (Glacial Ridge Training Center)

1. Population Served

The Glacial Ridge Training Center (GRTC), a 177-bed Intermediate Care Facility for the Mentally Retarded (ICF/MR), serves mentally retarded persons in Regions VI and VIII. It opened in 1973 after considerable demand and input from consumer groups, especially the Association for Retarded Citizens. Impetus toward deinstitutionalization and the original Welsch/Noot (Welsch vs. Likins at that time) lawsuit were both very much in evidence at that time. Both of these historical facts were very important in the development of the Center and are very apparent in both the quality and quantity of service the Center provides as a vital link in the continuum of care in this section of the state.

The role which the Center plays is best illustrated by the following description of the population served, the availability of community based alternatives to meet the needs of these clients, impact on clients, and the existing utilization of GRTC by the counties which it serves.

We and the counties we serve have done well in training and placement of persons so that we are nearly in compliance with 1985 Welsch/Noot requirements for placement. This has left us with a very handicapped population and our counties with virtually no unused resources. Of our population numbering 163,125 persons carry a primary mental retardation diagnosis within the profound range, 16 within the severe range, 9 mild, and 11 moderate. Forty residents have severe sensory deficits, such as blindness, deafness, etc. Thirty-eight are non-mobile, and 15 have severe ambulation problems. Thirty-nine have what could be called serious self-injurious behaviors which include pica, head banging, finger chewing, hair removal, rectal digging, and the like. Fifty-four have some type of what we might call behavior disorders or seriously aggressive behaviors

such as pinching others, hitting, property destruction including throwing objects, head butts to others, biting, and sexual aggressiveness. Fifty-seven have more avoidant and less threatening anti-social behaviors such as fairly constant crying, running away, screaming, self-stimulation, sexual acting out, and generally non-compliant behavior. Seventy-two have various kinds of seizure disorders. Ninety-two are being treated for various medical conditions, such as heart conditions, nerve disorders, upper respiratory problems, digestive tract problems. One hundred twenty eight are for the most part non-verbal. These problems exist in various combinations in all of our residents so that they can truly be described as multiply-handicapped and difficult to place. Many have already had repeated failures in community placement alternatives.

2. Capacity Lost/Placement of Clients

There are a total of twenty-eight licensed Rule 34 facilities in the regions served by GRTC, making up a total of 609 available beds. Virtually every county now has at least one group home or residential facility to serve mentally retarded people. However, there is very little overlap or duplication of service. For example, only 60 of the 609 beds are licensed as Class "B" facilities; i.e., able to serve persons who have few, if any, self-preservation skills and/or those who are multiply handicapped. Given the description of the current population at GRTC and the near 100 percent occupancy of the available community beds, it is obvious that the role being fulfilled by GRTC is critical at this point in time.

It is also noteworthy that 437 of the 609 available beds (more than 2/3) are under the direct ownership and control of only two persons. Thus, one might be fair in suggesting that the available community beds are relatively "tenuous" or "sensitive" to any changes in the availability

of funding that might reduce the profit motive in caring for mentally retarded persons.

3. Impact on Clients

The "appropriate role" of facilities serving mentally retarded persons has generally been defined as: 1) serving the most severely disabled, 2) providing respite care and preventive services, and 3) providing intensive treatment and behavioral training for persons with severe behavioral and emotional disorders. The data quoted and displayed clearly illustrates that 6RTC is fulfilling those needs for Regions VI and VIII and is doing so in a quantity which is well above the state average on a per capita basis.

There is, of course, a quality aspect which should not be overlooked. In addition to being fully licensed by the State Departments of Health and Public Welfare, the facility is fully certified by the federal government as an ICF/MR institution (eligible for Title XIX reimbursement) and meets all life safety code provisions. The qualitative measurement of which the Center is most proud is its status of full accreditation by the Accreditation Council for Mentally Retarded and Developmentally Disabled (ACMRDD). Glacial Ridge Training Center is one of only two facilities in the state and one of 70 in the nation to have achieved this status of recognition for quality service.

Descriptions of quality and quantity, how well a facility is fulfilling its prescribed role, etc., are, of course, only part of the question which must be addressed in times of declining economics and reassessment of social planning. In addition to the probable loss of quality, one must also consider such things as the ability of the rest of the "system" to "absorb" the clientele and what the costs of that "shuffling" would be if a particular facility should be closed or phased out.

Since the occupancy ratio for existing community facilities is near 100% and since the philosophy and practice toward admissions has for some years been only to admit persons for whom there are no suitable alternatives, one must logically look primarily toward the existing state hospital system as the only likely recourse for the majority of clients who would be affected by any possible closure.

Examination of Appendix 6 describes the existing population, capacity and percent of occupancy for each of the state-operated facilities currently in existence. Obviously, this is only at this particular point in time and must be viewed in that light. History has shown that such utilization figures are heavily influenced by such things as distances from the service, changes in the characteristics of the population, major changes in legislation, and perhaps most importantly, changes in funding mechanisms and the economy itself.

However, the chart is most useful in addressing the question of whether or not the "system" is capable of "picking up" the clients served if any one facility were to close. For example, there are a total of 235 designated mental retardation beds currently vacant in the 7 state hospitals serving mentally retarded persons. Since some small number or percentage of beds should be available for emergencies, court holds, respite care, etc., it is probably more realistic to look at a number smaller than 235 in assessing the ability of the system to "absorb" the closure of another mental retardation facility.

In light of the above, it should be noted that only three of the seven facilities serving mentally retarded persons have current occupancy rates of less than 90 percent. The vacancies in these three facilities total 157 beds, or approximately 2/3 of the total number of beds available.

Thus, in determining possible impact of closure one must conclude that the majority of mentally retarded clients would have to be transferred in some combination to one or more of those three facilities, irrespective of which facility were chosen for closure.

Distance from family members, community, friends and county social workers who have financial and case management responsibilities is, of course, an extremely important consideration when moving clients. The greater the distance, the more difficult it is to provide quality care and return persons to their communities and maintain family ties. In addition, added distances are very costly, both to the family and the counties who must visit their client, attend staffings, etc., in order to carry out their case management responsibilites.

Appendix H, which shows air miles from the county seats of the counties served by Willmar State Hospital to each of the state hospitals, can be used to indicate what increased travel could be necessary if another state hospital were to be designated as the receiving area for central and southwestern Minnesota. For example, in the case of GRTC which serves primarily Regions VI and VIII, the average increase in miles traveled for each visit by a family member or county worker would be 166 miles to the Brainerd State Hospital, 226 miles to the Fergus Falls State Hospital or 266 miles to the Moose Lake State Hospital. These three examples were chosen because of their vacancies and occupancy rates, but the chart may be used for similar comparisons to or between any of the existing facilities and receiving areas. This may also be reflected as increased costs of $33-$55 (20 cents/mile) or of time (3 to 5.5 hours at 50 mph) per trip. If one assumes desirable visitation frequency of at least once per month from some family member and at least four visits per year from a caseworker, the ramifications and costs become staggering.

4. Impact on Counties

The attached County Utilization Chart (Appendix I) illustrates the manner in which GRTC is used by the counties which it serves. There are, however, some important points that should be made that may not be readily apparent. For example, the 177 beds at GRTC make up only 6% of the total available state hospital beds designated for mentally retarded persons. However, over 15% of all state admissions and discharges take place at GRTC.

The figures for respite care also warrant special attention. It has been estimated that the availability of 6 beds for respite purposes "may prevent from 6 to 20 admissions or returns in a year." Since more than 20% of all respite care admissions in the state are at GRTC, it can be concluded that counties are utilizing the facility in a very cost effective manner and that the Center is responsive to the needs of the region it serves.

