

**COMMISSION FOR ECONOMY IN
GOVERNMENTAL EXPENDITURES**

**REPORT ON STUDY
OF
OPERATIONS OF SANATORIA;
AND
SENILE AND AGED PERSONS IN STATE HOSPITALS**

SENATE JOINT RESOLUTION NO. 53



SENATE DOCUMENT NO. 11 , 1962

COMMONWEALTH OF VIRGINIA
Department of Purchases and Supply
Richmond
1961

OPERATIONS OF SANATORIA;
and
SENILE AND AGED PERSONS IN STATE HOSPITALS
REPORT OF THE
COMMISSION FOR ECONOMY IN
GOVERNMENTAL EXPENDITURES

RICHMOND, VIRGINIA, December 8, 1961

To:

HONORABLE J. LINDSAY ALMOND, JR., *Governor of Virginia*

and

THE GENERAL ASSEMBLY OF VIRGINIA

Senate Joint Resolution No. 53, agreed to by the Senate and the House of Delegates on March 12, 1960, directed the Commission for Economy in Governmental Expenditures to make a study of the programs being conducted at the several sanatoria and other institutions for the care of tubercular patients. This Resolution also directed the Committee to determine the number of aged and senile persons being cared for in such institutions and in institutions under the control of the Department of Mental Hygiene and Hospitals and to ascertain whether it is possible to provide custody and care for such persons more economically than is now being done. The Resolution is quoted herein below:

Resolved by the Senate of Virginia, the House of Delegates concurring, That the Commission for Economy in Governmental Expenditures is directed to consider the programs being conducted at the several State sanatoria and other institutions for the care of tubercular patients with a view of determining whether economies can be effected therein. The Commission shall determine the number of beds available in such institutions and present and anticipate case loads thereof and shall consider whether mergers of some of such institutions can be effected now or in the near future. If it appears that such a merger or mergers be practical, the Commission shall determine how the best use can be made of the surplus facilities which would become available. In this connection the Commission shall also determine the number of aged and senile persons being cared for in such institutions and in institutions under the control of the Department of Mental Hygiene and Hospitals and whether it is possible to provide custody and care for such persons more economically than is now being done. All agencies of the State shall assist the Commission on its request. The Commission shall complete its study and make its report to the Governor and General Assembly not later than September one, nineteen hundred sixty-one.

Pursuant to the Resolution, the Committee considered the programs being conducted at the several State sanatoria for purposes of obtaining the information sought by the Resolution with respect to the sanatoria; determined the number of aged and senile persons being cared for in these institutions as well as the institutions under the control of the Depart-

ment of Mental Hygiene and Hospitals; and procured information relating to the care and custody of senile and aged persons in private agencies so that it could be determined whether it is possible to provide custody and care of such persons in State institutions more economically than is now being done.

In the conduct of this study the Commission was aided by the Auditor of Public Accounts, its Executive Secretary, and his staff and utilized the services of its consultant, Mr. Wesley R. Ellms of the firm of Worden & Risberg, Management Consultants, in making a special utilization study of the facilities of Blue Ridge and Catawba Sanatoria. In addition thereto the Commission received the full cooperation and assistance of Dr. Mack I. Shanholtz, State Health Commissioner; Dr. Hiram W. Davis, Commissioner of the Department of Mental Hygiene and Hospitals; the late Colonel Richard W. Copeland, Director of the Department of Welfare and Institutions; and the superintendents of tubercular and mental hospitals and the staffs of these institutions.

The Commission; its Executive Secretary, the Auditor of Public Accounts; and its consultant wish to acknowledge the splendid cooperation and the generous assistance of all of those who aided in its study.

Respectfully submitted,

D. WOODROW BIRD, Chairman

W. ROY SMITH, Vice-Chairman

THOMAS H. BLANTON

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Commission for Economy in Governmental
Expenditures

DIRECTIVES OF SENATE JOINT RESOLUTION NO. 53

Senate Joint Resolution No. 53 directed the Commission to consider the programs of the State Sanatoria for purposes of determining whether economies could be effected; to determine the number of beds available in such institutions and report the present and anticipated case load; to consider whether merger of some of the tubercular hospitals could be effected now or in the future; to determine the best use of surplus facilities, if and when mergers might be effected; to determine the number of aged and senile persons in the sanatoria, and in the mental hospitals; and to determine whether custody and care of aged and senile persons might be provided more economically than is now being done.

APPROACH USED IN MAKING STUDY

In the conduct of its study the Commission deemed it advisable to ascertain, insofar as possible, what other states were doing in connection with the care and custody of aged and senile persons. Therefore questionnaires were sent to each of the several states soliciting from them their programs, if any, and methods followed in caring for these persons. Various statistical data were obtained for study from the State sanatoria and the mental hospitals through Drs. Shanholtz and Davis, respectively; and available private facilities for senile and aged persons, including the chronically ill among these groups, were obtained from the Department of Welfare and Institutions.

The members of the Commission and its staff visited and observed the facilities and operations of Piedmont Sanatorium, Blue Ridge Sanatorium, Eastern State Hospital, and the Patrick Henry Hospital for Chronically Ill, Incorporated, at Newport News, Virginia. The latter institution is a nonprofit corporation serving seventeen counties and five cities in Tidewater Virginia.

A comprehensive study of the use of all buildings of Blue Ridge and Catawba Sanatoria was made by the Commission's consultant in order to ascertain whether additional bed space could be provided at one or more of the institutions among existing facilities for purposes of determining if the patients of both institutions could be cared for at one institution.

Information was obtained as to credit policies and collections from patients of the mental institutions and sanatoria for analysis and study in order to determine the extent to which the patients in these hospitals were paying for their care and custody and treatment while in these institutions.

The Committee reviewed the trend in the cost of operations of both the sanatoria and the mental hospitals as reflected in reports on audits by the Auditor of Public Accounts.

FINDINGS

A. *Sanatoria*

From information compiled and furnished by the sanatoria the following statements reflect the number of patients in the three sanatoria at June 30th of each of the years 1955 to 1961, inclusive:

BLUE RIDGE SANATORIUM

Year	Patients in Hospital	Decrease	
		Number	Percentage
1955	349		
1956	326	23	6.5902
1957	315	34	9.7421
1958	289	60	17.1919
1959	281	68	19.4842
1960	241	108	30.9455
1961	240	109	31.2320

The foregoing statement shows that the census taken at Blue Ridge Sanatorium on June 30, 1955 indicated that 349 patients were in that hospital. The census at June 30, 1961 reflected 240 patients in the hospital. Therefore, between the dates of June 30, 1955 and June 30, 1961, there was a decrease in the patient load of 109 persons, or 31.2320%.

CATAWBA SANATORIUM

Year	Patients in Hospital	Decrease	
		Number	Percentage
1955	283		
1956	271	12	4.2402
1957	237	46	16.2544
1958	258	25	8.8339
1959	206	77	27.2084
1960	204	79	27.9151
1961	201	82	28.9752

The census taken at Catawba Sanatorium on June 30, 1955 showed 283 persons in the hospital, whereas the census taken at June 30, 1961 reflected only 201 persons. Therefore, between the dates of June 30, 1955 and June 30, 1961 the patients in the hospital had decreased by 82 persons, or 28.9752%.

PIEDMONT SANATORIUM

Year	Patients in Hospital	Decrease	
		Number	Percentage
1955	377		
1956	363	14	3.7135
1957	359	18	4.7745
1958	349	28	7.4270
1959	340	37	9.8143
1960	337	40	10.6100
1961	323	54	14.3236

The statement indicates that the census taken at Piedmont Sanatorium on June 30, 1955 showed that 377 patients were in that hospital, whereas the census taken at June 30, 1961 showed a patient load of 323 persons, a decrease in the patient load of 54 persons between the dates of June 30, 1955 and June 30, 1961, or a percentage decrease of 14.3236.

The Commissioner of Health was requested to provide information with respect to available beds at each of the sanatoria and the number of beds in use for patients at June 30, 1960 and furthermore to project the

estimated number of patients which would be in the several hospitals for each of the fiscal years ended June 30, 1961 to 1963 inclusive. The following tabulation presents this information:

Sanatoria	At June 30, 1960			Aged Patients Who Could Be Safely Cared For Elsewhere	ESTIMATED OCCUPANCY		
	Beds Available	Beds Occupied	Percentage of Occupancy		Year June 30th		
					1960-61	1961-62	1962-63
White:							
Blue Ridge ..	382	241	63.1	5*	250	250	250
Catawba	390	204	52.3	17†	210	200	200
Totals	772	445	57.6	22	460	450	450
Colored:							
Piedmont	380	337	88.7		355	355	355
E. G. Williams ..	200	182	91.0		187	187	187
Totals	580	519	89.5		542	542	542

* Ready for discharge with no one to assume responsibility for their care

† About half of these patients would require care in a general hospital and the other half in a nursing home

Reference to this statement will show that only 63.1% and 52.3% of the available beds as reported by the hospitals were occupied at June 30, 1960 at Blue Ridge and Catawba Hospitals, respectively, whereas 88.7% and 91% of the available beds reported for Piedmont and E. G. Williams Hospitals, respectively, were occupied as of that date. Considering the four hospitals together one will see that 964 of the reported 1352 available beds were occupied at June 30, 1960, or an overall average occupancy of 71.3%.

The Commission was interested in ascertaining a trend in the net cost to the Commonwealth of maintaining and operating the tubercular hospitals for a ten year period using the fiscal year 1950 as a base year for comparative purposes. Since E. G. Williams Hospital had been in operation for only a few years, the trend in the cost of this hospital is not applicable to the period considered and therefore does not appear in the statements which follow.

BLUE RIDGE SANATORIUM

Year	Net Cost to Commonwealth		Increase	
	Amount	Percentage	Amount	Percentage
1950	\$439,390.99			
1955	737,422.59	67.8283	\$298,031.60	
1960	845,725.01	92.4766	406,334.02	

This statement shows that the net cost to the Commonwealth for operating Blue Ridge Sanatorium for the fiscal year ended June 30, 1950 was \$439,390.99. For the fiscal year ended June 30, 1955 the net cost to the Commonwealth aggregated \$737,422.59. Therefore the increase in the net cost to the Commonwealth for the year ended June 30, 1955 over the net

cost to the Commonwealth for the year ended June 30, 1950 was \$298,031.60, or 67.8283%. The net cost to the Commonwealth for the fiscal year ended June 30, 1960 for the operation of this institution aggregated \$845,725.01. When this figure is compared with the cost of operations for the fiscal year ended June 30, 1950, an increase of \$406,334.02 or 92.4766% is reflected.

