

November 9, 2007

Prairie St. John's Specialty Psychiatric Hospital | Public Interest Review Application



Meeting a Need. *Setting the Standard.*

 PRAIRIE ST. JOHN'S\_Woodbury

NAMI Scorecard 2007: Minnesota gets 1 out of 3 for Inpatient Mental Health Bed Access

Minnesota Psychiatric Society:  
Minnesota Has 16.8 Mental Health Beds per 100,000 people,  
40% below the national average

	1999	2001	2005
Adult inpatient mental health beds	830	852	867
Pediatric inpatient mental health beds	132	126	114
Adult inpatient chemical dependency beds	298	386	111

Psychiatric patients board in the emergency room twice as long waiting for an inpatient bed than non-psychiatric patients.

Patients are commonly transferred as far away as Rochester or Fargo for inpatient services due to all psychiatric beds in the twin cities being occupied



**PRAIRIE ST. JOHN'S™**

Specialty Psychiatric Hospital  
Public Interest Review Application  
11/9/2007

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**Submitted to: Minnesota Department of Health**

**November 9, 2007**



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## I. Executive Summary

Prairie St. John's, a private, Catholic affiliated psychiatric healthcare organization, proposes to build a 144 inpatient bed specialty psychiatric healthcare center in Woodbury, Minnesota. Phase One includes 96 beds, with 48 more to be added in Phase Two after 5 years, for a total of 144 beds – approximately half for children and adolescents, half for adults.

The need for additional psychiatric beds in Minnesota is incontrovertible:

- Minnesota: 16.8 beds/100,000 population; National Average: 28.2 beds/100,000
- Psychiatric patients commonly wait days in Twin Cities Emergency Rooms for a hospital bed
- Twin Cities patients are routinely transferred to Duluth, Rochester, and Fargo and other non- metro locations for services due to no local bed availability
- Media sources include regular examples of the tragic consequences of inadequate access to care

The State's overall mental health system extends well beyond acute care of severe episodes and rightly promotes a vast array of preventive, supportive and rehabilitative strategies.

Prairie St. John's specializes, however, in those services logically integrated with acute inpatient care and continued stabilization, including partial hospital, intensive outpatient/day treatment, and outpatient clinics.

Prairie St. John's\_Woodbury's primary service area would be the Eastern Metropolitan area. However due to the statewide bed shortage, patients are also expected to come from other areas.

The primary operational impact on other healthcare facilities would be positive due to providing increased options for emergency departments to transfer patients.

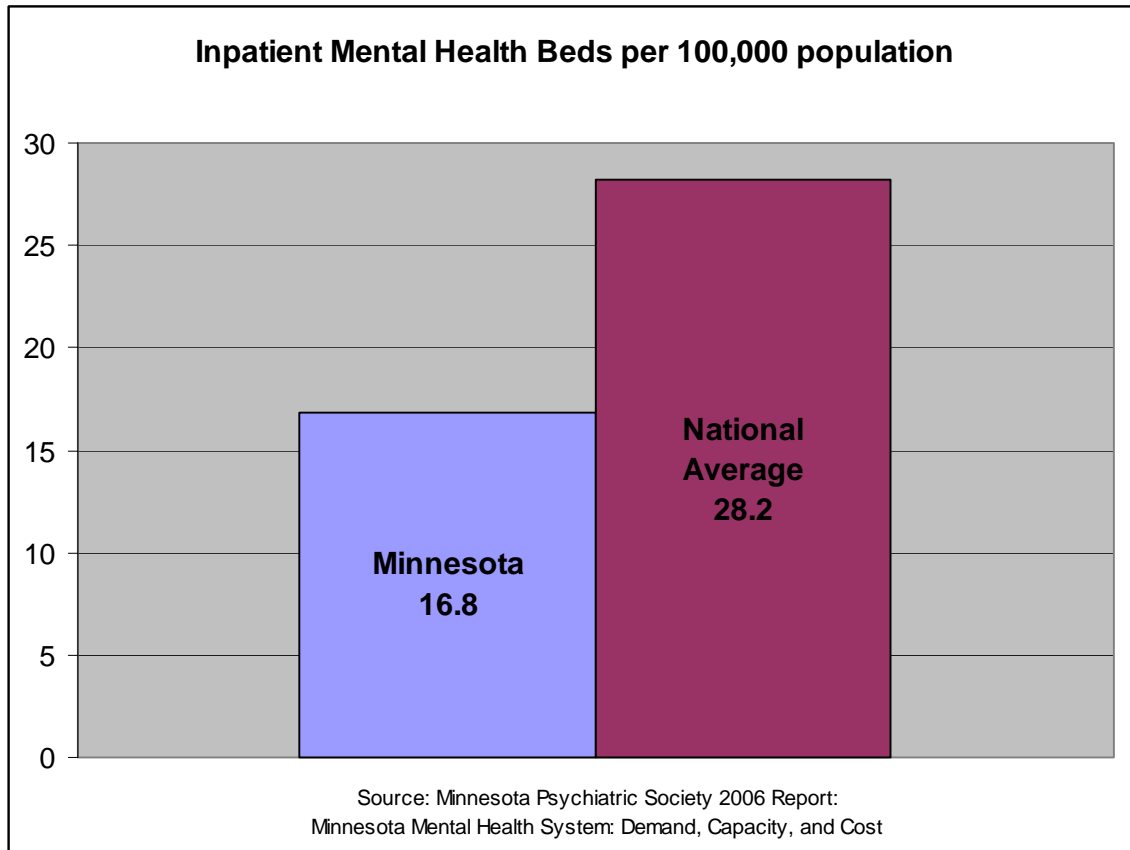
Prairie St. John's success in recruiting staff to provide services to its patients means that the providers needed to staff Prairie St. John's\_Woodbury will not come at the expense of local hospitals currently providing mental health services.