Finally, the fact that over 90% of admissions (other than respite care) are necessitated by severe behavioral and emotional problems points out a third vital role which is fulfilled by GRTC. In essence, the Center serves as a "backup" facility for mentally retarded persons whose behaviors have become so dangerous to himself or others that living in the community is impossible. Thus, their admission reflects the action of one of the county courts. The lack of an accessible regional facility to provide these services would severely hamper the counties' efforts to deal effectively with their deinstitutionalization efforts.

Developmental Disabilities Program. Policy Analysis Series #10: (An Update to Policy Analysis Series #5) Admissions/Readmissions to State Hospitals June 1, 1981, to December 31, 1981: The Behavior Problem Issue. St. Paul, MN: Developmental Disabilities Program, Department of Energy, Planning and Development, April 9, 1982.

factors, even though it should be mentioned that state hospital treatment is cheaper than private treatment.

2. Capacity Lost/Placement of Patients

The program accepts patients who had former treatment in private treatment centers. In most cases, these patients are unmanageable and need longer treatment. This makes it extremely difficult to find other community resources than another state hospital. Since other state hospitals are at or near capacity (see Appendix G), we have to conclude that there are no alternatives to treatment for a state hospital population.

3. Impact on Patients

The impact of closure on this treatment center would mean there is little alternative treatment available. The distance to alternate treatment (other state hospitals) would drastically increase, and if private treatment centers should take over this caseload, their costs would increase dramatically. During economic times when costs are already eliminating some private treatment beds, many patients would not receive treatment and would be subject to a continued deterioration of their health. For persons being committed, they would face more travel, being on waiting lists, and, since many patients' families do not have means of transportation, they would increasingly be deprived of family treatment.

4. Impact on Counties

Closure of the Chemical Dependency Unit would mean that counties would have a higher degree of transportation costs and time spent in travel leading to a lesser degree of county participation in treatment planning and aftercare. Counties would find it increasingly difficult to place a larger proportion of persons into treatment. Commitments

would become more expensive, either by having an increased commitment to private treatment centers or by commitment to a private hospital.

It would appear that counties could continue to seek private treatment centers for all those patients who are relatively easier to treat, have a smaller number of problems, are socially better integrated into society and have private financial resources available. On the other hand, it would appear that state hospitals shall continue to be needed to treat those patients who have no financial, socio-economic resources; who are former failures of private treatment centers; manifest in their behavioral pattern a rather destructive approach and are not suitable for private treatment centers. The hospital Chemical Dependency Unit has received many transfers of "unmanageable patients" from private treatment centers for which no available alternative exists.

D. Adolescent Treatment Program and Protective Unit

1. Population Served

The Adolescent Treatment Unit (ATU) is a specialized statewide psychiatric program for the residential treatment of emotionally disturbed adolescents between the ages of 12 and 17. The program is designed specifically for the adolescent boy or girl who needs a unique combination of group living experiences and an individual therapy program within a structured environment. The unit includes a self-contained special education program as well as an educational program providing attendance at community schools where feasible. At any one time, girls would make up 16 - 17 of the patients and boys 24 - 25 of the patients.

The Protective Component of the Adolescent Treatment Unit is a pilot project started in 1979 to provide treatment services to a small group of very severely disturbed male adolescents. These adolescents range in age from 11 to 16 and are experiencing emotional problems that make treatment impossible in a more traditional residential program. A higher staff-to-patient ratio, a more intense milieu and a greater emphasis on small educational group therapy sessions characterize this portion of the program.

Both components of the ATU serve a population that presents special problems requiring specialized services that community agencies find cost prohibitive to provide.

The uniqueness of these programs dictates that both accept referrals and take patients from throughout the state, not limiting them to the normal hospital receiving district.

When considering both programs, the average patient census is 45 with a routine length of stay of approximately 13 months. Twenty-five per cent of all discharges return to their home and community.

2. Capacity Lost/Placement of Patients

Should Willmar State Hospital and the ATU close, the adolescents obviously would continue to need inpatient psychiatric care. Placement in adult programs at other state hospitals is possible; however, this would mean custodial care for this age group since specialized programming could not be accomplished within the adult programs. Currently, adult programs are not licensed for residents under age 18.

The expertise and trained program staff are not easily replicated at other state hospitals. Cost factors prohibit starting small adolescent programs at the other state hospitals.

The number of community resources serving emotionally disturbed adolescents is limited and decreasing. Closing of residential treatment centers in the last two years has resulted in fewer residential options available for adolescents. Effective June 30, 1982, there will be 175 fewer residential treatment beds in the private sector.

3. Impact on Patients

As with other treatment programs dealing with the mentally ill, the interruption of programming for the adolescent would be traumatic. Since there are no similar state or civilian/private programs of a similar nature available for this patient, it is conceivable they would end up in either inadequate treatment programs or a custodial care program. Research indicates that mentally ill individuals put in this conflict tend to enter: the penal system, which obviously is an inappropriate placement since treatment facilities are generally not available, or in custodial type programs where active treatment is lacking resulting in increased lengths of stay.

4. Impact on Counties

Interruption of treatment for this population would have a significant impact on counties inasmuch as county supervisors would have to look elsewhere for treatment. Elsewhere meaning either outside the state of Minnesota or to private facilities with inadequate programming. In both cases, treatment costs for the limited alternatives would be prohibitive.

Potentially overlooked is the impact which closure would have on the local school district. Educational costs for each resident are the obligation of the student's home school district, but the Willmar School District is responsible for administration/delivery of the educational services.

There are currently 19 staff employed within the district who are full time in special education for the ATU. Their budget including support costs is $410,000 for the 1981-82 school year. This budget is recovered from the school district of residence for the student. Less than 10% of this budget is a direct cost to the local school district. In the event of closure of ATU, these 19 positions would very likely be eliminated. Conservatively, this would mean a payroll loss of approximately $400,000 for education services in addition to the payroll of the unit staff which is approximately two times greater.

II. IMPACT ON STAFF - EFFECTS OF CLOSURE

The hospital has been a major employer for persons living in this area since the early nineteen hundreds. Impact of closure on hospital staff is as follows:

A. Loss of Jobs

1. A total of 619 full time equivalent jobs (involves almost 700 persons) would be lost.
2. Fifty-five (55) couples are employed at Willmar State Hospital, which would result in a loss of total family income for 18% of the staff, many of whose skills are nontransferable in the community.
3. One hundred and fifty (150) or 25% are between the ages of 50 and 65. It is difficult to "start over" at this stage of one's career. Nontransferable skills, "over qualification," and the impracticality of returning to school are all issues.
4. Willmar State Hospital employs 9 service workers who could have difficulty securing other employment in the community.

B. Personnel Related Costs to the State (based on 600 staff)

1. Unemployment Compensation: $2,589,600.
2. Possibility of extended Unemployment Compensation benefits: $1,294,800.
3. Insurance (6-month premium payment for eligible employees): $430,680.
4. Severance payoffs: $639,600.
5. Annual Leave payoffs: $624,600.
6. Relocation (based on average from all contracts): $3,588,000.
7. Total potential costs as a result of closure: $9,167,280.

III. IMPACT ON COMMUNITY - EFFECTS OF CLOSURE

As a result of 75 years of working together, Willmar State Hospital has many overlapping relationships in this community. Closure would have a critical, immediate, and long-range impact on the area's economy and the elimination of several services provided to the community. A. Economic

1. Direct (based on latest data available - 3rd Quarter, 1982 - Minnesota Department of Economic Security - Labor Market Information Center)

   a. Willmar State Hospital percent of employment:

      (1) Constitutes 19.5% of all government employment in the county and 4.7% of total covered employment in the county.