CATAWBA SANATORIUM

Year	Net Cost to Commonwealth		Increase	
	Amount	Percentage	Amount	Percentage
1950	\$386,355.07			
1955	603,472.08		\$217,117.01	56.1962
1960	720,859.80		334,504.73	86.5796

The net cost to the Commonwealth for operating Catawba Sanatorium for the fiscal year ended June 30, 1950 amounted to \$386,355.07. The net cost to the Commonwealth for the fiscal year ended June 30, 1955 for this institution was \$603,472.08. Therefore the net cost for the fiscal year ended June 30, 1955 when compared with the net cost for the fiscal year ended June 30, 1950 reflects an increase of \$217,117.01, or 56.1962%. When the net cost to the Commonwealth of \$720,859.80 for the fiscal year ended June 30, 1960 is compared with the net cost to the Commonwealth for the fiscal year ended June 30, 1950, an increase of \$334,504.73 or 86.5796% is reflected.

PIEDMONT SANATORIUM

Year	Net Cost to Commonwealth		Increase	
	Amount	Percentage	Amount	Percentage
1950	\$391,662.65			
1955	720,649.98		\$328,987.33	83.9976
1960	982,616.25		590,953.60	150.8833

The net cost to the Commonwealth for operating Piedmont Sanatorium for the fiscal year ended June 30, 1950 aggregated \$391,662.65. The net cost to the Commonwealth for the fiscal year ended June 30, 1955 aggregated \$720,649.98. Therefore when the net cost for the latter fiscal year is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$328,987.33, or 83.9976%. When the net cost for the fiscal year ended June 30, 1960 is compared with the net cost for the fiscal year ended June 30, 1950, an increase of \$590,953.60, or 150.8833% is reflected.

The preceding statements reflected the total increase to the Commonwealth in the operations of the sanatoria, whereas the following statements reflect the increase in the net per capita cost for these institutions for the fiscal years ended June 30, 1955 and June 30, 1960 when compared with the base fiscal year 1950.

BLUE RIDGE SANATORIUM

Year Ended June 30	Average Number of Patients	Per Capita Cost	Increase	
			Amount	Percentage
1950	321.05	\$1,368.61		
1955	358.20	2,058.68	\$ 690.07	50.4212
1960	258.66	3,269.64	1,901.03	138.9022

With an average patient load of 321.05 for the fiscal year ended June 30, 1950 at Blue Ridge Sanatorium, the average per capita cost to the Commonwealth was \$1,368.61. With an average patient load of 358.20 at this institution, the per capita cost for the fiscal year ended June 30, 1955 amounted to \$2,058.68, an increase of \$690.07 or 50.4212% when compared with the fiscal year ended June 30, 1950. With an average patient load of 258.66 for the fiscal year ended June 30, 1960, the per capita cost to the Commonwealth amounted to \$3,269.64, an increase of \$1,901.03, or 138.9022% over the per capita cost for the fiscal year ended June 30, 1950.

CATAWBA SANATORIUM

Year Ended June 30	Average Number of Patients	Per Capita Cost	Increase	
			Amount	Percentage
1950	307.12	\$1,258.00		
1955	291.93	2,067.18	\$ 809.18	64.3227
1960	212.07	3,399.16	2,141.16	170.2034

The average patient load at Catawba Sanatorium for the fiscal ended June 30, 1950 was 307.12 and the per capita cost to the Commonwealth aggregated \$1,258.00. At June 30, 1955, with an average patient load of 291.93, the per capita cost to the Commonwealth aggregated \$2,067.18, an increase of \$809.18 or 64.3227% over the per capita cost for the fiscal year ended June 30, 1950. For the fiscal year ended June 30, 1960 the average patient load was 212.07 with a per capita cost to the Commonwealth of \$3,399.16. When this figure is compared with the per capita cost for the fiscal year ended June 30, 1950 there is reflected an increase of \$2,141.16, or 170.2034%.

PIEDMONT SANATORIUM

Year Ended June 30	Average Number of Patients	Per Capita Cost	Increase	
			Amount	Percentage
1950	255.59	\$1,532.38		
1955	372.75	1,933.33	\$ 400.95	26.1651
1960	347.17	2,830.36	1,297.98	84.7035

At June 30, 1950 the average patient load at Piedmont Sanatorium was 255.59 and the per capita cost to the Commonwealth was \$1,532.38. The average patient load for this institution for the fiscal year ended June 30, 1955 was 372.75 with a per capita cost of \$1,933.33. This reflects a per capita cost increase of \$400.95, or 26.1651% over the per capita cost for the fiscal ended June 30, 1950. This institution for the fiscal year ended June 30, 1960 had an average patient load of 347.17 with a per capita cost of \$2,830.36. When the per capita cost for the fiscal year ended June 30, 1960 is compared with the per capita cost for the year ended June 30, 1950, there is reflected an increase of \$1,297.98, or 84.7035%.

B. Mental Hospitals

One of the directives of Senate Joint Resolution No. 53 was that sanatoria and the mental hospitals and to determine whether custody and care of aged and senile persons might be provided far more economically than is now being done. Later on in this report we will present the number of senile persons in the several institutions and information with respect to the cost of care and custody of such persons in private facilities. It was

net cost to the Commonwealth for the care and custody of such persons in its own institutions with the cost for the care and custody of such persons in private institutions. In order to make such comparisons possible, the trend in the net cost to the Commonwealth of the mental hospitals and the net per capita cost to the Commonwealth for persons in these hospitals is presented as a part of this report. We now present the trend in the patient load of the six mental hospitals.

CENTRAL STATE HOSPITAL

Year	Average Patient Load	Increase	
		Number	Percentage
1950	4033		
1955	4570	537	13.3151
1960	4697	664	16.4641

For the fiscal year ended June 30, 1950 the average patient load of this hospital was 4033. For the fiscal year ended June 30, 1955 the average patient load was 4570 which, when compared with the figure for the fiscal year ended June 30, 1950, shows an increase in the average number of patients in the hospital of 537, or 13.3151%. For the fiscal year ended June 30, 1960 the average number of patients was 4697 or an increase of 664 or 16.4641% when compared with the fiscal year ended June 30, 1950.

EASTERN STATE HOSPITAL

Year	Average Patient Load	Increase	
		Number	Percentage
1950	1903		
1955	2216	313	16.4477
1960	2201	298	15.6594

For the fiscal year ended June 30, 1950 the average patient load of this hospital was 1903 persons. For the fiscal year ended June 30, 1955 the average patient load was 2216, an increase of 313 or 16.4477% when compared with the fiscal year ended June 30, 1950. For the fiscal year ended June 30, 1960 the average patient load at this institution was 2201 and when this figure is compared with the average patient load for the fiscal year ended June 30, 1950, it will be observed that there was an increase of 298, or 15.6594%.

WESTERN STATE HOSPITAL

Year	Average Patient Load	Increase	
		Number	Percentage
1950	2582		
1955	2793	211	8.1719
1960	2711	129	4.9961

For the fiscal year ended June 30, 1950 the average patient load of Western State Hospital was 2582. The average patient load for this institution for the fiscal year ended June 30, 1955 was 2793, an increase of 211 or 8.1719% when compared with the fiscal year of June 30, 1950. At June 30, 1960 the average patient load at this hospital was 2711 and when this figure is compared with the average patient load for the fiscal year ended June 30, 1950 there is reflected an increase of 129 or 4.9961%.

SOUTHWESTERN STATE HOSPITAL

Year	Average Patient Load	Increase	
		Number	Percentage
1950	1322		
1955	1486	164	12.4054
1960	1559	237	17.9273

The average patient load of Southwestern State Hospital for the fiscal year ended June 30, 1950 was 1322. For the fiscal year ended June 30, 1955 the average patient load was 1486 and when this figure is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of 164 or 12.4054%. At June 30, 1960 the average patient load was 1559. When this figure is compared with the average patient load for the fiscal year ended June 30, 1950 an increase of 237 or 17.9273% is reflected.

LYNCHBURG TRAINING SCHOOL AND HOSPITAL

Year	Average Patient Load	Increase	
		Number	Percentage
1950	1946		
1955	2284	338	17.3689
1960	2660	714	36.6906

For the fiscal year ended June 30, 1950 the average patient load at the Lynchburg Training School and Hospital was 1946. For the fiscal year ended June 30, 1955 the average patient load was 2284. When this figure is compared with the average patient load for the fiscal year ended June 30, 1950, there is reflected an increase of 338 or 17.3689%. For the fiscal year ended June 30, 1960 the average patient load of this hospital was 2660. When this figure is compared with that for the fiscal year ended June 30, 1950 there is reflected an increase of 714 or 36.6906%.

PETERSBURG TRAINING SCHOOL AND HOSPITAL

Year	Average Patient Load	Decrease	
		Number	Percentage
1950	242		
1955	225	<i>17</i>	<i>07.0247</i>
1960	205	<i>37</i>	<i>15.2892</i>

Italics indicate decrease.

For the fiscal year ended June 30, 1950 the average patient load at the Petersburg Training School and Hospital was 242. For the fiscal year ended June 30, 1955 the average patient load was 225. When this latter figure is compared with that for the fiscal year ended June 30, 1950, there is reflected a decrease of 17 or 7.0247%. For the fiscal year ended June 30, 1960 the average patient load for this institution was 205. When this figure is compared with that for the fiscal year ended June 30, 1950, a decrease of 37 or 15.2892% is reflected in the average patient load.

It will be observed from the foregoing statements that all of the mental hospitals, with the exception of the Petersburg Training School and Hospital, reflected increases in the average patient load during the ten-year period for which comparison is made.

In connection with its study the Commission was interested in ascertaining a trend in the net cost to the Commonwealth of maintaining and operating the mental hospitals for a ten-year period, using the fiscal year 1950 as a base year for comparative purposes. The following statements show by hospitals the trend in the net cost of operating these hospitals during the ten-year period.