II. Widely Recognized Need

*“In 2005, Minnesota had 16.8 mental health beds per 100,000 people, far short of the national average of 28.2 beds per 100,000” Minnesota Mental Health System, Demand Capacity, and Cost 2006 Update, Minnesota Psychiatric Society, 2006.*

Figure 1



While Minnesota can claim to be a leader in integrated, community based mental healthcare delivery systems, this does not explain a psychiatric inpatient capacity at 60% of the national average. In fact, despite successes in some areas of its mental health system, Minnesota’s psychiatric hospital bed shortage has let the Minnesota Department of Human Services to comment “Minnesota has experienced a significant problem with access to inpatient psychiatric beds. Access is a problem that affects all age groups but, is especially problematic for children and adolescents due in part to a shortage of inpatient capacity.”<sup>1</sup>

<sup>1</sup> DHS website 11/7/07 “Hospital Bed Shortage”  
[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_000085](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000085)



How can this be the case in a State that prides itself on healthcare innovations? It is quite simply the predictable result of Minnesota’s unusually harsh psychiatric managed care environment during the 1990’s – leading even to legal actions against major insurers for denying payment for needed care<sup>2</sup> – along with the general economic disincentives that large medical systems face for expanding psychiatric services.

Another clear indicator of a bed shortage is occupancy rates. As can be seen in Figure 2 below, Chemical Dependency and Psychiatric beds have much higher occupancy rates than general medical specialties.

Figure 2

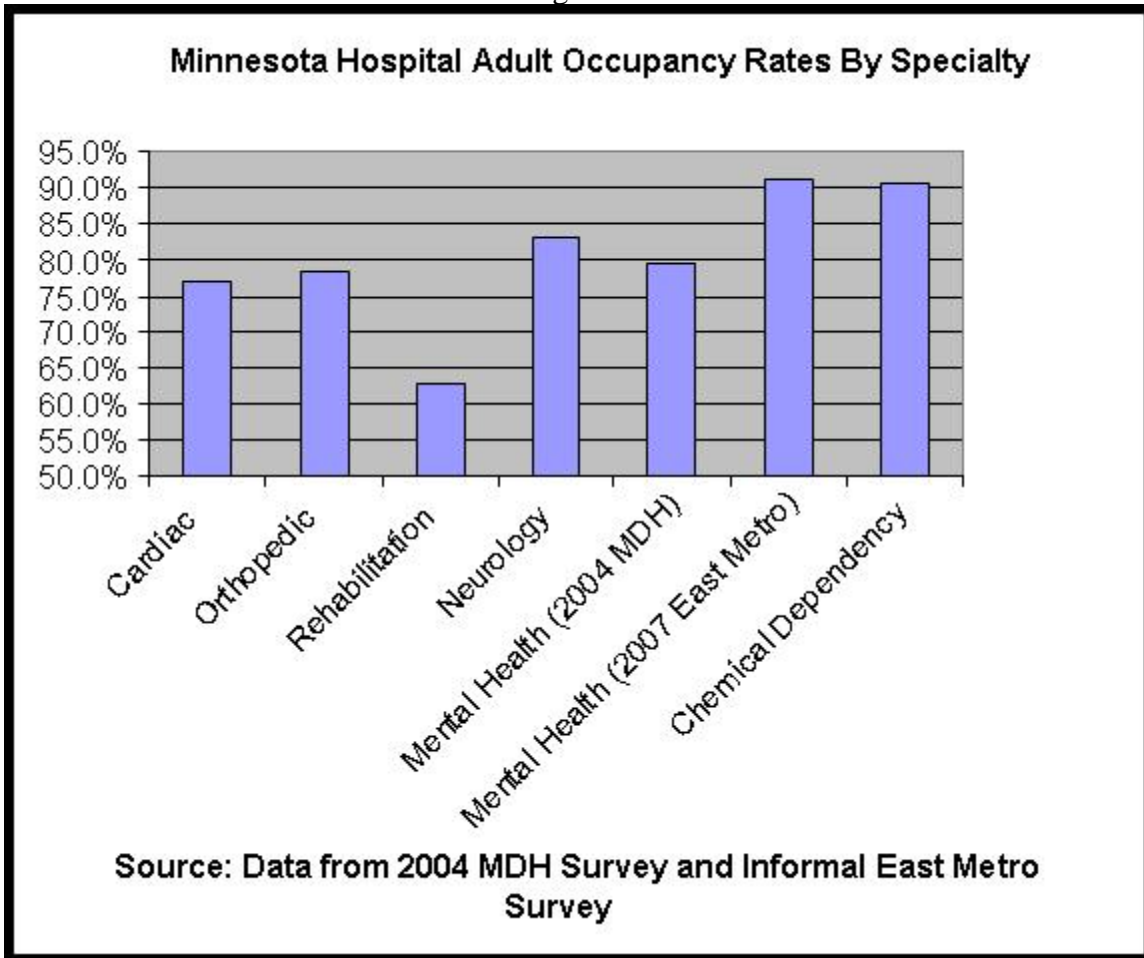


Figure 2 also shows that Psychiatric and Chemical Dependency beds currently operate above 90% occupancy. To reach average rates this high requires these units to be generally full. 100% occupancy is not possible for a variety of reasons including the

