Minnesota Hospital Public Interest Review:

Proposal for a Specialty Psychiatric Hospital in Woodbury, Minnesota

Minnesota Department of Health

February, 2008

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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

February 28, 2008

The Honorable Linda Berglin
Chair, Health and Human Services
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Minnesota Senate
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The Honorable Thomas Huntley
Chair, Health Care and Human Services
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The Honorable John Marty
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The Honorable Paul Thissen
Chair, Health and Human Services
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To the Honorable Chairs:

Minnesota Statutes, Section 144.552 requires that any hospital seeking to increase its number of licensed beds or an organization seeking to obtain a hospital license must submit a plan to the Commissioner of Health. The Commissioner is required to review each plan submitted under Minnesota Statutes, Section 144.552 and issue a finding to the Legislature on whether the plan is in the public interest.

In November 2007, the MDH received a proposal from Prairie St. John's seeking approval for the construction of a new specialty psychiatric hospital in Woodbury, Minnesota. Prairie St. John's is seeking legislative approval for the construction of a hospital that would open with 96 beds and expand to 144 beds after five years.

The enclosed report on the public interest review conducted by MDH finds that the proposal is not in the public interest. Although it is clear that the mental health system in Minnesota does not always serve patients well, MDH reached its finding based on the following conclusions:

- Although Twin Cities patients travel outside the region more often for psychiatric and chemical dependency hospitalizations than for other types of care, over 90 percent are treated at local hospitals. In 2006, about 2,600 Twin Cities residents traveled to other regions for psychiatric and chemical dependency care.
- Existing Twin Cities hospitals have recently added or will be adding 32 psychiatric beds and 4 chemical dependency beds in 2008, serving as many as 1,400 additional Twin Cities residents each year.

- The 2007 Legislature enacted a comprehensive mental health initiative aimed at transforming Minnesota's mental health care system in ways that improve the availability, quality, and accountability of mental health care in the state. Investments in both child and adult crisis services were a significant part of this initiative.
- Research evidence suggests that with appropriate availability of intermediate resources, a significant number of hospitalizations could be avoided and hospital days that occur now due to the lack of resources such as intensive residential treatment beds could be reduced. A 2007 study of Twin Cities hospitals found that better availability of these intermediate resources could free up additional inpatient capacity to serve over 2,700 additional patients per year.
- The scale of the proposed project is large relative to any documented need for additional mental health beds in the Twin Cities. The proposed hospital would serve 3,400 to 5,100 patients per year. As noted above, in 2006 about 2,600 Twin Cities residents traveled to other parts of the state for care and new hospital capacity already being added is expected to serve 1,400 Twin Cities residents. Even if current strategies to reduce the need for hospitalization do not succeed, Prairie St. John's proposal seeks legislative approval to add capacity in an amount that is as much as three to four times the level of documented need for additional services in the Twin Cities.
- MDH also concluded that the proposal would likely have a negative financial impact on existing hospitals that provide psychiatric and chemical dependency services, would likely have a negative impact on existing hospitals' ability to maintain their workforces, and would have a negative impact on the state budget compared to adding capacity at an existing community hospital rather than a specialty facility.

If you have questions or concerns regarding this public interest review, please contact Julie Sonier at (651) 201-3561 or julie.sonier@state.mn.us .

Sincerely,

Sanne Magnan, M.D., Ph.D.
Commissioner
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Section 1: Hospital Public Interest Review Process

Since 1984, Minnesota law has prohibited the construction of new hospitals or expansion of bed capacity of existing hospitals without specific authorization from the Legislature (Minnesota Statutes, 144.551). As originally enacted, the law included a few specific exceptions to the moratorium on new hospital capacity; other exceptions have been added over time, and there are currently 23 exceptions to the moratorium that are listed in the statute. Many of these exceptions apply to specific facilities, but some define an exception that applies more broadly (for example, an exception that allows for the relocation of a hospital within five miles of its original site under some circumstances).