      (2) Constitutes 22% of all government employment in the city of Willmar and 6.5% of total covered employment in the city.

      (3) Is the third largest employer in the area.

   b. Willmar State Hospital percent of wages paid:

      Constitutes 8.5% of total wages paid for covered employees in the county.

   c. Median income:

      Currently, husband/wife median income for Kandiyohi County is $17,003, which ranks 40th of 87. This is 18.7% below the state median of $20,919. Closure would increase this percentage dramatically.

   d. Poverty level:

      Closure would increase the poverty level in the area from 15.6% to 16.1%.

   e. Loss of professional staff:

      The county and city would lose the majority of the hospital's professionals.

f. Unemployment rate:

Would increase from 8.8% to 12.4%.

2. Indirect (based on U.S. Chamber of Commerce statistics)

a. Average employment ratio is 6:1. Every six-jobs brought in by new industry adds one more job in another local business. Using this ratio for closure, as opposed to new industry, 103 jobs in the community would potentially be in jeopardy by closure of Willmar State Hospital.

b. In an agricultural/industrial park based community, the following related effects occur for every 100 new jobs entering the community:

(1) 351 more citizens

(2) 79 more school children

(3) $1,636,880 more personal income

(4) $774,200 more bank deposits

(5) $893,700 more retail sales in one year

(6) 1 new retail business

(7) 47 new homes

Again, taken in reverse, the potential negative results could be 6 times the figures indicated above.

B. Community Services No Longer Available

1. Education

One of the most important and far-reaching responsibilities of the hospital is in the area of providing educational opportunities in our fields of specialty. Education internship affiliate relationships are in effect or have existed with 19 colleges, community colleges or vocational schools in the last ten years dealing with more than 13 fields of study. (See Appendix N). The hospital also uses its own expertise to provide and/or coordinate educational opportunities in the community through workshops

and consultations. Virtually every county of our region utilizes the expertise of this facility for education. Workshops conducted at the hospital (the number varies from one to four per year) have drawn people statewide from almost every human services field profession.

2. Facility provisions

The hospital provides several services which would create a closure impact. They are:

a. Telephone service

All state office telephone communications are coordinated through the use of the hospital's Dimension System. Closure would discontinue phone service for all state offices having extensions off our switchboard, their use of the North Star Network System and WATS line usage. Examples of state offices facing interrupted telephone service would be: Department of Transportation, State Highway Patrol, State Crime Bureau, Willmar Community College and District Judges. Movement of the switching equipment would incur significant expense and hours of use would be limited to the hours of operation of the state office to which it was transferred (hospital now provides 24-hour, 7-day-a-week service).

b. Office space

The hospital currently provides free space for the State Highway Patrol and Public Service, Weights and Measures Division, (totaling 1,000 square feet). Costs to lease comparable space in the community would be $8 - $10,000 per year.

c. Job sites

There are 24 Foster Grandparents and Senior Companions and 3 Green Thumb Aides visiting and assisting with programs for approximately 60 to 80 patients/residents. Each of these elderly persons spends 20

hours a week at Willmar State Hospital, or a total of 18,400 hours a year, enriching the lives of the participants and our patients/residents. Since these persons are all low income elderly, the benefits of stipends, physicals, meals and transportation which they receive keep them from having to apply for General Assistance through welfare as well as keeping them healthier and happier.

3. Inter-community relationships

Participating as a very integral member of a community for many years develops other community-hospital dependencies which merit identification. These are:

a. Local school district

As briefly mentioned earlier, 19 positions are provided by the local school district to provide educational opportunities to adolescents on our campus. Our mental retardation staff work closely with the school district special education program in meeting the educational needs of our mentally retarded residents.

b. Employees teach

Our staff shares their expertise with many other community agencies in the region in cooperative efforts to assist clients. A handful provide their expertise by teaching evening classes at the local community college.

c. Civil Defense shelters/disaster designations

Willmar State Hospital has space in its tunnel and basement areas where approximately 10,000 evacuees can be provided food and shelter in the event of a national disaster and is listed by the community civil defense system as a major component in its program. The hospital provides backup services for Rice Memorial Hospital in the event of local disasters. We are equipped to handle approximately 80 patients, providing care to medical, pediatric, and nonacute surgical patients.

d. Community volunteers at Willmar State Hospital

The impact of the closure of Willmar State Hospital in relation to the Volunteer Program would result in the following:

(1) The loss of over $63,000 annually in money and material assistance to patients/residents served at the hospital.

(2) The loss of between 5 - 1 5 thousand hours annually of direct service from volunteers to patients/residents.

(3) The loss of a positive public relations program regarding the disabilities (mental illness, mental retardation, and chemical dependency) in the community by both staff and volunteers.

(4) The potential loss of volunteers who have special interest and dedication to the hospital.

(5) The discontinuance of family support groups for all patients/ residents.

(6) The loss of a recently established network of volunteer programs.

(7) The reduction in community education and information opportunities regarding the disability groups.

IV. CAPITAL INVESTMENT

Long-range planning for new buildings, remodeling needs, operation efficiencies and day-to-day maintenance activities have established a highly versatile, modern and sound physical plant investment for the state. Highlights of the state's physical plant/operative investment on this campus are:

A. Buildings/Square Footage

The hospital is comprised of 27 major client and/or administrative buildings and 17 other minor structures (pump houses, pump stations, etc.) as well as tunnels (see Appendix 0). These buildings comprise over 587,145 square feet of state property. The 1980 American Appraisal Verification Report highlights the quality of the state's investment in physical plant facilities at this hospital.

B. Remodeling Plans

Long-range remodeling plans on this campus have been a part of maintaining a modern facility to meet all standards, license and patient/client needs. The most recent 10-year building program was completed in 1980 (see Appendix P) and included the following:

1. Installed a complete fire alarm system and other Life Safety requirements. Our fire alarm system is an automatic electrically supervised, manually operated system which automatically transmits a fire alarm within the hospital and to the City Fire Department at the same time. Willmar is the first state hospital in Minnesota to comply with all state and federal fire safety requirements and conditions of waiver.
2. All patient cottages were renovated by dividing dormitories into smaller bedrooms and updating our electrical and plumbing systems.
3. Our energy conservation program was started in 1973 with a combination of Capital Improvement Budget and in-house improvements. Between the years

of 1972 and 1981, we show a 40% saving in our steam production, an 85% saving in our No. 6 fuel oil usage and a 2% saving in our natural gas usage (see Appendix Q).

4. A new rehabilitation therapy building was constructed in 1979 with a solar system that provides cost free heat for the pool and the domestic hot water in the building. The solar system was a state demonstration project and is still providing valuable information about the capabilities of solar energy.
5. All program and administration buildings now meet handicapped accessibility standards.
6. We have automatic electrical switchgear, installed in November, 1978, which guarantees the hospital full, uninterrupted electricity at all times. This switchgear automatically transfers, in the event of interrupted electrical service, to a separate electrical service in six seconds. This complies with the 1973 Life Safety Code for emergency electrical power #5-10215. We have a contract with the local Kandiyohi Co-op Electric Power Association for ten years which provides equipment maintenance at no cost to the hospital.

C. Energy/Power Efficiency

The hospital has another very important factor which contributes to its position of having the lowest utility/energy usage per square foot of building space among state hospitals. We receive our electricity from the Federal Government (Bureau Power), and it is directed to the hospital on local Co-op electrical lines. The total cost for this electricity is approximately 3/4 of one cent per kilowatt. If we were to pay regular price for our electricity, it would cost the hospital approximately five cents per kilowatt.