CENTRAL STATE HOSPITAL

Year Ended June 30	Net Cost to		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$1,666,457.76			
1955	3,162,695.31	\$1,496,237.55		89.7855
1960	5,033,116.64	3,366,658.88		202.0248

The net cost to the Commonwealth for operating Central State Hospital for the fiscal year ended June 30, 1950 was \$1,666,457.76. For the fiscal year ended June 30, 1955 the net cost to the Commonwealth aggregated \$3,162,695.31. Therefore the net cost to the Commonwealth for the fiscal year ended June 30, 1955 over the net cost to the Commonwealth for the fiscal year ended June 30, 1950 was \$1,496,237.55 or 89.7855%. The net cost to the Commonwealth for the fiscal year ended June 30, 1960 for the operation of this institution aggregated \$5,033,116.64. When this figure is compared with the cost for the year ended June 30, 1950, an increase of \$3,366,658.88 or 202.0248% is reflected.

EASTERN STATE HOSPITAL

Year Ended June 30	Net Cost to		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 939,452.07			
1955	1,803,366.84	\$ 863,914.77		91.9594
1960	2,558,422.25	1,618,970.18		172.3313

The net cost to the Commonwealth for operating and maintaining Eastern State Hospital for the fiscal year ended June 30, 1950 amounted to \$939,452.07. The net cost to the Commonwealth for this institution for the fiscal year ended June 30, 1955 was \$1,803,366.84. Therefore the net cost for the fiscal year ended June 30, 1955 when compared with the net cost for the fiscal year ended June 30, 1950 reflects an increase of \$863,914.77 or 91.9594%. When the net cost to the Commonwealth of \$2,558,422.25 for the fiscal year ended June 30, 1960 is compared with the net cost to the Commonwealth for the fiscal year ended June 30, 1950, an increase of \$1,618,970.18 or 172.3313% is reflected.

WESTERN STATE HOSPITAL

Year Ended June 30	Net Cost to		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$1,303,139.25			
1955	2,316,029.74	\$1,012,890.49		77.7178
1960	2,877,377.41	1,574,238.16		122.8113

The net cost to the Commonwealth for the operation and maintenance of Western State Hospital for the fiscal year ended June 30, 1950 aggregated \$1,303,139.25. The net cost to the Commonwealth for the fiscal year ended June 30, 1955 aggregated \$2,316,029.74. Therefore when the net cost for

the latter fiscal year is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$1,012,890.49 or 77.7269%. When the net cost for the fiscal year ended June 30, 1960 of \$2,877,377.41 is compared with the net cost for the fiscal year ended June 30, 1950 an increase of \$1,574,238.16 or 120.8035% is reflected.

SOUTHWESTERN STATE HOSPITAL

Year Ended June 30	Net Cost to Commonwealth	Increase	
		Amount	Percentage
1950	\$ 699,180.04		
1955	*		
1960	1,825,382.91	\$1,126,202.87	161.0748

* Figures not available

The net cost to the Commonwealth for operating and maintaining Southwestern State Hospital for the fiscal year ended June 30, 1950 amounted to \$699,180.04. Comparable information for the fiscal year ended June 30, 1955 was not available; however, when the net cost to the Commonwealth of \$1,825,382.91 for the fiscal year ended June 30, 1960 is compared with the net cost to the Commonwealth for the fiscal year ended June 30, 1950 an increase of \$1,126,202.87 or 161.0748% is reflected.

LYNCHBURG TRAINING SCHOOL AND HOSPITAL

Year Ended June 30	Net Cost to Commonwealth	Increase	
		Amount	Percentage
1950	\$ 978,238.66		
1955	1,885,836.81	\$ 907,598.15	92.7788
1960	3,006,874.11	2,028,635.45	207.3763

The net cost to the Commonwealth for the operation and maintenance of Lynchburg Training School and Hospital for the fiscal year ended June 30, 1950 was \$978,238.66. The net cost to the Commonwealth for the fiscal year ended June 30, 1955 aggregated \$1,885,836.81. When the net cost for the latter fiscal year is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$907,598.15 or 92.7788%. When the net cost of \$3,006,874.11 for the fiscal year ended June 30, 1960 is compared with the net cost for the fiscal year ended June 30, 1950 an increase of \$2,028,635.45 or 207.3763% is reflected.

PETERSBURG TRAINING SCHOOL AND HOSPITAL

Ended Year June 30	Net Cost to Commonwealth	Increase	
		Amount	Percentage
1950	\$163,628.60		
1955	234,502.97	\$ 70,874.37	43.3141
1960	304,757.21	141,128.61	86.2493

The net cost to the Commonwealth for the operation and maintenance of Petersburg Training School and Hospital for the fiscal year ended June 30, 1950 was \$163,628.60. The net cost to the Commonwealth for the fiscal year ended June 30, 1955 aggregated \$234,502.97. Therefore when the net cost for the latter fiscal year is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$70,874.37 or 43.3141%. When the net cost of \$304,757.21 for the fiscal year ended

June 30, 1960 is compared with the net cost for the fiscal year ended June 30, 1950, an increase of \$141,128.61 or 86.2493% is reflected.

In the first statements, beginning on page 10, we presented information relating to the mental hospitals' average patient load for each of the fiscal years ended June 30, 1950; June 30, 1955; and June 30, 1960. Information with respect to the net cost to the Commonwealth for each of these three years was set forth in the foregoing statements relating to these institutions. We now present a comparison of the net per capita patient cost to the Commonwealth for these hospitals as well as the increase in the net per capita cost to the Commonwealth for the three fiscal years ended June 30, 1950; June 30, 1955; and June 30, 1960.

CENTRAL STATE HOSPITAL

Year	Net Per Capita Cost to Commonwealth		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 413.21			
1955	692.05	\$278.84		67.4814
1960	1,071.56	658.35		159.3257

The net per capita cost to the Commonwealth at Central State Hospital for the fiscal year ended June 30, 1950 was \$413.21. When this figure is compared with the net per capita cost of \$692.05 for the fiscal year ended June 30, 1955, there is reflected an increase for the latter year of \$278.84 or 67.4814%. The net per capita cost for the fiscal year ended June 30, 1960 was \$1,071.56. When this figure is compared with the net per capita cost for the fiscal year ended June 30, 1950, there is reflected an increase of \$658.35 or 159.3257%.

EASTERN STATE HOSPITAL

Year	Net Per Capita Cost to Commonwealth		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 493.67			
1955	813.80	\$320.13		64.8469
1960	1,162.39	668.72		135.4589

The net per capita cost at Eastern State Hospital for the fiscal year ended June 30, 1950 was \$493.67. When this figure is compared with the net per capita cost for the fiscal year ended June 30, 1955 of \$813.80, an increase of \$320.13 or 64.8469% is reflected for the latter fiscal year. When the net per capita cost for the fiscal year ended June 30, 1960 of \$1,162.39 is compared with the net per capita cost for the fiscal year ended June 30, 1950, there is reflected an increase in the net per capita cost for the fiscal year ended June 30, 1960 of \$668.72 or 135.4589%.

WESTERN STATE HOSPITAL

Year	Net Per Capita Cost to Commonwealth		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 504.70			
1955	829.23	\$324.53		64.3015
1960	1,061.37	556.67		110.2972

The net per capita cost to the Commonwealth at Western State Hospital for the fiscal year ended June 30, 1950 was \$504.70. For the fiscal year ended June 30, 1955 the net per capita cost aggregated \$829.23. When

this figure is compared with the net per capita cost for the fiscal year ended June 30, 1950, there is reflected an increase of \$324.53 or 64.3015%. When the net per capita cost for the fiscal year ended June 30, 1960 of \$1,061.37 is compared with that for the fiscal year ended June 30, 1950, an increase of \$556.67 or 110.2972% is reflected in the per capita cost for the year ended June 30, 1960.

SOUTHWESTERN STATE HOSPITAL

Year	Net Per Capita Cost to		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 528.88			
1955	*			
1960	1,170.87	\$641.99		121.3867

* Not available.

The net per capita cost for the fiscal year ended June 30, 1950 at Southwestern State Hospital was \$528.88. The information was not available for the fiscal year ended June 30, 1955 but when the net per capita cost of \$1,170.87 for the fiscal year ended June 30, 1960 is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$641.99 or 121.3867%.

LYNCHBURG TRAINING SCHOOL AND HOSPITAL

Year	Net Per Capita Cost to		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 502.69			
1955	825.67	\$322.98		64.2503
1960	1,130.40	627.71		124.8701

The net per capita cost to the Commonwealth at Lynchburg Training School and Hospital for the fiscal year ended June 30, 1950 was \$502.69. At June 30, 1955 the net per capita cost aggregated \$825.67. When this figure is compared with that for the fiscal year ended June 30, 1950, there is reflected a net per capita cost increase of \$322.98 or 64.2503%. When the net per capita cost of \$1,130.40 for the fiscal year ended June 30, 1960 is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$627.71 or 124.8701%.

PETERSBURG TRAINING SCHOOL AND HOSPITAL

Year	Net Per Capita Cost to		Increase	
	Commonwealth	Amount	Amount	Percentage
1950	\$ 677.27			
1955	1,042.24	\$364.97		53.8884
1960	1,486.62	809.35		119.5018

The net per capita cost to the Commonwealth for the fiscal year ended June 30, 1950 was \$677.27. The net per capita cost for the fiscal year ended June 30, 1955 was \$1,042.24. When this figure is compared with that for the fiscal year ended June 30, 1950, there is reflected an increase of \$364.97 or 53.8884%. The net per capita cost for the fiscal year ended June 30, 1960 was \$1,486.62. When this figure is compared with the net per capita cost for the fiscal year ended June 30, 1950, there is reflected an increase of \$809.35 or 119.5018%.

*Method and Procedure Followed in Screening and Determining
the Ability of Patients To Pay in Whole or in Part
For Their Care*

Patients who enter the sanatoria and mental hospitals under the law are required to pay as much of the cost of their care and treatment, up to a maximum amount, as they are able to do. During the course of the study the Commission reviewed the methods and procedures followed in screening and determining the ability of patients to make payments for their care and treatment as required by law at both the sanatoria and the mental hospitals.

The Commissioners of the Department of Health and of the Department of Mental Hygiene and Hospitals were requested to outline the methods and procedures followed by each of their agencies in screening and determining the ability of the patients admitted to their institutions to pay for their care and treatment.

The methods and procedures reported for the sanatoria are as follows:

“A socio-economic data form is filled out by the local health department and submitted to the sanatorium, usually along with the patient's written application for admission. This is used as a guide to the patient's ability to pay or to the ability of those legally liable for his support.

“Following admission, the patient is contacted by a representative of the business office, the medical social worker, and finally, the Superintendent and Medical Director. The latter makes the final decision as to what might be considered a reasonable charge in each case. Where necessary, additional interviews are carried out with members of the patient's family or others who might be legally liable for the patient's support.

