WILLMAR STATE HOSPITAL

Lester Johnson
Chief Executive Officer

WILLMAR STATE HOSPITAL

Table of Contents

LIST OF APPENDICES

It is impossible to plan or review a "continuum of mental health services" in Minnesota without addressing the "Hospital" or public residential system in some manner. This document does so by examining in detail the Willmar State Hospital, past and present, and examines the impact on the system, receiving area and clients if the hospital were to be closed today or in the near future. Some of the most salient points (extrapolated from the attached text and appendices) are as follows:

1. The Willmar State Hospital has a 75-year history of demonstrated excellence in providing treatment and training services to the mentally ill, chemically dependent and/or developmentally disabled persons throughout the State of Minnesota.

2. The combined trends of population increase and reduced availability of financial assistance will probably increase the client load, even though the campus already operates at an occupancy rate of nearly 95%.

3. The Willmar State Hospital, with approximately 600 beds, serves 23 counties in west central and southwestern Minnesota.

4. Approximately 500 mentally ill and 800 chemically dependent persons are treated and discharged each year by the Willmar State Hospital.

5. Although the average dally census for developmentally disabled persons is 160, over 50 admissions and discharges are made each year, reflecting a very active parental relief and placement program.

6. Prevailing philosophy, admission criteria, funding and commitment policies mean that 80% to 90% of all persons served by Willmar State Hospital have already been deemed as not eligible or appropriate for services in the private sector.

7. The Willmar State Hospital operates the only publicly supported programs for adolescents requiring a secure setting and persons whose addiction to narcotics requires methadone detoxification.

8. More than 619 full-time employees make Willmar State Hospital the third largest employer in the area, comprising almost 52 of all employment and 8.5% of all wages in the county.

9. Almost 70% of the annual budget of $14,000,000 is returned to the State's general fund through federal reimbursements and third party payees.

10. The Willmar State Hospital is the only campus in the state system to have obtained full accreditation for all its programs from the Joint Commission on Accreditation of Hospitals, the Accreditation

Council for Services for the Mentally Retarded and other Develop-mentally Disabled Persons, and the Council on Hospital and Institutional Dental Services. (This also involves meeting all federal certification and life safety standards.)

11. In spite of the high quality of care indicated by national accrediting bodies, the per diem rate at Willmar State Hospital is second from the lowest, and the energy use/square foot of building space is the lowest of all the state hospitals.

INTRODUCTION

Willmar State Hospital, established by enabling legislation 75 years ago, has served all of Minnesota at one time £or 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 i11. Since then it has served, with variation as it does today, more than 2C 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 bean 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 statewide 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%, 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.

I. CAMPUS PROGRAMS - EFFECTS OF CLOSURE

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 corresponding populations who have previous histories in state hospitals. Appendix A 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 B 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.

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 catchments area, a residual from

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

(Continued)

Appendix A - Mentally I11 and Chemically Dependent Admissions (Continued)

	In House Total OA April 1982			MI			CD			April-81-March 82		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
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 Out-Side Receiving Area	97	57	40	80	47	33	16	10	6	193	146	47
TOTAL										1,180	907	273

Source: Willmar State Hospital Quality Assurance Office

Appendix B

LENGTH OF STAY BY DISABILITY

Disability	30 days or less	30-59	60-89	90-119	120-149	150-179	Over
All Services (excluding 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 I11	48%	11%	8%	8%	3%	1%	20%

Source: Willmar State Hospital Quality Assurance Office

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. The ability to place these patients within alternate mental illness programs is dismal. See Appendix C 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 neither would nor 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. 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 people.

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 Faci1ities -- 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 IK needed.

Source: Willmar State Hospital Social Service Office

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 catchments area. Should the hospital close, distances would become formidable for patients, families and county social workers traveling to other facilities.

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 neither 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.

1. 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 become 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

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.

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

Impart 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.

5. Comparative Cost Issues

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 catchments area for in-house facilities indicates in-house 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.

B. Mental Retardation Program (Glacial Ridge Training Center)

1. Population Served

The Glacial Ridge Training Center (GRTC), a I77-bed Intermediate Care Facility for the Mentally Retarded (ICF/MR), serves mentally retarded persons in Regions VI and VI II. 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 was 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, 5 mild, and 11 moderate. Forty residents have severe sensory deficits, such as blindness, deafness, etc. Thirty-eight are non-mobile, and 15 have severe ambu-lation 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, and 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 nonverbal. 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 28 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 aid the near 100% 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 GRTC 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 he 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*

There are a total of 235 designated mental retardation beds currently vacant in the 7 state hospitals serving mentally retarded persona. 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 7 facilities serving mentally retarded persons have current occupancy rates of leas than 90%. 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 maintains family ties. In addition, added distances are very costly, both to the family and the counties who must visit their client, attend staffing, etc., in order to carry out their case management responsibilities.