<sup>2</sup> Marcotty J, and Howatt G. “Who Pays When Treatment is Court-Ordered? Auditor’s Report Finds Insurers Shift Costs of Mental Health to State.” Minneapolis-St. Paul Star Tribune. February 10, 2001



fluctuating coordination of admissions and discharges, staffing constraints, or clinical situations, e.g., patients with a clinical need for a single room when only double rooms are available.

The lack of child & adolescent inpatient capacity has reached a crisis level. Pediatric beds in Minnesota have decreased 14% from 1999 to 2005. There are now only 114 inpatient pediatric mental health beds available in the state.<sup>3</sup> The result of this lack of capacity is inadequate care being provided to children and adolescents with often tragic results. In addition, parents, teachers, and mental health professionals tasked with treating young patients in need of inpatient mental health services often feel their child or patient is being ignored by the health care system. This leads to frustration, reduced morale and other problems. In cases where acute psychiatric care is needed as an intervention, pediatric patients can wait for days or even weeks for space in the appropriate treatment setting to become available, or be turned away because the bar has been set so high for entry into the behavioral health care system due to the lack of capacity.

The apparent sharp rise from 80% to over 90% occupancy rates in recent years is consistent with Minnesota Psychiatric Society and Minnesota Department of Health data showing the number of beds per 100,000 population has decreased from 19.1 in 2004 to 16.8 in 2006.

*a. Consequences of the psychiatric bed shortage*

- 72 hour emergency room stays awaiting an inpatient psychiatry opening are common in the metropolitan area with
  - Inadequate facilities for patients at risk
  - Minimal clinical intervention
  - Possible discharge to home without definitive care being given
- Emergency departments forced to add sections for boarding psychiatric patients in lieu of inpatient treatment
  - Detracting from other more appropriate space allocations
  - At times turning away trauma or acute medical emergencies because all rooms are full
  - Still not providing the care needed
- Tragic examples of suicides and homicides resulting from these ER triage pressures appear in the media<sup>4</sup>
- Patients are routinely transferred well beyond the metro area in order to receive stabilization

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<sup>3</sup> “2006 Minnesota Mental Health Update” Minnesota Psychiatric Society.

<sup>4</sup> “Take A Number: Getting one of Minnesota's inpatient psychiatric beds is still a waiting game.” Minnesota Medicine, January 2007.



- As far away as Duluth, Rochester, or Fargo, even Milwaukee and Winnipeg
- Ambulance rides for these trips approximate the cost of a hospitalization
- Care delivered so far from home limits needed family involvement and aftercare planning
  
- Metro area patients transferred to the small out-state Community Behavioral Health Hospitals
  - Displacing local patients for whom the services were developed
  
- Involuntary commitment holds become standard operating procedure in an attempt to force a response from the inpatient services, and to coerce patients to remain in obviously sub-optimal situations
  
- Default (and unavoidable) rationing of services
  - Demoralizes emergency room and psychiatric treatment providers alike causing
    - Distortion over time in practitioner thresholds for alarm and concern
    - Incentives for mental health professionals to avoid working in treatment settings where the need is greatest
  - Puts tremendous pressure on inpatient treatment providers to discharge patients out as soon as possible
    - Over time practice standards are distorted, which contributes to:
      - Calloused approach
      - Over-reliance on medication treatments
      - Lowered safety criteria for discharge

Minnesotans suffering from mental illness deserve a full range of treatment options. There are vast differences in severity and courses of psychiatric illnesses. From mild cases of depression, to the most severe bipolar states; from tragic cases of schizophrenia to mild forms of anxiety – there is no single treatment or treatment setting appropriate for all patients. Prairie St. John's believes that all validated approaches are useful when administered appropriately, and adequate capacity for all treatment options should exist to meet the needs of all patients. When options are as severely limited as they are now, care providers can begin to rationalize not providing needed care based on the difficulty of providing treatment, which can result in tragic consequences<sup>5</sup>.

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<sup>5</sup> Perhaps the most disturbing local example involved a young man who beheaded his stepmother hours after his father brought him into the emergency room where he was told there were no grounds to hold his son against his will.



*b. Why hasn't more already been done?*

*“In contrast to concerns about overinvestment in some types of services, there are also situations that may lead to underinvestment in capacity to deliver health care services. For example, certain types of health care services (such as inpatient mental health services) are widely believed to be unprofitable for hospitals; as a result, health care providers may be reluctant to add more capacity for these services even if there is a community need for them.”* Factors and Incentives Driving Investment in Medical Facilities, Minnesota Department of Health (2007).