“A fair charge having been agreed upon by the patient and the Superintendent, the business office issues a monthly statement. When bills are not paid promptly, the patient and/or those responsible for his support are contacted through letters or personal interviews.

“To date no sanatorium has ever placed an account in an agency's hands for collection, nor has legal action been taken to collect. The reason for this is that tuberculosis being a communicable disease, it has been felt that the primary consideration should be to induce patients to accept proper treatment and follow it through to a successful conclusion. Individuals who have active pulmonary tuberculosis in a communicable form frequently feel quite well or reasonably well for long periods, and at times much difficulty is encountered in persuading them to go to the sanatorium in the first place, and then in keeping them in the sanatorium until they are ready for discharge. It has been the conviction of the Sanatorium Superintendents and Medical Directors, supported by the State Health Commissioner and Board of Health, that if any undue burden were to be placed upon the patient or his family or any financial assessment which the patient considered to be excessive, a fair number would leave the sanatorium before they are ready for discharge and while they may still have the disease in a dangerously communicable form; others might not even apply for admission.

“In actual practice the bulk of revenue collected is from hospitalization insurance carried by patients which covers, in most instances, a portion of the patient's stay in the sanatorium.”

The organization and procedures for the payment by or for persons in the mental hospitals is as follows:

“Immediately after a patient is admitted to a hospital, the Statistical division furnishes the Reimbursement Field Office with pertinent data necessary to begin the investigation of a patient’s ability to pay. Upon receipt of this information the Reimbursement Field Office mails appropriate forms to legally liable relatives or fiduciaries seeking information with respect to the financial condition of the patient or those legally responsible for him. When these forms are completed and returned to the Field Office they are reviewed for completeness and information as to whether the patient has an estate sufficient to pay for his care and custody or other relatives who are legally liable and to whom forms may be sent. If the latter is determined to be the situation, then appropriate questionnaires are sent to legally liable relatives or non-legally liable relatives, whichever is appropriate. The Field Office follows up on the return of these forms and when unable to obtain necessary information through correspondence as to an individual’s ability to pay, a field visit may be made. This field investigation may include reviewing court records, contacting relatives, other agencies, such as Social Security Board, Railroad Retirement Board, etc., to locate assets or income which will be of assistance in determining the amount to be paid.

“Upon obtaining all information possible, the Field Representative will review this information and attempt to obtain an agreement for the appropriate amount. In determining the appropriate amount, there is no set scale based on income and dependents and each case is considered on its individual merits. Upon receipt of a contract or agreement, the Field Representative will forward all pertinent information and a copy of the agreement to the Central Office for consideration and acceptance. If the Field Representative is unable to arrive at a satisfactory agreement, all pertinent information is forwarded to the Central Office with a recommendation as to the amount to be charged and that legal action be instituted.

“Upon the receipt of a satisfactory agreement, the Central Office sets up an account and notifies the contractor of the acceptance and advises as to the billing procedure and where payments are to be made. Statements are prepared and mailed each month showing the charges for the preceding month and the balance due as of the last day of the preceding month, or the date the patient was released from the hospital. All contractors are advised to make payments at the Central Office in Richmond where the accounts are maintained.

“In the event the Field Representative is unable to arrive at a satisfactory agreement, his entire file with a recommendation is forwarded to the Central Office for review where a determination is made as to appropriate charges. In the Central Office a petition to the court is prepared and forwarded to the local Commonwealth’s Attorney in the area where the legally liable relative or the fiduciary resides. This petition will request the court to order the legally liable relative or fiduciary to pay a certain amount, based on the patient’s estate or the individual’s ability to pay. The local Commonwealth’s Attorney represents the Department in such action and usually a Representative from the Reimbursement Division is present at the hearing to testify, if needed. At such hearing, the court will determine the amount which should be paid, an order is issued and an account is set up for the amount specified by the court. These accounts are billed and maintained on the same basis as contracts and agreements.

“The Department is authorized by statute to receive Social Security, Railroad Retirement benefits, Civil Service benefits and any other annuity benefit of this type on behalf of a patient, and is authorized to administer these funds. The process of filing claims for patients for whom the Department will act as payee is conducted in the Central Office through the Richmond District Office of the Social Security Board, the Railroad Retirement Board and direct with the Civil Service Commission in Washington, D. C. A portion of benefits received from these sources on behalf of a patient is distributed to the patient for his personal use at the hospital and charges up to the maximum rate are made from the balance.

“Each month a list of delinquent accounts is prepared in the Central Office and forwarded to the Field Representative at each hospital. It is the Field Representative’s responsibility to follow up on these delinquent accounts by mailing appropriate delinquent notices and by personal contact to collect, if necessary. The Field Representatives have the authority, by arrangement with local Commonwealth Attorneys, to obtain warrant for judgment and to enforce judgment by garnishment. If a judgment is not immediately collectible, it may be recorded which constitutes a lien against property or the estate of a patient or a contractor. Before the Field Representative is authorized to proceed to obtain a warrant for judgment or garnishment, prior approval must be issued in each individual case by the Central Office, and the local Commonwealth’s Attorney.

“After every effort has been made and an account is considered uncollectible, the balance may be written off by authority of the State Hospital Board.

“The Field Representative also follows leads as to hospitalization insurance benefits and files appropriate claims with the insurance companies when benefits are payable. Charges to insurance companies are on the basis of the maximum established charge at each hospital, and the contractor’s accounts are credited with the period for which the insurance paid.

“At the present time there are approximately 5,000 current accounts set up for reimbursement for monthly charges ranging from \$5.00 per month to \$125.00 per month.”

Collection Experience

The following statements present a ten-year trend in collections for each of the tubercular hospitals and the average paid per patient:

PIEDMONT SANATORIUM

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$37,757.69	255.59	\$147.73
1955	40,514.18	372.75	108.69
1960	32,266.10	347.17	92.94

CATAWBA SANATORIUM

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$58,947.00	307.12	\$191.94
1955	51,871.74	291.93	177.69
1960	49,460.59	212.07	233.22

BLUE RIDGE SANATORIUM

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$131,145.50	321.05	\$408.49
1955	124,318.71	358.20	347.06
1960	120,046.21	258.77	463.91

The statements which follow show similar information for the same fiscal years for each of the mental hospitals.

CENTRAL STATE HOSPITAL

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$ 14,723.31	4033	\$ 3.65
1955	90,415.39	4570	19.78
1960	243,290.13	4697	51.79

EASTERN STATE HOSPITAL

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$134,594.78	1903	\$ 70.73
1955	253,006.72	2216	114.17
1960	462,308.36	2201	210.04

WESTERN STATE HOSPITAL

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$ 94,506.13	2582	\$ 36.60
1955	284,433.31	2793	101.83
1960	504,492.52	2711	186.09

SOUTHWESTERN STATE HOSPITAL

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$ 41,606.17	1322	\$ 31.47
1955	79,280.56	1486	53.35
1960	174,995.08	1559	112.24

LYNCHBURG TRAINING SCHOOL AND HOSPITAL

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$ 23,608.18	1946	\$ 12.13
1955	135,583.90	2284	59.36
1960	386,555.85	2660	145.32

PETERSBURG TRAINING SCHOOL AND HOSPITAL

Fiscal Year Ended	Amount From Patients	Average Number Patients	Average Paid Per Patient
1950	\$ 599.34	242	\$ 2.47
1955	1,419.54	225	6.31
1960	6,061.00	205	29.57

Senile Patients in Sanatoria and Mental Hospitals

One of the directives of Senate Joint Resolution 53 was the ascertainment of the number of aged and senile persons in the State's sanatoria and mental hospitals. The turnover of patients in the sanatoria is much more rapid than is the turnover of patients in the mental hospitals. According to information provided by the State Health Commissioner there were 5 and 17 of such persons at Blue Ridge and Catawba, respectively, at June 30, 1960. No patients were reported for Piedmont or Ennion G. Williams Hospitals.

The Commissioner of Mental Hospitals was able to provide us information with respect to these patients in the mental hospitals at June 30th of each of the fiscal years 1956 to 1960, inclusive. The following tabulation presents this information.

Number of Patients in Hospital and Number 65 Years of Age and Over
As of June 30, For Five Year Period

State Hospitals	1956			1957			1958			1959			1960		
	Total Patients	65 and Over		Total Patients	65 and Over		Total Patients	65 and Over		Total Patients	65 and Over		Total Patients	65 and Over	
		Senile	All Other		Senile	All Other		Senile	All Other		Senile	All Other		Senile	All Other
Central	4,532	423	517	4,556	417	530	4,554	408	539	4,661	417	564	4,756	452	581
Eastern	2,239	317	402	2,199	301	420	2,251	314	402	2,208	325	419	2,293	322	415
Southwestern	1,537	169	203	1,517	164	216	1,532	166	219	1,563	151	230	1,539	145	222
Western	2,729	361	540	2,748	362	519	2,730	359	524	2,665	365	525	2,749	357	566
Total	11,037	1,270	1,662	11,020	1,244	1,685	11,067	1,247	1,684	11,097	1,258	1,738	11,337	1,276	1,784

Percent Distribution to Total Patients

Central	100.0	9.3	11.4	100.0	9.2	11.6	100.0	9.0	11.8	100.0	8.9	12.1	100.0	9.5	12.2
Eastern	100.0	14.1	18.0	100.0	13.7	19.1	100.0	13.9	17.9	100.0	14.7	19.0	100.0	14.0	18.1
Southwestern	100.0	11.0	13.2	100.0	10.8	14.2	100.0	10.8	14.3	100.0	9.7	14.7	100.0	9.4	14.4
Western	100.0	13.2	19.8	100.0	13.2	18.9	100.0	13.2	19.2	100.0	13.7	19.7	100.0	13.0	20.6
Total	100.0	11.5	15.1	100.0	11.3	15.3	100.0	11.3	15.2	100.0	11.3	15.7	100.0	11.3	15.7

At June 30, 1960 there were 1276 persons of 65 years and over who were categorized as aged and senile in the four mental hospitals listed in the statements. These persons amounted to 11.3% of the total patients in these hospitals at that date. The aggregate of such persons in the sanatoria and the mental hospitals was 1298.

Since the Commission was directed under the Resolution to determine whether custody and care of aged and senile persons may be provided more economically than is now being done, the late Colonel Richard W. Copeland was requested to appear before the Commission and to furnish it with information as to the cost of care and custody of these persons in licensed private and public institutions. Colonel Copeland advised that the cost of the care of aged and senile persons in proprietary and public nursing homes ranged from \$65.00 to \$325.00 a month. He emphasized the fact that these homes do not often provide adequate nursing or medical care. During the interview he stated that persons placed in such homes by the Department of Public Welfare under the Public Assistance Program were placed there on an actual cost basis but in no case at a cost in excess of \$150.00 per month.