In 2004, the Legislature established a new process for reviewing proposals for exceptions to the hospital moratorium (Minnesota Statutes, 144.552). This "public interest review" process requires that hospitals planning to seek an exception to the moratorium law submit a plan to the Minnesota Department of Health (MDH). Under the law, MDH is required to review each plan and issue a finding on whether the plan is in the public interest. Specific factors that MDH is required to consider in the review include:

- Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;
- The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;
- How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;
- The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and
- The views of affected parties.

Finally, the law requires that the public interest review be completed within 90 days, but allows for a review time of up to six months in extenuating circumstances. Authority to approve any exception to the hospital moratorium continues to rest with the Legislature.

Section 2: Prairie St. John's Proposed Specialty Psychiatric Hospital

Prairie St. John's, a private Catholic-affiliated health care organization, headquartered in Fargo, North Dakota, is seeking a legislative exception to the Minnesota hospital construction moratorium to build a specialty psychiatric hospital in Woodbury, Minnesota. As detailed in Table 1, the initial phase of the project would include inpatient beds for children, adolescents and adults with psychiatric disorders, and additional beds for adults with chemical dependency or co-occurring psychiatric and chemical dependency diagnoses. In addition, Prairie St. John's plan seeks to add 48 more beds after five years, for a total inpatient capacity of 144 beds.

According to information provided by Prairie St. John's, after its first year of operation the hospital would be expected to operate at about 90 percent occupancy. It would have about 3,377 admissions, and a total of 31,537 inpatient days (for an average length of stay of 9.3 days). Using these same assumptions of 90 percent occupancy and 9.3 days for the average length of stay, MDH calculated that when the hospital expands to its proposed 144 bed full capacity, it would have 5,086 admissions and 47,304 total inpatient days per year.

Table 1
Proposed Beds by Type of Service

	Number of Beds	Percent Distribution
Psychiatric		
Children	14	14.6%
Adolescents	28	29.2%
Adults	21	21.9%
Chemical Dependency		
Adults	12	12.5%
Co-occurring Psychiatric/Chemical Dependency		
Adults	21	21.9%
Total, Phase 1	**96**	**100.0%**
Phase 2 Future Expansion	48	
Total, After Expansion	**144**	

Source: Prairie St. John's submission

The proposed site for the new Woodbury hospital is a 20-acre plot bounded by Lake Road, Pouliot Parkway, Woodwinds Drive, and Century Avenue, with the main entrance from Woodwinds Drive. The proposed site is one block south of the HealthEast Woodwinds Hospital and is part of Woodbury's Medical Development Zone. According to Prairie St. John's, the cost to build the facility will be approximately $22 million. Prairie St. John's intends to rely on private capital sources to finance construction of the hospital.

Prairie St. John's plan for operating the hospital does not include the ability to care for patients who are medically unstable. For example, patients whose needs would not be able to be met at the proposed hospital include patients with need for intravenous therapies, transfusions, or telemetry. The facility would be able to care for patients who are combative or violent, as long as they do not need a prison level of security.

The hospital would not operate a general medical emergency department, but would staff a Needs Assessment department to admit patients to the hospital 24 hours a day, 7 days per week. The hospital would be required by federal law to provide emergency stabilizing treatment (within its limited capabilities) to patients regardless of their ability to pay.

Under federal law, Prairie St. John's Woodbury hospital would be considered an "Institution for Mental Disease" (IMD).[1] Generally, federal law prohibits Medicaid reimbursement for care provided to individuals between the ages of 21 and 64 at IMDs. Prairie St. John's application for public interest review initially assumed that the IMD exclusion would preclude them from accepting Medicaid patients between the ages of 21 and 64. However, the Minnesota Department of Human Services has clarified that the federal IMD exclusion only applies to Medicaid beneficiaries in Minnesota who are enrolled in the fee-for-service program (in other words, it does not apply to Medicaid beneficiaries who are enrolled in managed care plans). Furthermore, the state pays for IMD services to these Medicaid beneficiaries through a 100 percent state-funded "Program IM." Given this clarification, Prairie St. John's has committed to accepting patients from all payment sources at the proposed hospital. However, care for these fee-for-service Medicaid beneficiaries at Prairie St. John's would cost the state twice as much as it would at

[1] An institution for mental diseases is defined as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services." (42 U.S.C. 1396d(i))

other hospitals that are not IMDs, due to the loss of federal Medicaid matching funds. Minnesota loses federal matching funds for all of the care provided to individuals in Program IM, not just for mental health care.