Under a general hospital business model, highly reimbursed services such as cardiology or neurosurgery are inevitably preferred over lower reimbursed services such as Psychiatry. Attention to the bottom line naturally directs that greater capacity be focused where margins can be maximized. This creates a disincentive to prioritize capital investment in psychiatric services when returns can be 10-fold - or more - greater per dollar invested in other areas. Further, psychiatric service achievements are generally not considered as glamorous – or financially rewarding – among medical students as, for example, cardiac surgery, which discourages medical students from specializing in psychiatry.

Furthermore, it is taken as a given in most hospital board rooms that mental health services are “money losers.” In fact some of the apparently poor financial performance of psychiatric services within general hospitals is an artifact of accounting methods tailored to maximize credits under the Medicare and Medicaid programs, resulting in cost attributions to the psychiatry services that would otherwise be illogical.<sup>6</sup> Nonetheless, even when these attributions are factored out, psychiatry services offer less return on investment for a general hospital organization than nearly all alternatives. So there is a distinct conflict between community need and hospitals’ institutional interests in financial stability.

That hospitals are sensitive to community need is evidenced by the existence of the psychiatric inpatient resources that do exist. But the economic realities incline them to under-develop those services relative to the need.<sup>7</sup>

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<sup>6</sup> Reimbursement under Medicare and Medicaid is dependent on “administrative costs” attributable to the care of patients. This creates an incentive to earmark more administrative costs to services that have large numbers of Medicare and Medicaid patients.

<sup>7</sup> Metro hospitals have demonstrated a willingness to expand services to support their own Emergency Department flow of psychiatric patients, but none have the resources to expand capacity to make up for the overall community undersupply of psychiatric beds.



***c. Couldn't the 16-Bed Community Behavioral Health Hospitals Initiative Solve the Bed Shortage?***

Over the past few years, Minnesota has moved away from treating psychiatric patients in large regional treatment centers in favor of providing treatment in newly developed 16-bed Community Behavioral Health Hospitals dispersed throughout the state. Limiting capacity in these settings to 16 beds permits eligibility for certain Federal funds. Minnesota currently operates 10 CBHHs with a total bed capacity smaller than 160. However, in order to bring the State up to the national average of 28.2 beds per 100,000 people, Minnesota would need to open 35 additional CBHHs, a number far beyond current consideration<sup>8</sup>

Furthermore, Minnesotans are increasingly moving from dispersed rural settings to concentrated urban population centers.<sup>9</sup> While Prairie St. John's supports the State's effort to provide mental health services for the rural population with CBHHs, they will not meet all the needs of Minnesota's citizens. In highly concentrated population areas, economies of scale exist for larger psychiatric facilities providing care to larger numbers of patients. This approach also allows urban patients to be treated close to their own homes and support systems, rather than being transferred to a treatment center unfamiliar with the community resources available where the patient lives – a situation the CBHHs were supposed to prevent.

With a shortage of more than 500 beds statewide<sup>10</sup>, CBHHs will not address the entire problem and multiple approaches will be needed to address the diverse needs of psychiatric patients. Since Prairie St. John's is a private entity, allowing it to build a specialty psychiatric hospital will increase desperately needed inpatient bed capacity at no cost to the state. Prairie St. John's proposed facility will reduce pressure to divert scarce State funds into inpatient psychiatric care facilities, potentially freeing dollars for State investment in other needed programs.

***d. Are there enough psychiatrists?***

A seeming barrier to the addition of psychiatric beds in the State has been a shortage of psychiatrists to staff existing beds. Entire psychiatric units are at times unable to accept new patients because there is not a psychiatrist to treat patients on that unit. A study conducted by the Minnesota Psychiatric Society illustrates this shortage of psychiatrists in Minnesota: As of 2006, there were 33% fewer psychiatrists per capita in Minnesota than the national average. As noted above under "consequences of a bed shortage," this can become a vicious circle: the more rationed and haggard the inpatient setting becomes,

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<sup>8</sup> Extrapolation based on U.S. Census Data and 2006 Minnesota Mental Health System: Demand, Capacity, and Cost published by the MN Psychiatric Society

<sup>9</sup> 2000 U.S. Census Data

<sup>10</sup> Extrapolation based on U.S. Census Data and MDH Data



the less desirable it is for practitioners to work there, which further reduces morale, which harms patient care even more.

Prairie St. John's has been very successful at recruiting psychiatric physicians to its Fargo hospital, which serves patients from Eastern North Dakota and Northwestern Minnesota that have been designated as behavioral health provider shortage areas. Prairie St. John's employs national search firms, when needed, to recruit full time psychiatrists. It has historically employed more psychiatric physicians, especially in Child & Adolescent Psychiatry, than any other psychiatric facility in the upper Midwest. It has also successfully recruited Advanced Practice Psychiatric Nurses with prescribing privileges. Again, its singular focus on psychiatric treatment services creates an environment attractive to practitioners seeking to practice in a setting where they and the services they provide are valued.