Patrick Henry Hospital for the Chronically Ill, Inc. (Denbigh) Newport News, Virginia

During the course of the study, as previously stated, the Commission visited the Patrick Henry Hospital for the Chronically Ill, Incorporated, at Denbigh, Virginia. The Commission had received numerous favorable reports relative to the operation of this institution which serves 17 counties and 5 cities in the tidewater area of the State. The Commission was much impressed with this institution and the community effort which brought it into being and which continues to assist in its operation. This hospital is an example of what a community really can do to care for its aged persons. It is a nonprofit institution which gives first consideration to aged and senile persons under the Public Assistance Programs of the communities which participated in the establishment of the hospital. When facilities are available, full paying private patients are accepted by this hospital, provided they are legal residents of the counties and cities which are served by the institution. In addition to regular care, this institution provides nursing and medical services. The hospital has a bed capacity of 258 and generally has a waiting list of persons who desire to enter. The financial report of the institution for the six months' period ended June 30, 1960 showed a per diem cost of \$3.95 which amounts to approximately \$1,440 per annum per patient. The institution receives many services from various interested persons and groups of the communities it serves at no cost and this assists the institution in operating at a minimum amount. The aforementioned per diem cost represents only actual funds expended and does not include any contributed services.

Aged Persons Cared For Under Public Assistance Program

According to information provided by the State Department of Welfare and Institutions for the month of June, 1960, there were 1911 persons in public and private nursing homes in Virginia whose support was provided through public assistance. An analysis of these cases by categories shows that 1207 were supported under old age assistance, 50 under aid to the blind, 329 under aid to the permanently and totally disabled, and 325 under general relief.

The total cost for the support of aged persons through the Public Assistance Program for the fiscal year ended June 30, 1960, amounted to \$1,915,281, of which \$1,201,422 was provided by the Federal government, \$348,423 by the State and \$365,436 by the political subdivisions.

Care of Aged Persons in Other States

An analysis of the information obtained from other States relative to the care of their aged and senile persons disclosed that, while practically all of the States reporting were conscious of the needs of these persons, there was no consistent program or pattern for caring for them. In some of the States the aged and senile persons are cared for in their mental hospitals and tubercular sanatoria. A few States reported that they had, or were establishing geriatric buildings for the care of these persons at their mental hospitals. Several States advised that they were caring for the aged persons, in available spaces in the tubercular and mental hospitals, and placing others in private and public nursing institutions for non-psychotic aged persons, but one State reported that it discontinued the operation of its institution for the aged because of the tremendous cost involved. It would appear that of those States answering our inquiry, the majority are caring for these persons in private and public nursing homes under programs administered by their welfare departments.

RESULTS OF STUDY OF PRESENT AND POTENTIAL UTILIZATION of FACILITIES AT BLUE RIDGE AND CATAWBA SANATORIA

1. *Requirements of a Consolidated Sanatorium*

The average patient load for the year ended June 30, 1960 was 212 at Catawba and 259 at Blue Ridge, making a combined average load of 471 patients. For the year ended June 30, 1961, the combined average patient load had declined to 448. The recent experience of the sanatoria is that about 20% of the patients are sufficiently ambulatory to walk between buildings, if necessary, to get their meals. The patient load fluctuates somewhat at both institutions so that at times the census is greater than the average. Offsetting this factor however is the fact that there are always a number of cured patients at the hospitals whose discharge is delayed pending arrangements for their accommodation elsewhere. These could be accommodated in non-patient facilities. In addition, there are about ten individuals, reported as patients, whose physical condition requires an institutional environment but not treatment as patients. These individuals are given part time duties of varying degrees of effort for which they receive modest compensation. They too could be housed in sanatorium quarters other than the hospital bedrooms.

Whether the decline in the incidence of tuberculosis and in the length of treatment will continue is a matter of conjecture among experts in this field. If the trend does not reverse, and this is not expected, a capacity of 480 beds should be sufficient to meet the needs of the State. Even though this capacity should eventually require some expansion, it seems apparent that the inherent operating economics of a combined sanatorium in lieu of the two presently operated sanatoria far outweigh any foreseeable capital outlay.

2. *Present Utilization and Potential Capacities of the Sanatoria*

A. *Catawba*

Patient Facilities An analysis of present and potential bed space utilization (Exhibit A) shows that 386 beds are presently available. Utilization of bed spaces in one of the two solaria on each floor of the main infirmary, utilization of a former infirmary now used to house visitors, and conversion of the main infirmary pent-house from employee to patient use would increase the total beds available to 444. Minor improvements required to accomplish this increase in capacity are estimated not to exceed \$8,000.

By making some modifications, four enclosed porches of the infirmary annex can be converted to year round bed use. Such a change would not result in crowding, inconvenience, nor inefficient operation. The present high level of patient care would be retained. The cost of the necessary modifications is estimated not to exceed \$25,000. This change would add 40 beds to give a total sanatorium capacity of 484.

Staff Quarters An analysis of the utilization of employee quarters (Exhibit B) indicates that there are accommodations for 214 employees. Of these accommodations, 95 are occupied and 119 unoccupied. Many employees are housed whose duties do not require them to be. Other employees prefer to live off the grounds even though sanatorium quarters are available at low cost.

Only one of the single residents and one of the apartments is unoccupied. The remaining unoccupied quarters are dormitories or barracks. Some of these are not desirable. On the other hand, 24 of the 32 excellent single rooms in the nurses' home are unoccupied, as are 19 of the 43 in the nurses' home annex.

There seems little doubt that, with the possible exception of doctors' residences, the existing quarters are sufficient to accommodate a staff of the size required to service a sanatorium with 480 patients.

The residence of doctors on the grounds need not be mandatory as at present. Provision for a doctors' "call room" and arrangement of schedules to assure doctors always being at the hospital would permit all or part of the medical staff to live off the grounds. Some doctors would prefer this. Others would not.

Other Facilities

Water Although a new well has recently been driven it may become necessary to add another if the capacity is increased to 480 patients.

Sewage Disposal Experience may show that some minor additions may be required to the present facilities.

Steam The present plant is more than sufficient for a full capacity sanatorium.

Food Service The present preparation and serving facilities are adequate for full capacity operation.

Farm and Dairy Increasing the herd to provide sufficient milk for a patient population of 480 could be accomplished easily and would require no additional facilities.

Electricity No serious problem would result from increased requirement.

Laboratory Facilities would be ample.

Dental Facilities are adequate.

Educational An expanded program would be required, but present facilities are adequate.

Telephone Additional lines would be required but cost would be moderate.

Parking Additional parking area would be required at a cost of approximately \$10,000.

B. *Blue Ridge*

Patient Facilities The present reported bed capacity of Blue Ridge is 384. This can be increased six beds to 390 by utilizing, 1) a solarium on the third floor of the main hospital building and, 2) staff sick rooms on the fourth and fifth floors of the hospital west wing. These changes could be made without any significant cost.

An analysis of present and potential bed space utilization (Exhibit C) shows that the patient capacity at this institution can be increased to 485 by various building modifications. A description of these, together with the resulting increased capacity and estimated cost of each is given in the paragraphs which follow.

Main Hospital Building The capacity of the main hospital building (No. 21) can be increased by adapting the present enclosed sleeping porches to regular hospital use. Each of the three floors has two porches that can conveniently accommodate 6 beds, making a total increase of 36.

The modifications and additions necessary to adapt the porches and to accommodate the additional patients with sufficient toilet and other facilities are described below, together with their estimated cost. These changes and costs are stated in terms referring to the first floor but apply similarly to the second and third floors which are nearly identical.

Description of Change

<i>Improvement of Porches</i>	<i>Estimated Cost for One Floor</i>
1. Provide wash bowl and running water in center of each porch on outside wall	\$ 1,500
2. Between each of the double rooms fronting on the porches, provide sliding screens suspended from the ceiling to establish privacy for the proposed porch locations	1,200
3. Provide venetian blinds along the full length of porch	1,000
4. Cover porch floors with tile	2,000
5. Consider providing electric or steam heat to the porch areas. The porches are presently said to be sufficiently warm in winter, but it may be necessary to provide supplementary heating to equalize temperatures between the bedrooms and porches....	1,800
 <i>Additional Furniture and Fixtures</i>	
1. Provide each porch bed with two combination dresser tables, one clothes closet, and one bed lamp (\$250 per bed space)	3,000
 <i>Additional Auxiliary Facilities</i>	
1. Relocate the existing ice machine and refrigerator in the east diet kitchen (Room 147) to the west diet kitchen (Room 105). The Sanatorium has revised its meal serving techniques so that the existing diet kitchens will be unnecessary except as a location for storing and setting up between-meal beverage service	50
2. Remove all or part of the partition separating the east utility room (No. 146) and the east diet kitchen (Room 147). Rearrange the equipment in these two rooms to provide more convenient and effective sterilization.	500
3. Add one commode and one hand wash bowl to the existing east and west toilets (Rooms 108 and 144).	400
4. Rearrange both east and west washrooms (Rooms 145 and 107) as follows: 1) remove present wash tub and replace with a modern design suitable for bathing invalids; 2) add one shower stall; 3) add one dental cleaning bowl	1,500
5. Convert visitors' porch (Room 126) to a patient's lounge. Add outside door. Seal openings between this room and the employees' toilet and employees' lounge (Rooms 124 and 125). Provide forced exhaust for these two rooms. Provide heat for the area.	<u>800</u>
Total estimated cost for one floor	\$13,750
Total estimated cost for three floors	\$41,250

Wright Building (No. 7) This building, a gift of the Masons of Virginia, was constructed in 1925. Although over thirty-five years old, it is still in excellent condition and should serve many more years with moderate maintenance expense. It is presently used for male ambulatory patients on the first floor. The second floor is available for the same purpose but the patient load does not now require this. The building was originally constructed for all types of tubercular patients, including those requiring strict bed rest. However, the main hospital buildings have provided ample accommodations for bed rest patients so that the inconvenience of transporting patients has discouraged the use of the Wright building for non-ambulatory patients. In any plan intended to make maximum use of the Blue Ridge facilities it would appear most logical to utilize this building for ambulatory or semiambulatory cases only. Further, if possible, the building should be used entirely for patients of one sex.