The state's dollar investment in this campus, the manner in which the buildings have been maintained, the use of remodeling appropriations to maintain compliance with health, license, accrediting, and life safety standards, the new rehabilitation building, the lack of any major money appropriations necessary for physical plant items to continue operations, and the high level of energy/power efficiency on this campus are all credit issues in. any discussion concerning closure. Closure of such a facility with no major physical plant deficiencies requiring large expenditures in the near future could not be regarded as sound investment practice.

V. FISCAL IMPACT TO THE STATE

The cost of operating a state hospital is often an argument heard in advocating closure. A closer look indicates quite the opposite:

1. The actual costs of operating the hospital are significantly reduced to the state through reimbursement activities.
2. The per diem costs by the hospital for its services are comparatively reasonable.
3. Alternative treatment facilities will significantly increase county and state costs.

A. Operational Costs

Willmar State Hospital's budget in fiscal year 1981-82 as appropriated by the legislature was:

1. Salary Account Operating	- $12,456,991
2. Account	- 1,842,008
Total Budget Available	- $14,298,999

The annual cost of over $14 million in fiscal year 1981-82 is reduced by our reimbursement office collection projections for fiscal year 1981-82 of slightly less than $10 million (see Appendix R). Therefore, the projected unreimbursed cost of operating the hospital for fiscal year 1981-82 is:

1. Cost Totals	- $14,298,999
2. Reimbursed Costs	- 9,841,916
Net Cost to State	- $ 4,457,083

Almost 70% of hospital costs are recovered through reimbursement activities.

B. Hospital Per Diem Charges

An accepted theory in the field of business has been "highest quality for the least cost." The hospital's current average per diem cost of $70.75

per day is the second lowest in the State Hospital System. All programs are fully accredited and meet appropriate standards and licensure requirements. This hospital is providing high quality programs at one of the lowest costs.

The application of the actual net cost to operating Willmar State Hospital, $4,457,083 (fiscal year 1981-82 budget minus reimbursement/ recovery dollars), reduces the actual per diem cost to the state to $22.07.

C. Alternate Treatment Facility Costs

In all program areas direct costs outside the State Hospital System are substantially higher.

Private facilities of a comparable nature willing to provide treatment to our type of clients in our region charge per diem costs of $150 in general hospital settings (which excludes physician, special medical charges, etc.). Private treatment programs for adolescents have even greater disparities.

PROJECTED POPULATION GROWTH

COUNTY	CENSUS 1970	CENSUS 1980	PROJECTED CENSUS 1990	% CHANGE
Big Stone	7,941	7,716	7,500	-2.8*
Carver	28,331	37,046	48,456	30.8
Chippewa	15,109	14,941	14,777	-1.1*
Cottonwood	14,887	14,854	14,824	-0.2*
Jackson	14,352	13,690	13,060	-4.6*
Kandiyohi	30,548	36,763	44,226	20.3
LacquiParle	11,164	10,592	10,052	-5.1*
Lincoln	8,143	8,207	8,273	0.8
Lyon	24,273	25,207	26,165	3.8
McLeod	27,662	29,657	31,792	7.2
Meeker	18,387	20,594	23,065	12.0
Murray	12,508	11,507	10,586	-8.0*
Nobles	23,208	21,840	20,551	-5.9*
Pipestone	12,791	11,690	10,685	-8.6*
Redwood	20,024	19,341	18,683	-3.4*
Renville	21,139	20,401	19,687	-3.5*
Rock	11,346	10,703	10,093	-5.7*
Scott	32,423	43,784	59,108	35.0
Sibley	15,845	15,448	15,062	-2.5*
Stearns	95,400	108,161	122,655	13.4
Swift	13,177	12,920	12,662	-2.0*
Wright	38,933	58,962	89,268	51.4
Yellow Medicine	14,523	13,653	12,834	-6.0*
TOTAL	512,114	567,677	644,064	Projected increase population 1980-1

* - denotes decrease in population

76,387

11.8% Grow

MENTALLY ILL AND CHEMICALLY DEPENDENT ADMISSIONS

		In House Total OA April 1982			MI			CD			April 81-March 82		
		Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
06	Big Stone	5	2	3	5	2	3	0	0	0	15	11	4
10	Carver	5	5	0	2	2	0	3	3	0	16	14	2
12	Chippewa	17	11	6	12	7	5	5	4	1	39	32	7
17	Cottonwood	10	5	5	10	5	5	0	0	0	16	11	5
32	Jackson	3	1	2	3	1	2	0	0	0	6	5	1
34	Kandiyohi	38	25	13	29	17	12	9	8	1	131	94	37
37	Lac Qui Parle	9	7	2	8	6	2	1	1	0	24	21	3
41	Lincoln	1	0	1	1	0	1	0	0	0	13	11	2
42	Lyon	18	12	6	14	8	6	4	4	0	49	41	8
43	McLeod	22	12	10	18	9	9	4	3	1	57	42	15
47	Meeker	24	20	4	20	16	4	4	4	0	79	68	11
51	Murray	6	3	3	5	2	3	1	1	0	9	7	2
53	Nobles	9	4	5	8	4	4	1	0	1	21	15	6
59	Pipestone	5	4	1	4	3	1	1	1	0	15	12	3
64	Redwood	13	10	3	11	8	3	2	2	0	49	34	15
65	Renville	19	7	12	18	7	11	1	0	1	29	17	12
67	Rock	4	2	2	4	2	2	0	0	0	5	5	0
70	Scott	18	14	4	2	1	1	16	13	3	38	30	8
72	Sibley	2	1	1	2	1	1	1	0	1	5	4	1
73	Stearns	58	39	19	40	25	15	18	14	4	221	168	53
76	Swift	15	11	4	11	8	3	4	3	1	42	32	10
86	Wright	20	14	6	11	8	3	9	6	3	79	64	15
87	Yellow Medicine	7	4	3	5	4	1	2	0	2	29	23	6
Totals from Receiving Area		328	213	115	243	146	97	86	67	19	987	761	226
Totals from Outside Receiving Area		97	57	40	80	47	33	16	10	6	193	146	47
TOTAL											1180	[illegible]	273

LENGTH OF STAY BY DISABILITY

Disability	30 days or less	30-59	60-89	90-119	120-149	150-179	Over
All Services (exluding MR)	37%	24%	18%	8%	3%	2%	9%
Adolescent	14%	27%	5%	9%	14%	5%	27%
Chemically Dependent	32%	30%	24%	8%	2%	1%	2%
Mentally Ill	48%	11%	8%	8%	3%	1%	20%

MEAN AGE AT ADMISSION OF CURRENT

POPULATION BY DISABILITY

Disability	Mean Age
Adolescent	15.3
Mentally Ill	43.2
Chemically Dependent	36.2
TOTAL MEAN	31.5

Our inhouse population is younger which corresponds with younger admission age.

ADMISSIONS & DISCHARGES

1975-1981

Fiscal Year	Admission MI	CD	Total	Discharges MI	CD	Total
1974-1975	399	798	1197	415	851	1266
1975-1976	460	887	1347	411	845	1256
1976-1977	399	938	1337	435	939	1374
1977-1978	351	900	1251	359	885	1244
1978-1979	366	850	1216	351	859	1210
1979-1980	445	831	1276	412	812	1224
1980-1981	416	780	1196	427	776	1203
Seven Year Average	405	855	1260	401	852	1254
1982 to April 30	170	239	409	133	255	388

ALTERNATIVE TREATMENT FACILITIES WITHIN RECEIVING AREA

A. Halfway Houses — St. Francis Halfway House in Atwater.

B. Crisis Centers — One in Willmar, one in Worthington and one in St. Cloud. This is for short term placement and many times the facilities will not prescribe medications or treat.