Prairie St. John's became aware of the need for more Minnesota inpatient hospital beds due to the dramatically increasing numbers of Minnesota patients being admitted to its Fargo hospital. Our facility in Fargo receives 40% to 50% of its patients from Minnesota in any given month, of which up to 20% are from the 7 county metro area. Sending patients away from their community, support system, and family is the least optimal way to treat a patient suffering from a mental illness. Building a hospital in the Twin Cities area will allow patients that need inpatient services to receive that care in their own community. It is much easier to arrange for family visits, or to plan for discharge, when the patient will be discharged back to the community where the hospital is located. We fully support Minnesota's efforts to transition to community based services for the mentally ill, and we believe our hospital can provide much needed acute stabilization for patients who cannot safely participate in community based treatment

### **III. Organization Profile**

Prairie St. John's\_Woodbury will be an affiliate hospital of the Prairie St. John's psychiatric healthcare system, which started in Fargo 11 years ago. Founded by practicing psychiatrists with 26 inpatient child and adolescent psychiatry beds, it was the first specialty hospital licensed in the State of North Dakota. Prairie St. John's-Fargo has grown to a 91-bed hospital, treating psychiatric disorders and chemical dependencies<sup>11</sup>, with partial hospital, residential treatment and clinic facilities serving children, adolescents and adults. Prairie St. John's also operates treatment facilities in Moorhead, Minnetonka, and Woodbury, Minnesota.

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<sup>11</sup> In this proposal 'psychiatric disorders' and 'chemical dependencies' are referred to separately for emphasis, even though psychiatric disorders subsume chemical dependencies according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Similarly while the terms 'mental' or 'psychiatric' are used interchangeably, psychiatric disorders are generally understood to result from an interplay of biological, psychological and social factors (biopsychosocial).



A key to Prairie St. John's growth and effectiveness has been the commitment of its psychiatric physician founders to maintaining patient focused and community sensitive standards for clinical care. Prairie St. John's\_Woodbury's professional staff will replicate this exceptional approach by serving patients suffering from mental illness or chemical dependency with respect and dignity.

As a Catholic healthcare system, Prairie St. John's is a leader in patient-oriented mental health services, focused on healing the body and mind as a whole, spiritual ministry, and respect for patient dignity. Prairie St. John's philosophy of care is that a comprehensive treatment program must address the full range of our patients' needs, including the spiritual, as well as the psychological and physical aspects of our patients' mental health. Consistent with its Catholic affiliation, charity care constitutes a substantial portion of Prairie St. John's\_Fargo's services – 2,500 patient days of charity care per year is provided to patients unable to pay for needed services. This level of charity care – 12% of gross revenues – is among the highest of any hospital in the Upper Midwest. Prairie St. John's current programs are accredited, certified by, or members of, the following organizations:

- \* Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)
- \* Centers for Medicare and Medicaid Services (CMS)
- \* National Association of Psychiatric Health Systems (NAPHS)
- \* Catholic Healthcare Association (CHA)
- \* North Dakota Hospital Association (NDHA)
- \* Minnesota Hospital Association (MHA) (membership application completed)

While recognizing that a wide spectrum of mental health services are in short supply – supportive housing, case management, crisis intervention teams, etc. – Prairie St John's specializes in the continuum of care related to acute stabilization, comprehensive biopsychosocial diagnosis and related services. This continuum includes:

- Inpatient (24 hour) hospitalization for:
  - Severe symptoms that are potentially life threatening
  - Severe symptoms that have not responded to less intensive interventions or require a safe environment for definitive diagnostic re-evaluation or changing to alternative treatments
- Hospital Observation (up to 23 hours) to:
  - Establish rapid diagnosis and stabilization for outpatient care if feasible, or to
  - Establish persistent need for inpatient stabilization
- Partial Hospitalization Programs (5 hours per day, Monday – Friday) to:
  - Approximate the intensity of inpatient treatment when safety issues do not require 24 hour care
  - Intervene before inpatient care is required
  - Assist with transition from inpatient to outpatient care, often reducing the time spent inpatient.



- Day Treatment / Intensive Outpatient
  - 3 – 4 hours per day, 1 – 5 days per week
  - Longer term supportive care and re-integration
- Outpatient clinic
  - Standard outpatient therapies and evaluations including medication management

The hospital proposed will not bring the number of psychiatric beds in the Twin Cities up to the national per-capita average. It will not satisfy all of the unmet demand for services in the Twin Cities, nor will it address all the gaps in the overall mental health system. But it will be a significant and positive step forward in addressing one critical dimension of the area's overall mental healthcare system.

#### **IV. Project Description**

As part of Prairie St. John's commitment to acute psychiatric care, our Woodbury facility will include:

- outpatient clinics;
- intensive outpatient and partial hospital programs for both psychiatric disorders and chemical dependency;
- Inpatient beds described below.

The proposed Phase One inpatient capacity is 96 beds with an architectural design anticipating an eventual Phase Two expansion to a total of 144 beds. The Phase One licensed beds will be dedicated to the following psychiatric services (see Table 1):

- 14 beds for children with psychiatric disorders;
- 28 beds for adolescents with psychiatric disorders;
- 21 beds for adults with psychiatric disorders,;
- 12 beds for adults with chemical dependency; and
- 21 beds for adults with co-occurring chemical dependency and psychiatric disorders.