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. This may also be reflected as increased costs of $33-555 (20cents/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 D) 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". (1) 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

[1]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 Issues. St. Paul, MN: Developmental Disabilities Program, Department of Energy, Planning and Development, April 9, 1982.

COUNTY UTILIZATION Appendix D

Counties	In-House 5-11-81	January 1980 - January 1981		Currently Here 5-11-82	January 1981 - January 1982		Welsch-Noot Target-1987
		Admissions	Discharges		Admissions	Discharges	
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
Lac Qui Parle	5	0	1	4	0	1	5
Lincoln	6	1	2	6	0	0	20
Lyon	5	2	3	6	2	3	
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

(Continued)

COUNTY UTILIZATION - Appendix D (Continued)

Counties	In-House 5-11-81	January 1980 – January 1981		Currently Here 5-11-82	January 1981 – January 1982		Welsch-Noot Target-1987
		Admissions	Discharges		Admissions	Discharges	
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)	

Source: Willmar State Hospital Quality Assurance Office

essence, the Center serves as a "backup" facility for mentally retarded persons whose behaviors have become so dangerous to him 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.

5. 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", 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.

C. Chemical Dependency Program

The Chemical Dependency Program at Willmar State Hospital consists of 113 licensed beds serving the chemically dependent (drug and alcohol-related) of the hospital's 23 southwestern counties of Minnesota. In addition, the hospital is unique in that it provides a statewide methadone detoxification program for hard core narcotic users. Typically, the admitting ratio is four alcohol-related patients to one hard core drug user patient. Alcoholics' Anonymous sponsorship along with support from chemical dependency practitioners in the community is essential to a sustained recovery.

1. Population Served

The Chemical Dependency Unit of Willmar State Hospital has between 700 and 900 admissions per year. The average population is slightly over 100 with an increasing trend. More than 77% of today's clients are under 45 years of age at discharge. The characteristics of the population are distinctly different from a population of a private treatment center (Source: Walker Assoc. 1981). Willmar State Hospital chemical dependency population is, in comparison with private treatment centers, less educated, serves more

minorities, serves more separated and divorced persons, has more court and other chemical dependency program referrals (recidivists), patients who are significantly more dependent upon public and governmental support, have more prior admissions to Detox Centers, and more prior admissions to primary inpatient treatment. Willmar State Hospital serves a more difficult patient population than either free-standing or non-state hospital programs. Because of these distinct and significant, population differences, comparative studies are very difficult with respect to treatment outcome, length of stay and cost 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, 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 higher 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 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 hospi-

tals shall continue to be needed to treat those patients who have no financial or 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 accepts referrals and takes 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 percent 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 i11, the Interruption of programming for the adolescent would be traumatic. Since there is 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 111 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 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 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 is currently 19 staff employed within the district that 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.

5. 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 then aside from possible placement in a closed hospitals psychiatric unit or placement into a "high-powered" out-of-state residential treatment facility (e.g., Brown Schools in Texas, Menninger Clinic, Devereaux, etc.).

Reference was made in the Impact Study to 175 fever 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.

6. 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 instate facility costs might provide some information:

Willmar State Hostpital	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.

*ATU = Adolescent Treatment Unit
FCU = Protective Component Unit

Gerard Schools	$82/day	+ outside consultation, transportation, etc.
Gillfillan Center	$72/day	+ outside consultation, transportation, etc.
Woodland Hills (Positive Peer Culture)	$62/day	+ outside consultation, transportation, etc.

II. IMPACT ON STAFF - EFFECTS OF CLOSURE

The hospital has been a major employer of 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 of 18% for 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. Non-transferable skills, "over qualification", and the impracticability 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 (baaed 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 19.52 of all government employment in the county and 4.72 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 six 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 year dealing with more than 13 fields of study. 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 provides 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 non-acute 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 5-15 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. 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 - $12,456,991
2. Operating 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 Billion. Therefore, the projected nonreimbursed 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 licen-sure 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.

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	-	-	-	-	-
Kandlyohi	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.

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.