Like the main hospital, the Wright building has two continuous enclosed porches on each of its two floors. These porches may be adapted to provide convenient and efficient accommodations for six beds each, thus increasing the capacity of the building by 24. Since the building is intended for patients who are ambulatory or semiambulatory, the additional beds would not require changes as extensive as have been described for the main hospital building. The recommended modifications and additions are described below together with their estimated costs.

<i>Description of Change</i>	<i>Estimated Cost for Both Floors</i>
1. Convert the present washrooms on each floor to men's toilets	\$ 3,000
2. Convert the room adjacent to and west of the elevator on each floor to a men's washroom	2,000
3. Convert the room adjacent to and east of the elevator on the second floor to a patient's lounge	750
4. Cover each of the four porch floors with tile	3,500
5. Provide venetian blinds along the full length of each of the four porches	1,500
6. Provide each porch bed with furniture (\$250 per bed space)	6,000
7. Provide, if necessary, for additional heating. Although patients presently sleep on the porches in winter, it may be necessary to add auxiliary heating to equalize temperatures between the porches and the connecting bedrooms	2,000
Total for building	\$18,750

Trinkle Building (No. 20) Constructed in 1922, this is the oldest hospital building at Blue Ridge. Although inactive for approximately eighteen months, it served adequately up to the time its use was discontinued. Very few complaints are said to have been made by patients or nurses concerning the location or condition.

The structure is masonry, except for the floors and roof beams. It has ample fire escapes and recent fire inspections have been favorable. With various modifications and improvements this building will serve well for ambulatory female patients. The capacity of the building can be increased 22 beds by utilizing the present enclosed porch areas.

<i>Description of Change</i>	<i>Estimated Cost for Both Floors</i>
<i>Improvement of Porches</i>	
1. Remove existing porch lights and replace with indirect overhead lighting, supplemented by individual bedside lights controlled by the patient	\$ 2,500
2. Cover porch floors with tile	2,500
3. Remove existing radiators in each bed room facing on porch and replace with baseboard convectors located at the foot of the bed spaces and the adjacent area on the porch side of the partition	3,500
4. Provide venetian blinds for all porch areas	1,500
<i>Additional Furniture and Fixtures</i>	
1. Provide for sliding screen, suspended from the porch ceiling around each bed location	2,500
2. Construct a clothes closet, projecting from the outside porch columns, between each of the double rooms. Construct three built-in dressers between each outside column of the porches	5,000
<i>Additional Auxiliary Facilities</i>	
1. Replace present elevator	15,000
2. Convert the present combined toilet and washroom located on each of the two floors to toilets only	1,500
3. Convert the present utility rooms on each floor to washrooms. Convert one of the two single bedrooms located on each floor to a utility room	1,500
4. Convert the existing room located on the second floor over the nurses' room into an examining room for patients	400
5. Enclose open porch on each end to provide lounge area for patients. This will require additional heating and lighting facilities	3,500
6. Rearrange call system so that entire building is in communication with the single nurses' station	1,000
7. Improve interior lighting system	3,000
Total for building	\$43,400

Hospital West Wing (No. 21) This addition to the main hospital building was constructed in 1949 and includes most of the latest features considered desirable for a tuberculosis hospital. It has no porches. Additional beds can be made available on the fourth and fifth floors by utilizing rooms designated as solarium (Rooms 448 and 548) These two rooms should provide four additional bed spaces.

The wing of the second floor of this building was designed as a separate diet kitchen. It has recently been decided by the food service management that better meals and less expensive service can be provided from the central kitchen—thus making the decentralized kitchen space available for other use. This area can be converted into six double and one single bed rooms. Although requiring rather extensive modifications, 13 additional beds may be accommodated in this very convenient area. Removal of existing partitions, rearrangement and addition of utilities, construction of new partitions, and all other work would cost approximately \$20,000.

Staff Quarters Analysis of the utilization of employee quarters (Exhibit D) shows that there are total accommodations for 184 employees. Of these, 95 are occupied and 89 unoccupied. Less than one-third of the 76 bed capacity of the new nurses' home is occupied. Fourteen of the 39 beds in the Davis building are unoccupied.

Many employees are quartered in various buildings not originally intended for dormitory use. If Blue Ridge were operated at maximum capacity, some of these employees might be required to give up their quarters.

Nurses' aides should be encouraged to live on the grounds. The quarters in the Davis building might become inadequate for this use if the two sanatoria were consolidated at Blue Ridge. In this event, additional quarters could be easily provided in the Garrett building by subdividing the presently unused wardroom into separate dormitory rooms. The probability of this need is so small, however, that no additional cost is estimated for this contingency.

Other Facilities

Water Water is supplied by the City of Charlottesville, and the present supply mains are entirely adequate to handle the increased load.

Electricity Electricity is supplied by the Virginia Electric and Power Company. The Power Company furnishes and maintains the necessary transformers and therefore an increased load would pose no problem to the institution.

Sewage Blue Ridge has its own disposal plant which has been designed to accommodate a sanatorium of five hundred patients. Therefore, there would be no problem in connection with sewage disposal.

Telephone The present switchboard is expansible and could easily be increased to accommodate more lines.

Parking There is a large unused parking lot on the south side of the Main Hospital which is seldom used. This would be more than adequate to handle the increased population.

Heat The present power plant has three boilers ; only one of which is used in cold weather. There are tentative plans to improve one of the boilers by providing it with a Spreader-Stoker. This improvement would be desirable regardless of the size of the population.

Laboratory Equipment The present X-ray and fluoroscope equipment are adequate for the larger population. It is possible that certain laboratory facilities in connection with the development of cultures might require augmenting.

Dental There is a possibility that one additional dental chair would be required.

Educational The present plan is to eliminate the student nurses' program, and, if this is followed through, there will be no need for some of the present educational spaces and equipment. However, with an increased population, there might be a need for reinstating the nurses' educational program. In any case, the present educational spaces and equipment would be sufficient. Patients participating in educational programs would be increased but could easily be accommodated with present facilities.

Food Preparation and Serving The present kitchen is more than adequate to handle the increased population. It would appear that the larger population would require some meals to be served in the Trinkle and Wright buildings in which case it would be necessary to provide a suitable vehicle for transporting food to these buildings. The food service management states that this would pose no serious problem. A substantial portion of the food preparation is performed by inmates of the Convict Honor Camp. The serving of an increased number of meals at Blue Ridge would mean that more convicts could be utilized in the kitchen. The added cost of such convict labor would be relatively small inasmuch as the same guard force would be adequate for the larger number of convicts.

Milk Only about half of the present dairy facilities are utilized. An increased consumption would serve to reduce substantially the unit cost of milk.

3. *Comparative Cost of Modifications*

CATAWBA

Hospital Buildings	Estimated Cost	Added Beds	Estimated Cost per Added Bed
Main infirmary building			
Adapting penthouse to patient care	\$ 3,000	18	\$170
Infirmary annex			
Adapting porches to bed spaces	25,000	40	630
Visitors' Cottage			
Cleaning, painting and rehabilitating for patient use	5,000	16	310
Total (average)	\$33,000	74	\$550
Other Facilities			
Water—Add new well (tentative)	4,000		
Parking—Additional area	10,000		
Total estimated cost of modifica- tions*	\$47,000		

BLUE RIDGE

Hospital Buildings	Estimated Cost	Added Beds	Estimated Cost per Added Bed
Main hospital building			
Adapting porches to bed spaces	41,250	36	1,150
Wright building			
Adapting porches to bed spaces	18,750	24	780
Trinkle building			
Adapting porches to bed spaces	43,400	22	1,970
Hospital west wing			
Adapting kitchen area to bedrooms	20,000	13	1,540
Total (average)	\$123,400	95	\$1,300
Employee Buildings			
No changes required		
Other Facilities			
No changes required			
Total estimated cost of modifica- tions*	\$123,400		

From the above it may be seen that either sanatorium may be adapted to the total patient load of both for a comparatively small cost.

* The above cost estimates are based on observations and are necessarily not as firm as if based on engineering specifications. They are nevertheless believed to be conservative and sufficient to accommodate all required changes.

4. *Operating Savings Resulting From Consolidation
Determination of Savings*

An approximate but conservative analysis of operating costs indicates that consolidating the sanatoria in one location should result in a net annual saving to the State of \$523,608 in personal services and \$29,000 in supplies and contractual services for a total (rounded) of \$552,000. This saving amounts to 35% of the combined net operating cost of \$1,566,584 for the year ended June 30, 1960.

The following steps were employed in estimating the operating costs of a single sanatorium accommodating the total patient population:

1. Both sanatorium superintendents were asked to estimate, in conference with their staff, the increased personnel necessary to accommodate the patients of both sanatoria at their institution.
2. The average of the superintendents' estimates was subtracted from the current actual combined staffs of the two sanatoria to arrive at the net reduction in positions.
3. The average annual salary was determined for each of the major functions. The reduction in personnel (determined in Step 2) was extended by the average salary to obtain the net cost saving in personal services.
4. The savings in fuel, power, supplies, and other expenses was estimated on the assumption that the increased requirements in a consolidated institution would be substantially less than the total requirements of two separately operated institutions.

The anticipated savings in personal services are itemized as follows:

Function	Present Combined Staff	Average Combined Staff As Estimated by Superintendents	Reduction in Staff	Average Annual Salary	Net Reduction in Salaries
Administration	15.0	9.5	5.5	\$6,024	\$ 33,132
Care and maintenance of patients	302.0	211.0	91.0	3,360	305,760
Maintenance of buildings and grounds	22.0	11.5	10.5	3,960	41,580
Operation of farm and dairy ...	18.0	9.0	9.0	2,784	25,056
Convict Honor Camp	9.0	4.5	4.5	3,792	17,064
Operation of food service	64.0	36.0	28.0	2,448	68,544
Operation of power plant	12.0	6.0	6.0	3,576	21,456
Maintenance of employees	12.0	7.5	4.5	2,448	11,016
Total or Average	454.0	295.0	159.0	\$3,293	\$523,608

The anticipated savings in supplies and contractual services are itemized as follows:

Fuel	\$15,000
Electric Power	9,000
Cleaning supplies	2,000
Building materials and supplies	1,000
Power plant and elevator maintenance	500
Insurance	1,500
Total	\$29,000

Analysis of Staff Requirements

The present number of patients per staff member is shown below together with the estimated number of patients per staff member of the consolidated sanatorium.