Section 3: Evaluation of Prairie St. John's Proposal in Relation to Statutory Review Criteria

This section of the public interest review evaluates the proposal to build a psychiatric hospital in Woodbury using each of the five factors specified by Minnesota Statutes, §144.552 .

Factor 1: Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services

The primary source of information that Prairie St. John's has used to justify the need for additional inpatient mental health beds in Minnesota is a comparison of the number of inpatient mental health beds per 100,000 population in Minnesota (16.8) compared to the national average (28.2). The original source of this data is the American Hospital Association's (AHA's) annual survey, and these figures comparing Minnesota and U.S. inpatient mental health capacity have been cited by several recent reports and studies of hospital capacity and mental health care in Minnesota.

Using the AHA survey data to compare Minnesota and national capacity for inpatient hospital services is problematic for several reasons. First, the survey is voluntary and a sizeable percentage of hospitals (about one third) do not participate. Second, for some hospitals that do participate in the survey the published data contain some significant differences from what they have reported to MDH about their capacity. Third, even if the data were complete and accurate it is not clear that Minnesota *needs* the same level of inpatient mental health capacity as the national average.

MDH's analysis of whether the new hospital is needed to provide timely access to inpatient psychiatric and chemical dependency services considers several issues:

- **Current inpatient capacity and utilization:** What is current inpatient capacity for psychiatric and chemical dependency services in Minnesota and how does service availability vary by age group? How have capacity and utilization of services changed over the past several years? What evidence is there of a shortage of capacity – for example, do patients travel longer distances for psychiatric and chemical dependency care than they do for other services?

- **If new beds are needed, is the proposed facility the best way to meet this need:** How does the mix of services that is proposed to be provided at the new hospital compare to the services that are needed by psychiatric and chemical dependency patients in Minnesota?

- **Are there alternatives to adding new beds to the system that would serve patients better:** Currently, many patients stay longer than needed in the hospital because of a lack of appropriate services that are needed once they leave the hospital. If inpatient mental health capacity is often full, is adding more beds the solution, or would enhancing other types of services free up inpatient capacity to serve additional patients?

Current inpatient capacity and utilization: To accurately determine the current capacity for inpatient behavioral health services, MDH collected information by telephone from every hospital in Minnesota that provides psychiatric or chemical dependency services in a specialized unit.

Table 2 provides summary information on the numbers of psychiatric and chemical dependency beds in Minnesota by type of facility. There are currently 1,458 hospital beds in psychiatric units and 533 chemical dependency beds. About 74 percent of psychiatric beds and 25 percent of chemical dependency beds are in community hospitals, with the remainder in state operated facilities. About 6 percent of the beds in psychiatric units and 22 percent of chemical dependency beds are not currently being staffed for reasons described in more detail later in this section. Table 1 in Appendix 1 provides detailed information on the number of psychiatric and chemical dependency beds by hospital.