C. Mental Health Units — One at Rice Hospital in Willmar, one at Hutchinson Hospital in Hutchinson and one at the St. Cloud Hospital in St. Cloud. Hospitalizations are brief on mental health units and they are not equipped to handle longer term patients.

D. Day Treatment Facilities — One at Willmar, one at St. Cloud and one at Worthington. These programs are designed only for those individuals who need occasional support in the community and are not for the acutely ill and do not provide structured living.

E. Sheltered Workshops — One in Willmar, one in Worthington and one at St. Cloud. However, these programs rarely provide full time work for sheltered employees and consequently do not provide the structure that is needed.

CAPACITY/OCCUPANCY RATES AS OF MAY - 1982

Anoka State Hospital	Brainerd State Hospital	Cambridge State Hospital	Faribault State Hospital	Fergus Falls State Hospital	Moose Lake State Hospital	St. Peter State Hospital	Willmar State Hospital
Licensed 347	Licensed 600	Licensed 588	Licensed 845	Licensed 717	Licensed 705	Licensed 438	Licensed 644
Certified 257	Certified 600	Certified 556	Certified 810	Certified 717	Certified 663	Certified 438	Certified 644
Useable 342	Useable 600	Useable 550	Useable 810	Useable 613	Useable 635	Useable 429	Useable 628
CD 90	CD 55	CD 00	CD 00	CD 410	CD 269	CD 118	CD 118
MI 257	MI 80	MI 00	MI 00	MI	MI 293	MI 143	MI 333
MR 00	MR 448	MR 550	MR 810	MR 316	MR 143	MR 177	MR 177

POPULATION - MAY 1, 1982

CD 78	CD 54	CD 00	CD 00	CD 164	CD 184	CD 52	CD 92
MI 219	MI 78	MI 00	MI 00	MI 117	MI 184	MI 174	MI 321
MR 00	MR 326	MR 513	MR 777	MR 265	MR 123	MR 183	MR 162
	MLC 36						

VACANCIES & PERCENT OF OCCUPANCY

Vac. CD 12	CD 1	CD 0	CD 0	CD 120	CD 85	CD 66	CD 26
% Oc 87	98	0	0	70	68	44	78
Vac. MI 38	MI 2	MI 0	MI 0	MI comb. w/CD	MI 109	MI *31	MI 12
% Oc 85	98	0	0		63	121	96
Vac. MR 0	MR 86	MR 37	MR 33	MR 51	MR 20	MR *6	MR 14
% Oc 0	81	93	96	84	86	103	92
Total Vac: 50	89	37	33	171	214	29	52
Total % Oc 86	92	93	96	77	72	89	89

*denotes over capacity

Appendix H

DISTANCE (FROM COUNTY SEAT - AIR MILES)

Counties	A.S.H.	B.S.H.	W.S.H.	S.P.S.H.	F.S.H.	C.S.H.	F.F.S.H.	M.L.S.H.
Big Stone	164	130.	74	152	186	164	76	202
Chippewa	128	128	30	106	134	136	98	188
Cottonwood	138	190	90	72	98	158	192	228
Jackson	152	206	110	78	100	170	199	242
Kandiyohi	90	98		84	108	96	106	152
Lac Qui Parle	150	138	56	132	160	158	97	206
Lincoln	164	170	76	124	142	176	134	238
Lyon	142	158	60	100	130	156	141	116
McLeod	52	116	50	36	54	72	148	144
Meeker	62	88	24	68	86	72	122	134
Murray	158	194	90	102	130	176	176	242
Nobles	170	216	114	104	130	188	204	258
Pipestone	182	206	104	130	160	199	176	260
Redwood	106	136	38	66	94	122	142	186
Renville	92	122	24	66	88	106	130	168
Rock	192	226	124	132	160	210	196	278
Stearns	50	56	52	96	102	46	116	96
Swift	118	100	30	116	142	122	78	166
Wright	28	86	58	68	70	40	140	110
Yellow Medicine	120	128	32	94	124	132	210	188
Carver	33	120	80	44	95	64	172	134
Scott	34	126	90	46	96	62	182	134
Sibley	68	138	64	23	72	96	163	166

Counties	In-house 5-11-81	January 1980 - January 1981 Admissions	Discharges	Currently Here 5-11-82	January 1981 - January 1982 Admissions	Discharges	Welsch Noot Target - 19
Big Stone	3	2	2	2	0	0	3
Chippewa	9	1	0	7	0	2	8
Cottonwood	10	1	1	9	0	0	8
Jackson	4	0	1	4	0	0	5
Kandiyohi	10	11	9	10	5	6	12
LacQuiParle	5	0	1	4	0	1	5
Lincoln	6	1	2	6	0	0	
Lyon	5	2	3	6	2	3	20
Murray	8	1	0	8	0	1	
McLeod	8	2	1	5	1	3	14
Meeker	11	2	1	10	4	5	10
Nobles	4	0	1	5	1	1	7
Pipestone	7	1	1	5	2	4	5
Redwood	10	4	3	9	3	8	10
Renville	6	2	3	8	2	3	9
Rock	5	6	6	5	3	3	5
Stearns	4	4	2	4	3	6	47
Swift	3	0	1	3	1	2	6
Wright	7	2	2	7	0	1	10
Yellow Medicine	10	1	2	11	4	6	7
Totals from our receiving area	135	43	42	128	31	55	190
Counties other than primary receiving area	16	1	1	35	21	3	
Grand Totals	151	44 (23 P.R.'s)	43 (23 P.R.'s)	163	52 (22 P.R.'s)	58 (22 P.R.'s)	

SELECTED DEMOGRAPHIC CHARACTERISTICS OF PRIMARY INPATIENT CLIENTS

CHARACTERISTIC	STATE HOSPITAL (N=358)	FREESTANDING (N=254)	NON-STATE HOSPITAL (N=236)
EDUCATION:			
No High School Diploma	170 (48%)	93 (37%)	74 (31%)
High School Graduate	137 (38%)	107 (42%)	96 (41%)
Some Additional Schooling	44 (12%)	39 (15%)	34 (14%)
MARITAL STATUS:			
Divorced	106 (30%)	45 (18%)	27 (11%)
Married	62 (17%)	89 (35%)	88 (37%)

SELECTED REFERRAL SOURCE AND PAYMENT INFORMATION ON PRIMARY INPATIENT CLIENTS

CLIENT DESCRIPTOR	STATE HOSPITAL (N=358)	FREESTANDING (N=254)	NON-STATE HOSPITAL (N=236)
Primary Source of Referral:			
Employer	1 (1%)	29 (11%)	16 (7%)
Court, Legal	113 (32%)	23 (9%)	56 (25%)
Primary Source of Payment:			
Personal/Private	3 (1%)	17 (11%)	5 (2%)
Insurance, non-govt.	26 (7%)	197 (78%)	165 (70%)
Public, governmental	289 (81%)	36 (14%)	51 (22%)