Function	Ratio of Patients to Staff Members			Ratio for a Consolidated Sanatorium**
	Catawba	Present Ratio Blue Ridge	Combined*	
Administration	30.3	32.4	31.4	49.6
Care and Maintenance of Patients	1.6	1.5	1.6	2.2
Maintenance of Buildings and Grounds	19.3	23.5	21.4	41.0
Operation of Farm and Dairy	26.5	25.9	26.2	52.3
Convict Honor Camp (paid personnel only)	53.0	51.8	52.3	104.7
Operation of Food Service for Patients and Employees	5.9	9.3	7.4	13.1
Operation of Power Plant	35.3	43.2	39.3	78.5
Maintenance of Employees	35.3	43.2	39.3	62.8
Overall Average	1.0	1.0	1.0	1.6

* Calculated by dividing the present total number of patients by the present total number of staff members of the two sanatoria.

** Average of the staffing estimates of the two superintendents divided by present total number of patients.

As expected, the staff requirements for all functions except "care and maintenance of patients" would remain nearly the same regardless of the patient population. Consequently the number of patients per staff member in these functions is approximately doubled. The overall ratio for the sanatorium would increase from 1.0 patients per staff member to 1.6 patients.

The increased number of patients per staff member for "care and maintenance of patients" reflects the anticipated improvement in effectiveness anticipated for the nursing staff made possible by optimum use of available beds. It is possible, of course, that the sanatorium superintendents were optimistic in their analysis of additional nursing staff requirements. On the other hand, there appears to be a possibility of greater

savings than those contemplated in the staffing estimates of other functions. At Catawba, for example, the convicts are utilized for grounds keeping and a few other related activities. At Blue Ridge this type of personnel is employed in the kitchen but not on grounds. It seems quite likely therefore that either institution could effect significant labor savings by the use of convict labor to handle additional functions. Blue Ridge, for example, has one paid food service employee for each 9.3 patients compared to Catawba's 5.9. If the convict labor were employed at the latter institution, its ratio could undoubtedly be increased to that of Blue Ridge. As a matter of fact, such an improvement is equally practical under present conditions.

5. Comparative Desirability of the Two Sites for a Consolidated Sanatorium

General

Either Blue Ridge or Catawba can accommodate the combined patient loads of the two sanatoria. Modifications would be necessary at either sanatorium, but would require relatively modest capital outlays that would be fully offset within a few months by savings in operating costs. A decision as to which site is the more advantageous must be based, therefore, on several factors beside capacity. To assure that all factors are considered and given proper weight, they are discussed, pro and con, in the following section.

In Favor of Catawba

1. The facilities at Catawba are, in general, more modern and better adapted to patient care. A greater proportion of rooms are under the same roof and are suitable to ambulant or non-ambulant cases interchangeably. Although present dining facilities accommodate both patient and staff personnel, thus limiting patient service to those having negative tests, this disadvantage could be easily corrected.

Because of the smaller capacity of the main hospital buildings at Blue Ridge, it will be necessary to utilize the Trinkle and Wright buildings for some nonambulatory cases if the present proportion of such cases (about 80%) continues. The less serious cases may be selected for these buildings so that their transportation to and from the main hospital building will present only minor inconveniences and no danger to the patient. Nevertheless, this is a disadvantage. Although the Trinkle and Wright buildings are well constructed masonry buildings, their age will inevitably result in greater maintenance costs in the future.

Blue Ridge has an offsetting advantage in its excellent auditorium and somewhat better educational and recreational facilities.

2. Catawba has had less difficulty in obtaining registered nurses for its staff. This is a serious problem at Blue Ridge and there appears to be no easy solution in the near future.

In Favor of Blue Ridge

1. Blue Ridge benefits from its proximity to the Medical School of the University of Virginia at Charlottesville. Since the major surgery of both sanatoria is performed at the University of Virginia hospital the Blue Ridge location would be superior in

respect to the convenience and cost of surgical cases. In addition, a group of doctors and surgeons is required to visit Catawba from the University Hospital every two weeks for diagnostic evaluation of patients who have been given a provisional Catawba diagnosis indicating surgery. The inconvenience and cost of this visitation would be reduced at Blue Ridge. Although Catawba's distance from the University is a definite disadvantage, only six or seven cases a month are transferred to the University Hospital and the expense is not very high. However, Catawba patients on whom surgery has been performed are now transferred to Blue Ridge for convalescence before returning to Catawba. If Blue Ridge were discontinued, the convalescence would be necessary at University Hospital where per diem rates are high.

2. Sanatorium physicians would probably prefer the Blue Ridge location because of the educational and other opportunities available at the Medical School and Hospital of the University. Medical students are able to visit Blue Ridge for clinical instruction.
3. Blue Ridge is nearer the center of population of the State. Transportation is less of a problem for both patients and visitors.

CONCLUSIONS AND RECOMMENDATIONS

1. Based solely on utilization as a tuberculosis sanatorium, it appears that Catawba would have a moderate advantage over Blue Ridge. The advantage is not decisive, however, and the desirability of the discontinued sanatorium for other use may be a more important factor.

All possible practical utilizations of the two sanatoria plants were explored to assure selection of the one which would be most advantageous to the Commonwealth. Among the plans considered were the following:

Either Blue Ridge or Catawba could be used for this purpose. Although such utilization would increase the facilities for geriatric patients, it was determined that the operating cost in either sanatorium would be greater than if geriatric wings were added to existing mental hospitals. Furthermore, the sanatoria facilities are in many respects too elaborate for such a purpose and it was considered desirable to find an activity which would make fuller use of them.

As a General Hospital

Consideration was given to the possible donation or sale of either of the plants to a local community or non-profit private group for operation as a general hospital. It appeared, however, that the remote location of Catawba made this undesirable and there was not sufficient need for such a facility in the Charlottesville area.

As a Chronic Disease Hospital

This consideration was ruled out on the basis that the State does not now recognize the treatment of chronic diseases as a Commonwealth responsibility. Consideration of a revision to this concept does not come within the purview of this study by the Commission.

As an Institution Controlled by the University of Virginia

Considerable thought was given to the possibility of placing the Blue Ridge facility under the management of the Medical School of the University of Virginia. In doing this, however, it became

apparent that the use would be primarily for educational and research purposes. Such use would be expensive and the advantage largely of an educational nature. The Commission therefore concluded that it was not fully qualified nor authorized to judge the desirability of such a transfer.

2. After due consideration of the above and other alternative uses of the discontinued sanatorium, the Commission recommends that Blue Ridge be placed under the jurisdiction of the Department of Mental Hygiene and Hospitals for operation as an Intensive Treatment Center for the mentally ill. It is further recommended that the Center establish a close working relationship with the Medical School of the University of Virginia toward the end of obtaining the greatest possible benefit to both institutions in respect to the training of psychiatrists, psychologists, social workers, and psychiatric nurses.

The Commission weighed the alternative of providing such intensive treatment facilities as part of an expanded program of psychiatry under the Medical School of the University of Virginia. We concluded that this would not provide as immediate and pronounced benefits to the Commonwealth as would an Intensive Treatment Center. This conclusion, however, should not be construed to indicate that the Commission is necessarily opposed to the full development of the Psychiatric Department of either the Medical School of the University of Virginia or the Medical College of Virginia. Rather, it is of the opinion that these departments would be more appropriately fostered, developed, and justified by their respective parent institutions.

The Commission believes that the establishment of the proposed institution will effect important long term economies. Early diagnosis, intensive therapy, and thorough after-care such as would be furnished by the proposed institution would eliminate the need for many patients to be transferred to long-term or chronic treatment units of the State mental hospitals. There is abundant evidence that prompt and efficient psychiatric treatment by trained personnel may halt the progress of mental illness, cure the patient and return him to the community as a self-supporting, taxpaying individual instead of a tax liability.

The period of hospitalization under intensive treatment is usually short so that there is less social disruption for patients and their families. This is especially important to employers who may hold the patient's job for him with assurance that intensive treatment will return the patient in good health in a short time.

The maximum utilization of new treatment measures, under optimum conditions, foresees a high admission and discharge ratio which in the long run should reflect a need for fewer beds to be constructed. The relatively greater immediate cost of short term treatment is considerably more economical than the long term lower cost which extends over the years. Not only are there dollar savings but also an immeasurable relief in human misery and suffering.

It is recommended that three types of treatment be furnished. First, and most important, would be the intensive early treatment of incipient disorders. To a large extent the institution would act as a receiving hospital, although the majority of the patients would be expected to be cured within a few months and returned to normal life. Some patients would be referred to other mental hospitals for continued treatment. Conversely, a certain number of patients at the latter would be referred to the Center for special types of treatment.

A second function of the institution would be to provide rehabilitation services to the mentally ill. The facilities at Blue Ridge are well adapted to this service inasmuch as one of the buildings could be devoted exclusively to this type of treatment. Furnishing this service would relieve the increasing load of mentally ill persons upon the Woodrow Wilson Rehabilitation Center and would permit an effective concentration of this highly specialized type of treatment and patient education.

A third service would be "day-night" outpatient accommodations. This would encourage mildly ill persons to spend a day or a night at the institution for special treatment without disruption to their normal activities. It would also permit former patients to return, as required, for after-care treatment. Studies have shown that this type of service can reduce re-admissions to the mental hospitals to one-third that which would otherwise be expected. This service also could be confined entirely to one of the separate buildings at Blue Ridge.

There are too many factors bearing on mental illness to permit an accurate appraisal of the long-range economic effects resulting from the type of treatment envisaged at the proposed institution. It is possible, however, to draw some reasonable conclusions as to the economic justification of this proposal.

The Department of Mental Hygiene and Hospitals has made a tentative estimate that a population of approximately 400 patients can be accommodated and treated at an annual per capita gross cost of about \$2,750. This cost, approximately double that of the present non-intensive treatment in the mental hospitals, would amount to about \$1,100,000 per year. Experience indicates that payments from patients would amount to about 15% of this cost, or \$165,000 per year. The rehabilitation service would be about 80% supported by federal funds for the first five years, resulting in an estimated annual reimbursement of about \$100,000. The net operating cost of the institution to the Commonwealth would therefore be about \$835,000 per year. The actual *additional* cost to the Commonwealth would be less than this, however, since probably about 300 of the 400 average population would have to be accommodated in other State mental hospitals if the proposed institution were not available. The net cost per patient year in the other hospitals is about \$1,100 and the 300 patients would have therefore required an expenditure of about \$330,000. Deducting this amount from the net cost of \$835,000 indicates that the actual *additional* cost of the institution to the Commonwealth would be about \$505,000.