Table 2
Inpatient Capacity for Psychiatric and Chemical Dependency Care, 2008

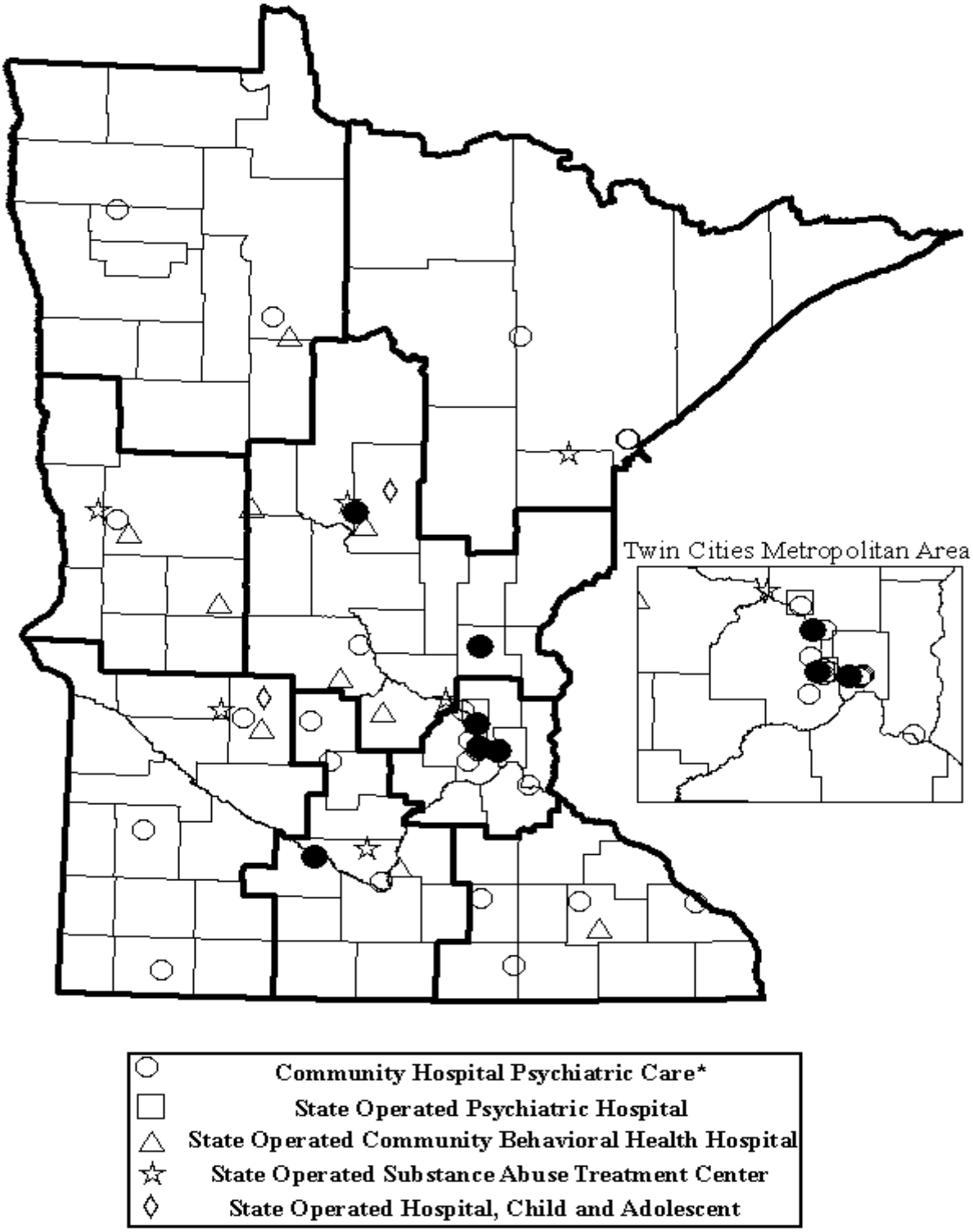
	Psychiatric Care		Chemical Dependency	
	Number of Beds	Currently Staffed	Number of Beds	Currently Staffed
Community Hospitals	1,086	1,042	132	132
State Operated Services:				
Anoka-Metro Regional Treatment Center	175	175	0	0
Community Behavioral Health Hospitals	160	122	0	0
Child and Adolescent Behavioral Health Services	37	26	0	0
Community Addiction Recovery Enterprise			401	283
Total	**1,458**	**1,365**	**533**	**415**
Percent Distribution:				
Community Hospitals	74.5%	76.3%	24.8%	31.8%
State Operated Services:				
Anoka-Metro Regional Treatment Center	12.0%	12.8%	0.0%	0.0%
Community Behavioral Health Hospitals	11.0%	8.9%	0.0%	0.0%
Child and Adolescent Behavioral Health Services	2.5%	1.9%	0.0%	0.0%
Community Addiction Recovery Enterprise	0.0%	0.0%	75.2%	68.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: MDH, telephone survey of hospitals with a psychiatric or chemical dependency unit; Minnesota Department of Human Services