Table 1

Service	Beds
Inpatient Child	14
Inpatient Adolescent	28
Inpatient Adult	21
Inpatient Adult Co-Occurring (MICD)	21
Inpatient Adult Chemical Dependency	12
<b>Total Inpatient Beds (phase 1)</b>	<b>96</b>
Future Expansion Beds (phase 2)	48
<b>Total Inpatient Beds (phase 1 &amp; 2)</b>	<b>144</b>

The facility's design includes a capability to redistribute beds between units so that services can be enhanced or reduced to meet changing demands. The future expansion beds are not slotted for a particular specialty within psychiatry. They may be added to enlarge one of the initial services or to create entirely new units with different specialties (such as geriatric psychiatry, medical-psychiatric, or adolescent chemical dependency) depending on the evolving needs of the referring communities.

Phase One will begin as soon as possible. After legislative approval and review by Department of Health engineers, we will begin building immediately. We anticipate Phase One will take six to nine months to build. The decision to build Phase Two will be based on the Average Daily Census of phase one units. We project Phase One will have an Average Daily Census (ADC) of 75% of full occupancy within 6 - 9 months, with 4% increases in ADC yielding a 95% ADC in approximately 5 years, at which time Phase Two construction will begin.



## V. Site Description

See Exhibit 4 for preliminary site plan. The site for the hospital is one block south of Woodwinds Health Campus on Woodwinds Drive in Woodbury, MN. The building plans are for an aesthetically welcoming three-story facility nestled between wooded hills and scenic wetlands on 20 acres in Woodbury's newly established "Medical Development Zone." It will incorporate the latest thinking on health promotion in psychiatric facility design by capitalizing on the influence of nature and light in particular on mood along with anticipating the increased role of information technology both for medical records as well as for treatment augmentation. The design of the building reflects a focus on patient rights and patient respect. The site provides an excellent balance of serenity, ease of access for patients, and rapid access to emergency medical services. The close proximity to other attractive medical facilities, such as Woodwinds Hospital, will also help remove the stigma attached to psychiatric medical treatment.

## VI. Value to Society of Mental Health Treatment

- Treatment success rates for depression and anxiety range from 50-90%<sup>12</sup> These treatment response rates are higher than for angioplasty, a common procedure for cardiovascular disease<sup>13</sup>
- In a study of major occupational groups in the United States, depression was associated with larger numbers of work absences (more than 9 missed work days in 3 months) than any other conditions except cancer and cardiovascular problems.<sup>14</sup>
- A Yale University study of the impact of cost-containment measures on health service use and costs at a large corporation found that cost-containment strategies typical of managed care (increased deductibles and co-payments, prior authorization and utilization review procedures) resulted in a "highly significant and substantial 34% reduction" in outpatient service use per patient per year over three years, and a significant decline of 37.7% in total psychiatric costs per user. However, this decline in mental health service use was fully offset by their concurrent 36.6% increase in non-mental health service costs. The mental health users had a 21.9% increase in sick days as well<sup>15</sup>

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<sup>12</sup> multiple studies, Coalition for Fairness in Mental Illness Coverage Fact Sheet, National Association of Private Psychiatric Health Systems, 2000; also Governors' Blue Ribbon Commission on Mental Health 2000. Report of the Commission.

<sup>13</sup> American Psychiatric Association, Division of Government Relations, May 2002.

<sup>14</sup> Kouzis AC, Eaton WW. Emotional disability days: prevalence and predictors. *Am J Public Health* 84: 1304-1307, 1994.

<sup>15</sup> Rosenheck RA, Druss B, Stolar M, Leslie D, and Sledge W: Effect of declining health service use on employees of a large corporation. *Health Affairs* September/October, 192-203, 1999.