Source: Walker and Associates, 1981

SELECTED CHEMICAL DEPENDENCY HISTORY OF PRIMARY INPATIENT CLIENTS

CLIENT DESCRIPTOR	STATE HOSPITAL (N=358)	FREESTANDING (N=254)	NON-STATE HOSPITAL (N=236)
Prior Admissions To Detox:			
None	196 (55%)	190 (75%)	221 (94%)
1	71 (20%)	37 (15%)	15 (6%)
3-5	31 (9%)	10 (4%)	0 (-)
6+	39 (11%)	8 (3%)	0 (-)
Prior Admissions to Primary Inpatient Treatment:			
None	114 (32%)	173 (68%)	191 (81%)
1	75 (21%)	46 (18%)	44 (19%)
2	59 (17%)	20 (8%)	1 (1%)
3-5	66 (18%)	12 (5%)	0 (-)
6+	44 (12%)	3 (1%)	0 (-)

PATIENT AND CHEMICAL DEPENDENCY PROGRAM
CHARACTERISTICS
OF SELECTED STATE HOSPITAL (SH) AND PRIVATE TREATMENT
CENTERS (PTC) IN PERCENT

	STATE HOSPITAL	PRIVATE TREATMENT CENTER
Referral Source: AA	1	4
Court	32	9
Other CD Program	40	20
Marital Status: Divorced	41	20
Source of Payment Private	8	89
No Past AA Experience	51	55
Former Convictions	56	38
Admitted from Detox Center	45	15
Discharged to Halfway House	16	3

TREATMENT OUTCOME (PRE-POST) OF CRITERIA
FOR STATE HOSPITAL (SH) AND SELECTED PRIVATE
TREATMENT CENTERS (PTC) IN PERCENT

	STATE HOSPITAL		PRIVATE TREATMENT CENTER	
	PRE	POST	PRE	POST
Abstinence	--	40		63
Productivity	35	60	77	86
Unemployment	75	51	33	27
Financial Assistance	43	18	4	6
Paid Supervised Living	50	20	5	4

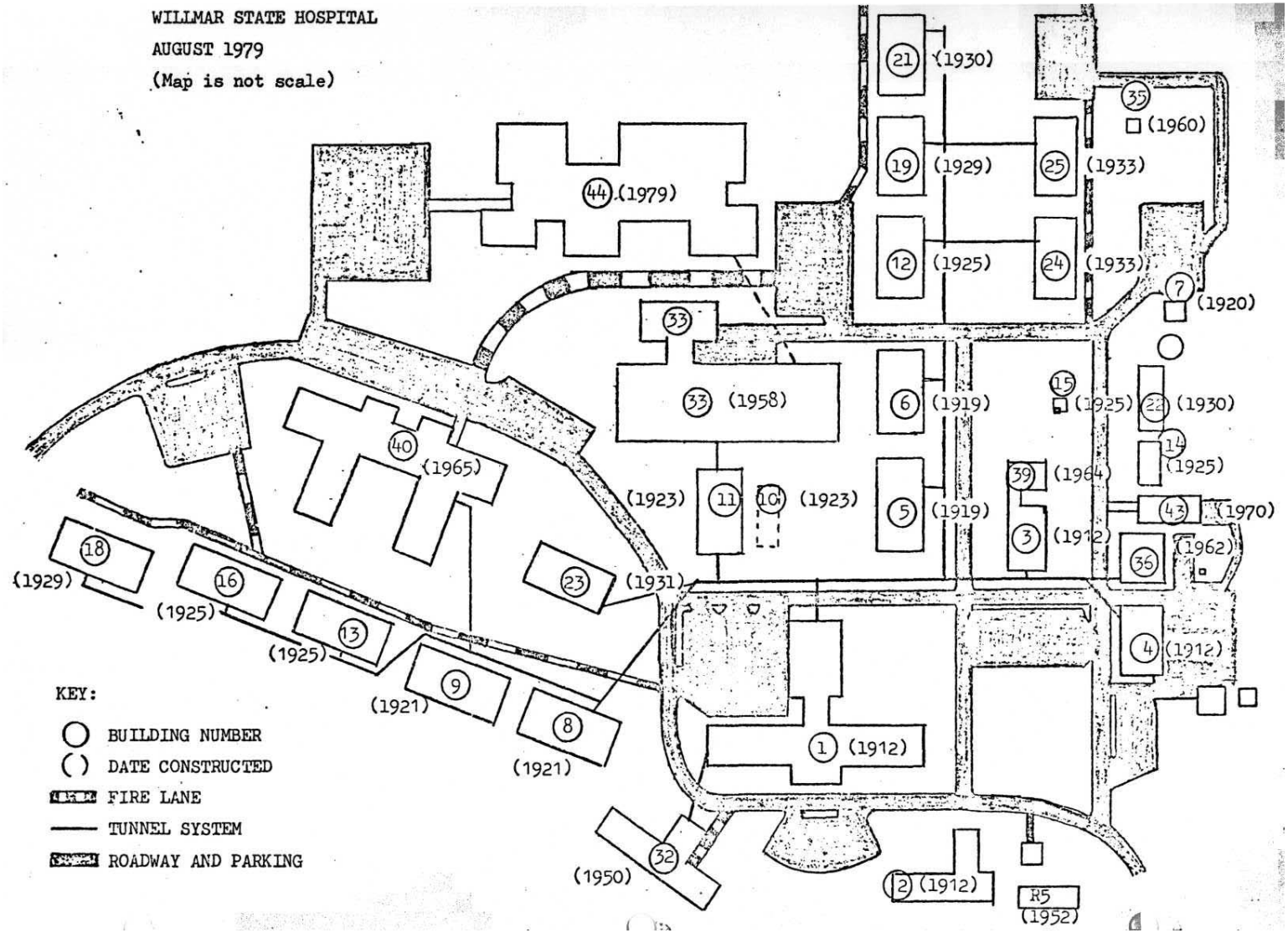
COST OF SELECTED TREATMENT CENTERS

	STATE HOSPITAL	PRIVATE TREATMENT CENTER	HALFWAY HOUSE
Per Diem $	44	69	23
Per Person $	1776	1631	2140
Length of Stay (Days)	44	24	91

Source: Walker and Associates 1981

EDUCATIONAL AFFILIATIONS

Educational Institution	Affiliated Field
Alexandria AVTI, Alexandria, MN	Dietetic Assistant Program
Anoka AVTI, Anoka, MN	Occupational Therapy Assistant
Augustana College, Sioux Falls, SD	Student Teaching (Special Education)
Bemidji State University, Bemidji, MN	Community Services
Dakota State College, Madison, SD	Social Services
Duluth AVTI, Duluth, MN	Occupational Therapy Assistant
Gustavus Adolphus College, St. Peter, MN	Adolescent Unit
Hutchinson AVTI, Hutchinson, MN	Chemical Dependency
Indian Counselor Alcoholism Training Project, Duluth, MN	Chemical Dependency
Mankato State University, Mankato, MN	Recreation
Moorhead State University, Moorhead, MN	Student Teaching
St. Catherine's, St. Paul, MN	Occupational Therapy
St. Catherine's School of Science, St. Paul, MN	Occupational Therapy Assistant
St. Cloud AVTI, St. Cloud, MN	Child Development Assistant Program
St. Cloud Hospital School of Nursing, St. Cloud, MN	Nursing
University of North Dakota	Occupational Therapy
Willmar AVTI, Willmar, MN	Secretarial Interns
Willmar Community College, Willmar, MN	Social Services
Worthington Community College, Worthington, MN	LPN Program