The distribution of beds for psychiatry and chemical dependency care across Minnesota is shown in Figure 1 and Table 3. Existing capacity is concentrated in the Twin Cities area: for example, six Twin Cities hospitals operate over 50 percent of the total psychiatric beds. While the Twin Cities region accounts for just over half (51 percent) of all hospital beds in Minnesota, it accounts for about 61 percent of the psychiatric beds. For several Twin Cities hospitals that operate psychiatric or chemical dependency units, these services represent a large share of their business. Several Twin Cities hospitals that operate dedicated psychiatric and/or chemical dependency units – St. Joseph's Hospital, University of Minnesota Medical Center – Fairview, Regions Hospital, and Hennepin County Medical Center – reported that psychiatric and chemical dependency accounted for over 20 percent of total inpatient days in 2006.[2] Notably, the state as a whole has 25.8 psychiatric beds per 100,000 population, and the Twin Cities metropolitan region has 29.4 beds per 100,000. These figures are very close to the national averages that Prairie St. John's used from the AHA survey, but the large differences between this analysis and the AHA data also likely indicate that the AHA survey data are not a reliable source of information on either state or national capacity.

[2] Data from MDH, Health Care Cost Information System.

Figure 1
Inpatient Psychiatric and Chemical Dependency Services



* A filled circle indicates that the hospital also has a chemical dependency unit

Table 3
Distribution of Psychiatric and Chemical Dependency Beds by Region

	Number of Staffed Beds		Distribution of Beds		Beds per 100,000 Population	
	2004	2008	2004	2008	2004	2008
Psychiatry						
Twin Cities Metro	817	837	53.4%	61.3%	29.5	29.4
Central	177	114	11.6%	8.4%	26.1	15.7
Northeast	111	107	7.3%	7.8%	34.4	33.7
Northwest	24	30	1.6%	2.2%	12.1	15.0
South Central	81	54	5.3%	4.0%	28.3	18.6
Southeast	107	117	7.0%	8.6%	22.3	23.8
Southwest	149	68	9.7%	5.0%	66.0	30.5
West Central	64	38	4.2%	2.8%	34.7	20.2
Total	**1,530**	**1,365**	**100.0%**	**100.0%**	**29.7**	**25.8**
Chemical Dependency						
Twin Cities Metro	145	139	31.3%	33.5%	5.2	4.9
Central	107	79	23.1%	19.0%	15.8	10.9
Northeast	40	40	8.6%	9.6%	12.4	12.6
Northwest	0	0	0.0%	0.0%	0.0	0.0
South Central	44	46	9.5%	11.1%	15.4	15.8
Southeast	0	0	0.0%	0.0%	0.0	0.0
Southwest	51	51	11.0%	12.3%	22.6	22.9
West Central	77	60	16.6%	14.5%	41.8	31.8
Total	**464**	**415**	**100.0%**	**100.0%**	**9.0**	**7.9**

Includes both community and state operated hospitals.

Sources: MDH, 2004 and 2008 hospital surveys; Minnesota Department of Human Services; population estimates from the Minnesota State Demographic Center

Several Twin Cities hospitals have recently added or are in the process of adding behavioral health beds. Regions Hospital added 16 psychiatric beds, Hennepin County Medical Center will add 12 beds and St. Joseph's Hospital anticipates adding 4 beds to its psychiatric care unit and 4 to its chemical dependency unit in 2008 (these figures are included in Table 3). However, some hospitals report that they are not currently operating all of their psychiatric beds, for a variety of reasons including staffing shortages.