## VII. Primary Service Area

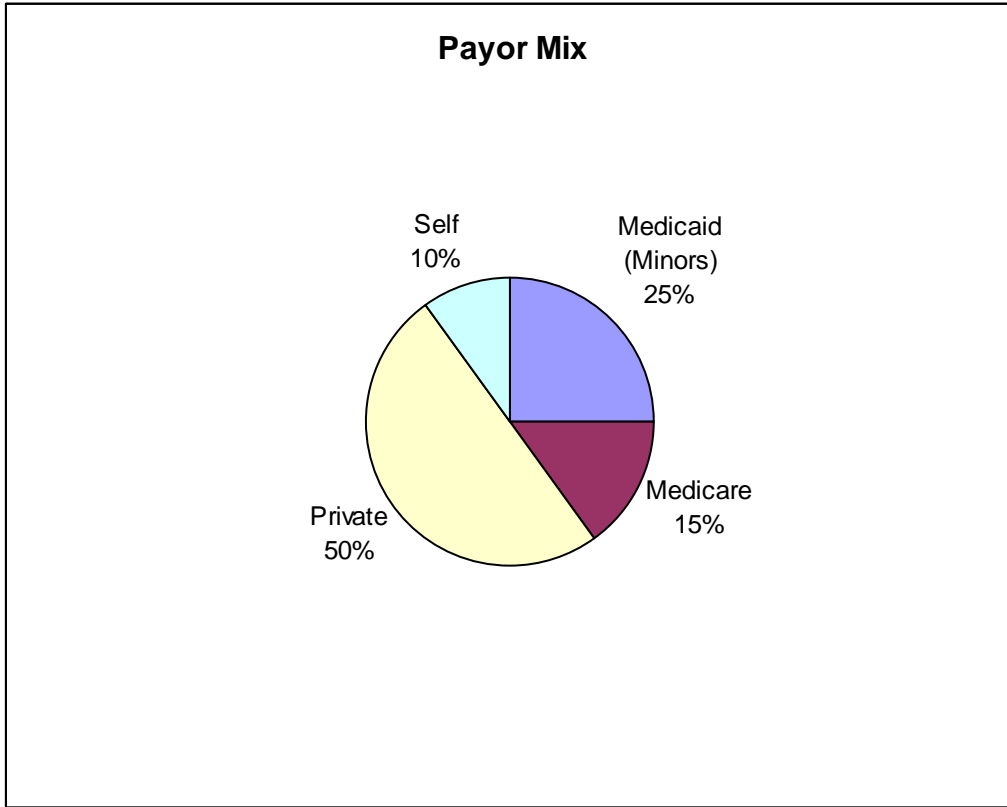
The primary service area for Prairie St. John's psychiatric hospital will be the East Twin Cities metro area. This area is much larger than the primary service area for a general hospital because psychiatric patients can be supervised and transported longer distances than trauma patients without risking the health or safety of the patient in the same way, and there are simply fewer alternative destinations. According to a recent Minnesota Psychiatric Society study, between April 2003 and January 2006, there were nearly 1,500 hospital to hospital transfers for over 1,300 mental health patients.

The East Metro Acute Care Work Group is currently studying the problems and bottlenecks in the mental health system in order to more efficiently utilize the services currently available. While we anticipate that at peak demand times, mental health patients may still wait in ERs for an available bed, the waits should be shorter and less frequent.

Prairie St. John's\_Woodbury will relieve other hospitals' emergency departments, so that they can focus their care on the patients they specialize in. Timely referral of a mental health patient out of an emergency department frees up space and staff to treat the critically injured or gravely ill. Psychiatric patients in the E.R. typically require 1:1 supervision due to the unpredictable nature of their mental states, unwillingness to seek treatment, and the availability of dangerous items such as syringes, scalpels, medications, etc... It is in the public interest to transfer mental health patients to the appropriate level of care as soon as possible to free up precious resources and to save finite healthcare dollars diverted to boarding psychiatric patients in the emergency department.



**VIII. Anticipated Payor Mix**



The anticipated payer mix for the proposed Woodbury facility is based on demographics for the Twin Cities area, coupled with Minnesota payor data from our Fargo facility. Nearly all Medicaid dollars come from the care of children and adolescents, due to the Institution for Mental Disease exception to Medicaid reimbursement for adults age 22 to 64.

The payor mix does not include over \$2,000,000 in charity care projected to be provided annually at the Woodbury facility. In Fiscal Year 2006, Prairie St. John’s performed 12% of its net revenues in the form of charity care. In Fiscal year 2005, it was 10%. We commit to provide the same amount of uncompensated care at the new hospital in Woodbury as well.

Note that federal regulations left over from “de-institutionalization” in the 1960’s deny Medicaid coverage for inpatient services for patients age 22 to 64 performed in stand alone psychiatric facilities. We will not be able to receive Medicaid reimbursement for these patients and therefore will not divert Medicaid dollars flowing to other community resources for adult Chronically Mentally Ill (CMI) patients.



## **IX. Benefit to the Community**

Prairie St John's mission is clear and known by its employees: Offering Hope and Healing to Those Suffering from Psychiatric Conditions and Addictions. As a specialty facility focused solely on mental health and chemical dependency services, the proposed Woodbury hospital will remove the opportunity cost disincentive that affects general hospitals' decisions on psychiatric services. Through the vertical integration of its services, Prairie St. John's will use its resources as efficiently as possible. This approach allows Prairie St. John's to offer high caliber and innovative services, while at the same time giving back to the community it serves through charitable works consonant with its Catholic roots.

The proposed hospital will benefit the community by providing full-spectrum patient focused mental health care. There is currently a lack of providers in all mental health care in the state, and our project will provide needed inpatient and outpatient services. Currently, patients overwhelm the resources available to care for them. This can create confusion and bottlenecks in the system due to different systems and agencies operating in different ways. Prairie St. Johns has a proven record of responding to community needs quickly and seamlessly by offering a variety of less-intensive treatment options to inpatient hospitalization. We strive to keep patients in the least restrictive treatment based on their needs. We also focus on gradual return to the community through step-down care. We can adapt our procedures to effectively and efficiently provide extremely high quality mental health care while working with outside agencies.