WILLMAR STATE HOSPITAL
AUGUST 1979
(Map is not scale)
21 (1930)
35 (1960)
19 (1929)
25 (1933)
44 (1979)
12 (1925)
24 (1933)
7 (1920)
33
33 (1958)
6 (1919)
15 (1925)
22 (1930)
14 (1925)
40 (1965)
39 (1964)
(1923)
11
10 (1923)
5 (1919)
43 (1970)
3 (1912)
36 (1962)
18 (1929)
16
23 (1931)
(1925)
13
(1925)
4 (1912)
9
(1921)
8
(1921)
1 (1912)
32
(1950)
2 (1912)
R5
(1952)
KEY:
BUILDING NUMBER
DATE CONSTRUCTED
FIRE LANE
TUNNEL SYSTEM
ROADWAY AND PARKING

CAPITAL IMPROVEMENT - TEN-YEAR PLAN

Institution	Project	Appropriation and Year	Contract Award Date	Progress As of 10-1-80	Estimated Completion Date
Willmar State Hospital	Demolish or sell two residences	$6,400 1973-75		Completed	
WSH	Fire Alarm System	$144,000 1973-75		Completed	
WSH	Install storm windows	$10,000 1973-75		Completed	
WSH	Rehabilitate auditorium	$35,000 1973-75		Money turned back	
WSH	New Activities Building	$2,000,000 1975-77		Completed	
WSH	Life Safety	$350,000 1975-77		Completed	
WSH	Ward remodeling	$85,000 1975-77		Completed	
WSH	Construct a 10-foot bituminous roadway fire lanes	$30,000 1975-77		Completed	
WSH	Furniture	$65,000 1975-77		Completed	
WSH	Carpeting	$20,000 1975-77		Completed	
WSH	Air Conditioning	$18,000 1975-77		Completed	
WSH	Demolition	$10,000 1975-77		Funds were transferred to another hospital.	
WSH	Life Safety	$70,000 1978-79		Completed	
WSH	Remodeling	$85,000 1978-79		Completed	
WSH	Renovation Well #4	$173,500		Completed	

Institution	Project	Appropriation and Year	Contract Award Date	Progress As of 10-1-80	Estimated Completion Date
Willmar State Hospital	Parking Lot - Activities Building			Completed	
WSH	Furniture	$30,000 1978-79		Completed	
WSH	Carpeting	$10,000 1978-79		Completed	
WSH	Handicap Code compliance	$150,000 1978-79		Completed	
WSH	Install solar energy in the new Activities Bldg.	$225,000 1978-79		Completed	
WSH	Fuel saving money	$22,000 1978-79		Attic insulation completed.	
WSH	Replace roof on Bldg. 1, 13 cottage porches, & #5 pump house.	$80,000 1981	August 1981	Completed	
WSH	Handicap Accessibility - Elevators on Cottages 14 & 15.	$174,000 1981	September 1981	Project started 10-1-81.	7-1-82
WSH	Renovation of Medical Treatment Center	$265,000 1981	September 1981	Contractor will 10-19-81.	5-5-82
WSH	Energy Conservation Retrofit Work	$175,255 1981	September 1981	Project started 10-1-81.	6-1-82
WSH	Pull, Inspect and Repair Well #5	$5,000 1981	August 1981	Well has been pulled and inspected; repairs and installation bid opening 10-8-81.	11-30-81
WSH	Remodel bathroom facilities in MR buildings	$154,000 1981	This project was approved by the 1981 Legislature but financing withheld by Department of Finance.		

WILLMAR STATE HOSPITAL

CONSUMPTION AND PRODUCTION FOR CALENDAR YEARS

1972-73-74-75-76-77-78-79-80-81

Year	Steam Lbs.	#6 F.O. Gals.	Gas M.C.F.	K.W.'s
1972	123,845,875	354,900	82,097	3,553,120
1973	108,540,175	139,390	101,902	3,679,290
1974	98,470,350	149,540	84,847	3,845,280
1975	90,024,440	264,250	64,351	3,478,920
1976	89,974,890	321,710	48,071	3,485,220
1977	74,318,940	199,450	54,771	3,378,220
1978	80,550,925	247,760	54,766	3,458,780
1979	79,909,475	281,820	51,736	3,895,500
1980	74,028,275	82,130	74,576	4,084,540
1981	74,634,900	53,680	80,250	4,117,040
Difference Between 1972-1981	49,210,975	301,220	1,847	563,920
	40% less	85% less	2% less	14% more

Since we started our energy conservation program we reopened three patient buildings for the MR program and installed air conditioning in MTC, Bldg. 1 and the 3rd floor of the Administration Building. In 1979 our new Activities Building with air conditioning was opened for use. This building was constructed with a solar system that heats the swimming pool and the domestic hot water, so there is no cost of heating the water in this building.

PROJECTED REIMBURSEMENT OFFICE REPORT

07/01/81 thru 06/30/82

	Mentally Ill	Mentally Retarded	Chemical Dep.	TOTAL
MEDICAL ASSISTANCE	3,181,018	5,042,287	170,547	8,393,852
MEDICARE	167,904	744	54,576	223,224
PRIVATE INSURANCE	525,504	0	109,620	635,124
OTHER (private pay, etc.)	362,904	179,628	47,184	589,716
GRAND TOTALS	4,237,330	5,222,659	381,927	9,841,916
WSH COSTS	66.76	79.82	65.67	70.75 (Average)

The per capita cost of care charged by D.P.W. is 87.95 per day; the above figures of per diem costs for Willmar State Hospital are costs submitted to Medicare per contract with the State of Minnesota.

Projection is based on actual reimbursement collection reports of 07/01/81 thru 04/30/82 - and projected for a twelve-month period.

The average per diem cost of $70.75 above is slightly higher than the average per diem cost contained in Department Budget/Expenditures/Encumbrance Report (B.E.E.). The Reimbursement Office per diem average costs include items not considered in the B.E.E. Report such as depreciation on hospital buildings and equipment, bonding costs, operational costs of central office, etc.

IMPACT OF CLOSURE STUDY

ADDENDUM

Submitted to:

Cindy Turnure
Chemical Dependency Program Division
Department of Public Welfare

By:

WILLMAR STATE HOSPITAL

July 21, 1982

MENTAL ILLNESS PROGRAM

I. ALTERNATIVE PLACEMENTS – NUMBERS OF BEDS:

County	Halfway House	Crisis Center	Mental Health Center	Day Treatment	Sheltered Workshop
Big Stone	-		-	-	-
Carver	_	-	-	-	-
Chippewa	_	-	-	—	-
Cottonwood	_	-	-		-
Jackson	-	-	-	-	-
Kandiyohi	14	4	12	75	140
Lac Qui Parle	-	-	-	—	-
Lincoln	-	-	-	-	-
Lyon	-	-	-	-	-
McLeod	-	-	12	-	-
Meeker	-	-	-	-	
Murray	-	-	-	-	-
Nobles	4	1	2	16	20
Pipestone	-	-	-	—	-
Redwood	-	-	-	-	7
Renville	-	-	-	-	-
Rock	-	-	-	-	-
Scott	-	-	-	-	-
Sibley	-	-	-	-	-
Stearns	8	6	44	20	45
Swift	-	-	-	-	-
Wright	-	-	-	-	95
Yellow Medicine		-	-	-	-
TOTALS:	26	11	70	111	307

Note: Nursing Homes were not included.

II. COMPARATIVE COST ISSUES – MI

There are three individual variables that must come into focus in assessing cost efficiencies of various systems. They are:

(a) Length of stay
(b) Cost per day
(c) Severity of illness/history/chronicity

While many facilities can show a shorter length of stay, the cost per day is much higher. The problem is compounded when one compares cost of treatment experience as it is difficult to get similar samples for comparative purposes.