Table 4 provides information on Minnesota's current capacity for psychiatric and chemical dependency care by age group[3] and region of the state. In total, there are currently 157 psychiatric beds for children and adolescents. Only three community hospitals (Abbott Northwestern, Mayo Clinic's specialty psychiatric hospital, University of Minnesota Medical Center – Fairview) provide dedicated psychiatric beds for children; in addition to these hospitals, three others (Miller-Dwan Medical Center, St. Cloud Hospital, and United Hospital) have dedicated units for adolescents. There are also currently two state-operated facilities for the psychiatric treatment of children and adolescents, in Brainerd and Willmar; the Minnesota Department of Human Services has recently announced that it will consolidate these services at one location (Willmar) with 26 beds.

[3] It is difficult to group beds by age category with much precision, since hospitals use varying definitions of child, adolescent, and adult.

Table 4
Inpatient Capacity for Psychiatric and Chemical Dependency Care, by Age and Region

	Total Staffed Beds	Child	Adolescent	Combined Child/ Adolescent	Adult	Geriatric	Not Designated By Age
Psychiatry							
Twin Cities							
Metro	837	15	52	24	690	56	0
Central	114	0	8	0	78	0	28
Northeast	107	0	16	0	59	0	32
Northwest	30	0	0	0	8	12	10
South Central	54	0	0	0	24	8	22
Southeast	117	0	0	16	59	14	28
Southwest	68	26	0	0	42	0	0
West Central	38	0	0	0	38	0	0
Total	**1,365**	**41**	**76**	**40**	**998**	**90**	**120**
Chemical Dependency							
Twin Cities							
Metro	139	0	27	0	112	0	0
Central	79	0	16	0	56	0	7
Northeast	40	0	0	0	40	0	0
Northwest	0	0	0	0	0	0	0
South Central	46	0	0	0	46	0	0
Southeast	0	0	0	0	0	0	0
Southwest	51	0	0	0	51	0	0
West Central	60	0	14	0	46	0	0
Total	**415**	**0**	**57**	**0**	**351**	**0**	**7**

Includes both community and state operated hospitals. Includes capacity being added by hospitals in 2008 and planned consolidation of state-operated facilities.

Source: MDH, telephone survey of hospitals with a psychiatric or chemical dependency unit; Minnesota Department of Human Services

Prairie St. John's proposal would expand the existing capacity for inpatient child and adolescent psychiatry by 27 percent statewide and 46 percent in the Twin Cities, as shown in Table 5. For adults, the proposal represents about a 4 percent increase in statewide capacity for psychiatry and chemical dependency, and 6 percent in the Twin Cities.

Utilization trends: Between 2001 and 2006, the number of inpatient days for psychiatric care at Minnesota hospitals (community hospitals and state operated facilities) declined by about 16 percent, even though the number of admissions increased by 4 percent (see Table 6). During the same period, the number of reported chemical dependency admissions declined by 20 percent, but the total number of patient days increased by 4 percent.

Table 5
Proposed Increase in Inpatient Capacity, by Age Group

	Current Number of Beds /1		Proposed New Beds	Percent Increase	
	Twin Cities	Statewide		Twin Cities	Statewide
Children and Adolescents:					
Psychiatric care	91	157	42	46.2%	26.8%
Adults:					
Psychiatric care	746	1,088	21	2.8%	1.9%
Chemical dependency	112	351	12	10.7%	3.4%
Combined	**858**	**1,439**	**54***	**6.3%**	**3.8%**
Total /2					
Psychiatric care	837	1,365	63	7.5%	4.6%
Chemical dependency	139	415	12	8.6%	2.9%
Combined	**976**	**1,780**	**96***	**9.8%**	**5.4%**

/1 Number of staffed beds
/2 Includes beds not designated by age.

*Includes beds designated for co-occurring psychiatric chemical dependency.
Includes both community and state operated hospitals.

Source: MDH, telephone survey of hospitals with a psychiatric or chemical dependency unit; Minnesota Department of Human Services; Prairie St. John's submission.