As previously mentioned, our studies have indicated that the consolidation of the tuberculosis sanatoria will effect savings in operating costs of approximately \$550,000 per year. Hence, based upon the foregoing assumption we can conclude that there will be no long range increase in State expenditures as the result of these recommendations.

Even though the costs should considerably exceed predictions, however, there seems little question that in the long run the intensive treatment center would have a beneficial economic effect.

There will be some necessary expenditures to permit Catawba to accommodate the populations of both sanatoria and to adapt Blue Ridge to the requirements of the proposed institution. The exact costs required to adapt both institutions to these uses can be determined only after a detailed study of requirements. Preliminary observations indicate that the total cost would not exceed \$150,000. To this must be added the expenses of transferring the Blue Ridge operation to Catawba.

The Commission is of the opinion that Blue Ridge is superior to Catawba as an intensive treatment center for a number of reasons. First, and perhaps most important, is its proximity to the University of Virginia. This should facilitate close cooperation in interchanging psychiatric internes, psychologists and similar personnel. It will permit additional training at the University for the personnel of the center and will provide excellent clinical opportunities for students of the Medical School.

Secondly, the facilities of Blue Ridge are more adapted to the types of treatment envisaged at the institution. Separate and desirable buildings are available for the three types of treatment.

A third advantage of the Blue Ridge location is that it is more convenient to a greater part of the State's population and will encourage the visitation of relatives and friends. This is highly beneficial in the types of treatment to be provided by the Center. The out-patient facilities will also be more conveniently located than would be the case if the institution were at Catawba.

The consolidation of the sanatoria activities at Catawba will require careful planning and considerable time. It will necessarily cause some unfortunate disruption in the personal lives of the staff at Blue Ridge. It is believed, however, that the majority of the personnel who do not wish to move to Catawba can be retrained by the Department of Mental Hygiene and Hospitals to perform similar services for the new institution.

In recommending the consolidation of the sanatoria at Catawba the Commission concluded that the facilities there are entirely adequate to provide the necessary services and treatment of tubercular patients and there is ample space available for construction of additional facilities in the event of a reversal of the downward trend in the incidence of tuberculosis.

3. It is the intention of the Commission that the Department of Mental Hygiene and Hospitals should take positive steps to assure that the Intensive Treatment Center operates permanently as a short term treatment institution. To this end it is recommended that periodic reports be issued showing the number of new admissions, the number of readmissions, the average length of stay and such other data as will permit an evaluation of its function. It further recommends that when treatment of any patient is necessary beyond a period of ninety days that the number of such extended treatments should be reported periodically together with the reasons for the extensions.

4. The Commission recommends that Section 37-125.1 of the Code of Virginia be amended to eliminate the present ceiling of \$125 per month for the care, treatment and maintenance of patients so that the full cost of the patient's care, treatment and maintenance may be recovered within his ability, or the ability of such person or persons legally liable for his support, as presently provided in Sections 37-125.1 and 37-125.5 of the Code of Virginia.

5. With relation to the care of aged and senile persons, the Commission reached the conclusion that there were no facilities which could provide equal care, including Medical and Nursing services, as economically as the hospitals of the Department of Mental Hygiene and Hospitals.

EXHIBIT A
ANALYSIS OF
PRESENT AND POTENTIAL BED SPACE UTILIZATION
CATAWBA SANATORIUM

	Reported Patient Capacity	Beds Actually Available	Beds Easily Made Available	Beds or Bed Spaces Available With Modifi- cation of Buildings
Main Infirmary (Building 15)				
Second Floor	51	51	55A	55
Third Floor	51	51	55	55
Fourth Floor	51	51	55	55
Fifth Floor	51	51	55	55
Sixth Floor		51B	55	55
Seventh Floor	51	51	55	55
Eighth Floor			18C	18
Total	255	306	348	348
Infirmary Annex (Building 17)				
First Floor	30	40D	40	60E
Second Floor	30	40	40	60
Total	60	80	80	120
Visitors Cottage (Building 25)				
First Floor		16F	
Grand Total	315	386	444	484

A Each floor of the infirmary has two solariums for the occasional use of patients. It appears that a single solarium would be adequate for this purpose. The second solarium could easily accommodate four patients. Communication and electrical outlets are already provided. The necessary furniture would be additional but could be transferred from the other sanatorium.

B The sixth floor of the main infirmary is fully equipped for the care of bed rest patients. This floor has never been required and has never been included in reports of patient capacity.

C The penthouse of the main infirmary was intended for domiciling members of the staff. Elevator service is provided only to the seventh floor. The penthouse could be used conveniently for ambulant patients.

D Each floor of the infirmary annex is fully equipped to accommodate 40 patients. Since the construction of the main infirmary this capacity has never been required. The capacity has been reported as 30 since that time.

E The infirmary annex has two long enclosed porches on each floor. These porches adjoin the bedrooms and are interchangeable as sleeping areas. Adding Venetian blinds, bedside lights, necessary additional furniture and probably other minor alterations will make it possible to locate 10 beds on each of the porches. It is roughly estimated that the total outlay to accommodate these beds would not exceed \$20,000.

F Building No. 25 was formerly used as an infirmary and can still be used for such purpose if it is cleaned thoroughly, painted, and some minor repair work accomplished. It should be used primarily for ambulant patients. Although the maximum number of patients which could be accommodated by the building would be somewhat less than optimum for economical nursing care, the additional operating cost would not be serious.

EXHIBIT B

ANALYSIS OF THE UTILIZATION OF EMPLOYEE QUARTERS
 KONTAKANITHI CATAWBA SANATORIUM

Building Number	Description of Housing Units*	Units Occupied 9-16-61	Units Available	Units Unoccupied
3	Male Dormitory (Negro) (10 triple rooms)	8	30	22
4	Female Dormitory (Negro) (6 double rooms)	5	12	7
5	Female Dormitory (Negro) (5 single rooms)	1	5	4
6	Employee Residence	1	1	0
7	Employee Residence	1	1	0
8	Employee Residence	1	1	0
9	Staff Apartments (4 four-room apartments)	4	4	0
10	Employee Residence	1	1	0
14	Employee Residence	1	1	0
15	Infirmary (9 single rooms in pent-house)**	2	9	7
18	Employee Residence	1	1	0
19	Employee Residence	1	1	0
20	Staff Apartments (6 two-room apartments)	6	6	0
21	Male Dormitory (White) (6 double rooms)	4	12	8
22	Male Dormitory (White) (barracks with 20 beds)	12	20	8
24	Staff Apartments	3	4	1
25	Visitors Cottage (16 single rooms)**	0	16	16
27	Nurses Home (1 Apartment; 31 single rooms)	8	32	24
28	Employee Residence	1	1	0
29	Nurses Home Annex (1 apartment; 42 single rooms)	24	43	19
30	Male Dormitory (White) (5 single rooms)	3	5	2
32	Employee Residence	1	1	0
33	Employee Residence	0	1	1
34	Employee Residence (2 flats)	2	2	0
36	Employee Residence	1	1	0
38	Employee Residence	1	1	0
39	Employee Residence	1	1	0
40	Employee Residence	1	1	0
	Total	95	214	119

* A housing unit is the accommodation provided for one employee.

** Maximum utilization of the infirmary would require these rooms for ambulatory patients.

EXHIBIT C
 ANALYSIS OF PRESENT
 AND POTENTIAL BED SPACE UTILIZATION
 BLUE RIDGE SANATORIUM

	Reported Patient Capacity	Beds Actually Available	Beds or Bed Spaces Available With Modi- fication of Buildings
Main Hospital			
First Floor	33	33	45C
Second Floor	35	35	47C
Third Floor	39	41A	53C
Total	107	109	145
West Wing			
First Floor	19	19	19
Second Floor	33	33	46D
Third Floor	33	33	33
Fourth Floor	36	38B	38
Fifth Floor	36	38B	38
Total	157	161	174
Trinkle			
First Floor	30	30	41E
Second Floor	30	30	41E
Total	60	60	82
Wright			
First Floor	30	30	42F
Second Floor	30	30	42F
Total	60	60	84
Grand Total	384	390	485

A Two additional beds can be made available by utilizing a solarium on the second floor of the Main Hospital Building.

B Two additional beds can be made available by utilizing a bedroom set aside for staff members, but seldom used for this purpose.

C Each of the three floors of the Main Hospital Building can have its capacity increased by 12 beds through utilization of existing enclosed porches.

D A former kitchen on the second floor of the West Wing can be converted to patient bedrooms. This would increase the capacity by 13 patients.

E The Trinkle Building capacity can be increased by utilizing the porch areas on each of the two floors. Each porch should accommodate 11 patients, making a total increase in capacity of 22.

F The Wright Building capacity can be increased by 24 through utilization of porch areas which will add 12 beds to each floor.

EXHIBIT D
ANALYSIS OF THE UTILIZATION OF EMPLOYEE QUARTERS
BLUE RIDGE SANATORIUM

Building Number	Description of Housing Units*	Units Occupied 9-8-61	Units Available	Units Unoccupied
3	Garrett Annex (Former culinary department) — Apartment	1	1	0
4	Garrett Building			
	Apartment	1	1	0
	Rooms	3	6	3
7	Wright Building — Rooms	3	6	3
8	Medical Staff Apartments	3	4	1
9A	Duplex Residence	1	1	0
9B	Duplex Residence	1	1	0
11	Single Residence	1	1	0
13A	Duplex Residence	1	1	0
13B	Duplex Residence	1	1	0
14	Single Residence	1	1	0
15	Women's Staff Dormitory —			
	Rooms	2	8	6
16	Staff Apartments	4	4	0
18	Davis Building (Former nurses home)			
	Apartments	2	2	0
	Rooms (17 single, 11 double)	25	39	14
19	New Nurses Home			
	Apartments	1	3	2
	Rooms (34 single, 21 double)...	22	76	54
20	Trinkle Building — Rooms	5	10	5
22A	Single Residence	1	1	0
22B	Single Residence	1	1	0
22C	Single Residence	1	1	0
22D	Single Residence	1	1	0
28	Dormitory (Negro)	7	8	1
29	Prisoners' Quarters	1	1	0
30	Farm Residence	1	1	0
35	Farm Residence	1	1	0
39	Farm Residence	1	1	0
40	Farm Residence	1	1	0
44	Residence	1	1	0
	Total	95	184	89

* A housing unit is the accommodation provided for one employee.