A recent survey of the Willmar State Hospital's catchment area for inhouse facilities indicates inhouse per day treatment for psychiatric patients ranging from a low of $124.00 to a high of $260.00. The per diem rate for Willmar State Hospital as of June 30, 1982, was $87.95. The average cost per day of the facilities surveyed in our receiving area was $192.00 This figure, compared to Willmar State Hospital's figure, reveals the difference of $104.05 per day over and above the June 30, 1982, cost of maintaining a patient for one day in this facility. It should be noted, however, that these figures are averages and considered to be representative of this area only and do not include charges for consultations, medications, transportation, etc.

MENTALLY RETARDED PROGRAM

I. COMPARATIVE COST ISSUES

Cost comparisons between the public and private sectors serving mentally retarded persons are virtually impossible to make for at least two reasons:

The first reason, simply stated, is that the populations being served by the two sectors are fundamentally different. By policy, admissions may not be made to the public sector if there is an alternative placement available in the private sector which can provide for the client's needs. As can be seen by the "population descriptions" (Page 7 of the Impact Study), this results in the public sector serving more profoundly retarded and multiply handicapped clients.

The second reason for not attempting cost comparisons is the difference in accounting and billing methods. "Per diem" in the public sector includes all aspects of the clients care in a single figure. The private sector, however, bills separately for residential care, day programs, medical care, transportation, etc.

Thus, until similar accounting procedures and similar samples of the population are used, accurate cost comparative data is virtually nonexistent.

I. ALTERNATIVE PLACEMENTS*

Chemical dependency alternative care facilities within Willmar State Hospital's receiving district are:

A. Detox: There are 52 beds of 8 detox centers available which cannot be considered as alternative to primary treatment.

B. Primary Residential Free-Standing:

(a) New Life Treatment Center -- 15 beds, Pipestone, Mn.

(b) Project Turnabout -- 30 beds, Granite Falls, Mn.

C. Primary Residential Hospital Based:

(a) St. Cloud Hospital -- 35 beds, St. Cloud, Mn.

(b) VA Hospital – 49 beds, St. Cloud, Mn.

(c) Wright Way CD Center – 16 beds, Buffalo, Mn.

The above totals 145 treatment beds of private facilities within the receiving area.

D. Halfway Houses:

(a) St. Francis House – 14 beds for mentally ill and chemically dependent persons, Atwater, Mn.

(b) Unity House – 9 beds, Worthington, Mn.

(c) Heron Lake Halfway House – 7 beds, Heron Lake, Mn.

(d) Focus XII Halfway House - 12 beds, St. Cloud, Mn.

Since halfway houses require primary treatment prior to admission, they really cannot be considered an alternative to primary treatment.

E. Therapeutic Communities: There are none in the receiving area.

F. Board and Lodging Facilities: There are none in the receiving area.

* Source: Department of Public Welfare Chemical Dependency Directory.

I. ALTERNATIVE PLACEMENTS

Willmar State Hospital's Adolescent Treatment Unit program is often looked upon as the last treatment option available prior to an out-of-state placement. Many of the adolescents treated at Willmar State Hospital (over 70%) have already experienced treatment in one or more residential treatment centers in the state. Placement of these adolescents into other private sector facilities has been and probably would continue to be impossible. Only a few of the state's Rule 5 facilities are willing to deal with actively psychotic adolescents (e.g., Golden Valley Adolescent Treatment Program, Fairview, Wilson Center) or adolescents who are violently acting out (Fairview, Golden Valley). Additionally, many residential treatment centers have age restrictions that rule out older adolescents. Given this set of circumstances, it is unlikely that many of the adolescents currently on the Adolescent Treatment Unit program could be effectively handled in existing programs throughout Minnesota. Those adolescents on the Protective Component Unit of Willmar State Hospital have no other options available to them aside from possible placement in a closed hospital psychiatric unit or placement into a "high-powered" out-of-state residential treatment facility (e.g., Brown Schools in Texas, Meninger Clinic, Devereaux, etc.).

Reference was made in the Impact Study (see Page 17) to 175 fewer residential treatment beds in the private sector effective June of 1982. These facilities include the following:

(a) Bethany - 36-bed facility in Duluth
(b) L'Chain - 20-bed facility in the Twin Cities
(c) Winona Heights - 65-bed program in Winona
(d) St. Michael's - 55-bed program on the Wisconsin side of the Mississippi River in southern Minnesota

All of the above beds were reported closed as of June 30, 1982. II.

COMPARATIVE COST ISSUES

While actual cost comparisons are impossible and perhaps meaningless when comparing different services, different populations and different staff-to-patient ratios, the following in-state facility costs might provide some information:

Willmar State Hospital ATU = $87.95 per day PCU = $164.20 per day *

Fairview		
Crisis	$271/day + $40 therapy/day =	$311 + consultation
Short Term (6 weeks)	$225/day + $40 therapy/day =	$265 + consultation
Long Term (6 months)	$189/day + $40 therapy/day =	$229 + consultation

Wilson Center $280/day + outside consultation, etc.

Golden Valley ATP $189/day + $36 therapy/day = $225 + lab, x-ray, consultation, etc.

Gerard Schools $ 82/day + outside consultation, transportation, etc.

Fillfillan Center $ 70/day + outside consultation, transportation, etc.

Woodland Hills $ 62/day + outside consultation, transportation, etc.
(Positive Peer Culture)

* ATU = Adolescent Treatment Unit
PCU = Protective Component Unit

SOURCES OF DATA USED IN IMPACT STUDY

Appendix	Title of Chart/Graph	Resource
A	Projected Population Growth	1970-80 Census Data, U.S. Bureau of Census
B	Mentally Ill and Chemically Dependent Admissions	WSH Quality Assurance Office
C	Length of Stay by Disability	WSH Quality Assurance Office
D	Mean Age at Admission of Current Population by Disability	WSH Quality Assurance Office
E	Admissions and Discharges, 1975-1981	WSH Medical Records and Program Evaluation
F	Alternative Treatment Facilities Within Receiving Area (MI Program)	WSH Social Service Office
G	Capacity/Occupancy Rates as of May - 1982	Joyce Gilbertson, Department of Public Welfare
H	Distance from County Seat - Air Miles	State map
I	County Utilization	WSH Quality Assurance Office
J	Selected Demographic Characteristics of Primary Inpatient Clients (CD Program)	Walker and Associates, 1981
K	Selected Referral Source and Payment Information on Primary Inpatient Clients (CD Program)	Walker and Associates, 1981
L	Selected Chemical Dependency History of Primary Inpatient Clients	Walker and Associates, 1981
M	Patient and CD Program Characteristics of Selected State Hospital and Private Treatment Centers in Percent	Walker and Associates, 1981
N	Educational Affiliations	WSH Staff Development Office
O	Map	WSH

Appendix	Title of Chart/Graph	Resource
P	Capital Improvement - 10-Year Plan	WSH
Q	WSH Consumption and Production for Calendar Years 1972 through 1981 (Energy)	WSH Physical Plant Office
R	Projected Reimbursement Office Report, 07/01/81 through 06/30/82	DPW Reimbursement Office and WSH Reimbursement Officer

References

Walker and Associates: An Analysis of Outcomes Achieved by a Sample of Primary Inpatient Treatment Programing in Minnesota. Minneapolis, Mn, 1981 (mimeo)

Turnure, Cynthia: Minnesota's Chemical Dependency Programs: A Preliminary Evaluation Report Presented to the Legislature.

Department of Public Welfare, State of Minnesota: Directory of Chemical Dependency Programs in Minnesota, 1981. Chemical Dependency Program Division, Department of Public Welfare, St. Paul, Mn., 1981.