Prairie St. John's is affiliated with the Catholic Church and is actively involved in the communities it serves. As a health care organization guided by Catholic values, Prairie St. John's follows the Ethical and Religious Directives of the United States Conference of Catholic Bishops, which require:

- Promoting and Defending Human Dignity
- Attending to the Whole Person
- Caring for the Poor and Vulnerable
- Stewarding Resources
- Promoting the Common Good
- Acting on Behalf of Justice
- Abiding by the Ethical and Religious Directives of the Catholic Church

Prairie St. John's has been a leader in psychiatric care in North Dakota since its inception, and has roots in Minnesota with Partial Hospitalization Programs and/or clinics in Woodbury, Minnetonka, and Moorhead. Prairie St. Johns is actively involved with



early intervention programs in North Dakota. We will continue to lead the way with innovative psychiatric treatments and interventions in Minnesota as well. We are currently developing an early intervention program to help school counselors adequately assess students with mental health concerns. Once completed and made available to school districts, this program will help teachers and counselors recognize problems early on, so that students can receive the help they need before they become seriously ill.

## **X. Cost**

The estimated cost for the physical plant of the hospital is twenty two million dollars. This includes approximately \$3 million for land acquisition, \$17 million for design and construction and \$2 million for furnishings and equipment. We have reached an agreement with JLT Group for the purchase of the land, and we are working closely with RJ Ryan construction for the design and construction of the building. We plan to devote 30% of the square footage in this project to outpatient services including Clinic, PHP, and group therapy. However, the cost per square foot for these services is substantially less than inpatient programming due to differing building codes for “institutional use” (inpatient) and “business use” (outpatient). We estimate that roughly 85% of the cost for the project is directly related to the inpatient hospital and supporting services, while 15% is for the “medical office” space devoted to outpatient services.

## **XI. Market Analysis**

The market for inpatient psychiatric care is clouded by the severe shortage of beds available in the East metro. One Minnesota Psychiatric Society report from 2006 stated, “Because of the bed shortage in both acute care and community care across Minnesota, there has been an increasing trend in wait times, hospital diversions, and transfers.” This has a trickle-down effect on the rest of the psychiatric care facilities. It results in more acute patients being cared for by less-intense facilities, where staff and facilities are not equipped to deal with the needs of the patient. This causes a decreased ability to effectively treat psychiatric patients, which in turn leads to higher relapse rates and more mental health patients for the system to deal with.

There are currently three hospitals operating psychiatric inpatient beds in the East Twin Cities metro area: United Hospital, St. Josephs Hospital, and Regions Hospital. According to publicly available data, United’s Average Daily Census (ADC) is 89% of their operational capacity, and Regions’ ADC is 98% of their operational capacity. St. Josephs did not provide data to the workgroup by the time of this submission.

According to a 2006 Department of Health report, “Psychiatric patients board in the emergency room twice as long waiting for an inpatient bed than non-psychiatric patients” because of the shortage of inpatient beds available. To meet this need, Regions and United are both adding behavioral health beds from their banks of licensed, unstaffed beds, but their expansion will not satisfy the needs of the East Metro. Their expansion



will provide a measure of relief to their own emergency departments, but far more beds are needed in the East Metro than are currently being added. Between April 2003 and January 2006, Regions transferred patients from their Emergency Department to another facility's psychiatric unit 465 times. The 20 beds being added by Regions and United, while important and needed, will not meet the needs of the current patient load, and will not provide any expansion capacity for the growing population in the East Metro.

## **XII. Effect on Other Hospital Systems**

Psychiatric inpatient treatment is generally a very costly service for hospitals. Under a general hospital approach, mental health services are subsidized by more lucrative services such as cardiology and orthopedics. Only 25% of general hospitals currently provide inpatient psychiatric services. The hospitals that do offer psychiatric services do so for varying reasons, including legislative obligation, market necessity and education of new psychiatrists. We believe that with the current bed crisis, other hospitals will only feel relief with the addition of new psychiatric beds. Emergency departments will no longer need to board patients for the length of time they currently do, which is good news for the hospitals, their mental health and other emergency room patients as well as their families.

Prairie St. John's also utilizes four national employment search firms when hiring new employees. We recognize the shortage of mental health professionals in the State and we do not want to burden other health systems by raiding their staffs. That being said, we do realize that employees typically want to work in the community they live in to reduce commutes, and that Woodbury is a community where doctors, nurses, and therapists choose to live. We may see applicants wishing to work closer to where they live, but we have no intention of recruiting employees away from other health systems. We will also invite our employees from North Dakota to temporarily relocate to Minnesota in order to assure our hospital begins operations smoothly and with the same policies, procedures, and dedication of our Fargo facility. With the combination of these efforts, we do not believe the new hospital will disrupt the existing mental health delivery system. In the long term, Prairie St. John's aspires to help train and educate new mental health professionals to help grow the supply of needed mental health professionals.

## **XIII. Views of Affected Parties**

Prairie St. John's sent letters inviting comments from all hospital systems servicing the Twin Cities Metro area. Those systems are: Allina, Gillette, Health East, Park Nicollet, Fairview, HCMC, Lakeview, North Memorial, and Regions. To date, we have not received formal responses to the letters. Informal discussion with leadership from these entities confirms that it is a widely held perception that additional services are needed.

Some concern has been raised in discussions with us, particularly by those advocating for community based programs geared towards chronically and persistently mentally ill adults, that our project may divert needed funding. We believe this fear is based on a



misunderstanding of the economics involved, particularly as it relates to the different funding streams for mental health services delivered to different populations. The situation with Child & Adolescent beds is viewed as so desperate that funding concerns have not been raised: everyone agrees we need more pediatric behavioral health beds.