Table 6
Trend in Utilization of Inpatient Psychiatric and Chemical Dependency Services at Minnesota Hospitals

	2001	2006	Percent Change, 2001 to 2006	Utilization per 1,000 population 2001	2006
Psychiatric Care*					
Admissions	33,496	34,982	4.4%	6.7	6.7
Patient Days	492,325	413,869	-15.9%	98.9	79.1
Average Length of Stay	14.7	11.8	-19.5%		
Chemical Dependency Care					
Admissions	8,163	6,504	-20.3%	1.6	1.2
Patient Days	102,193	106,262	4.0%	20.5	20.3
Average Length of Stay	12.5	16.3	30.5%		
Total Hospital Admissions					
Admissions	577,211	616,091	6.7%	116.0	117.8
Patient Days	2,824,272	2,803,952	-0.7%	567.4	536.0
Average Length of Stay	4.9	4.6	-7.0%		

*Includes a small number of chemical dependency admissions at state facilities.
Includes both community and state operated hospitals.

Sources: MDH, Health Care Cost Information System; Minnesota Department of Human Services; Minnesota State Demographic Center

Travel patterns: As shown in Table 7, Minnesota residents experienced about 35,000 hospitalizations for psychiatric care and nearly 10,000 hospitalizations for chemical dependency in 2006. The numbers for psychiatric care and chemical dependency in Table 7 differ from Table 6, because Table 6 describes Minnesota hospitals (including treatment of patients from out of state), while Table 7 describes care for Minnesota residents (including care received out-of-state).

Although psychiatric and chemical dependency care accounted for only about 7.2 percent of the total number of hospitalizations, together they accounted for about 13 percent of inpatient days at community hospitals and 20 percent of all inpatient days (community hospitals and state operated facilities combined). About 93 percent of psychiatric admissions and 80 percent of chemical dependency admissions occurred at community hospitals; because lengths of stay at state operated facilities are much longer; however, community hospitals provided about 66 percent and 38 percent of total days of care for psychiatric and chemical dependency patients, respectively.

Table 7

Psychiatric and Chemical Dependency Hospitalizations of Minnesota Residents, 2006

	Number of Hospitalizations	Percent	Number of Patient Days	Percent	Average Length of Stay (Number of Days)
Community Hospitals					
Psychiatric Care	32,945	5.3%	267,594	11.1%	8.1
Chemical Dependency Care	7,837	1.3%	44,636	1.8%	5.7
Other Medical Care	579,412	93.4%	2,104,337	87.1%	3.6
Total	**620,194**	**100.0%**	**2,416,567**	**100.0%**	**3.9**
State Operated Services					
Psychiatric Care	2,445	55.2%	133,525	65.5%	57.5
Chemical Dependency Care	1,987	44.8%	70,306	34.5%	36.9
Total	**4,432**	**100.0%**	**203,831**	**100.0%**	**48.2**
All Facilities					
Psychiatric Care	35,390	5.7%	401,119	15.3%	11.5
Chemical Dependency	9,824	1.6%	114,942	4.4%	12.0
Other Medical Care	579,412	93.4%	2,104,337	80.3%	3.6
Total	**624,626**	**100.7%**	**2,620,398**	**100.0%**	**4.2**

Sources: MDH analysis of hospital discharge data (includes Minnesota residents hospitalized in neighboring states, except Wisconsin) and data from the Minnesota Department of Human Services. Psychiatric care for State Operated Services includes a small number of chemical dependency admissions.

Most of the time, Minnesota residents receive hospital care in the same region of the state where they live. Residents of some parts of the state are more likely to travel outside their own region for care than others, as shown in Figure 2. In general, Minnesotans are more likely to travel outside of their own region for psychiatric and chemical dependency hospital care than for other types of care. For example, Twin Cities residents are hospitalized in their own region about 90 percent of the time for psychiatric and chemical dependency care, compared to 97 percent of the time for other types of care.

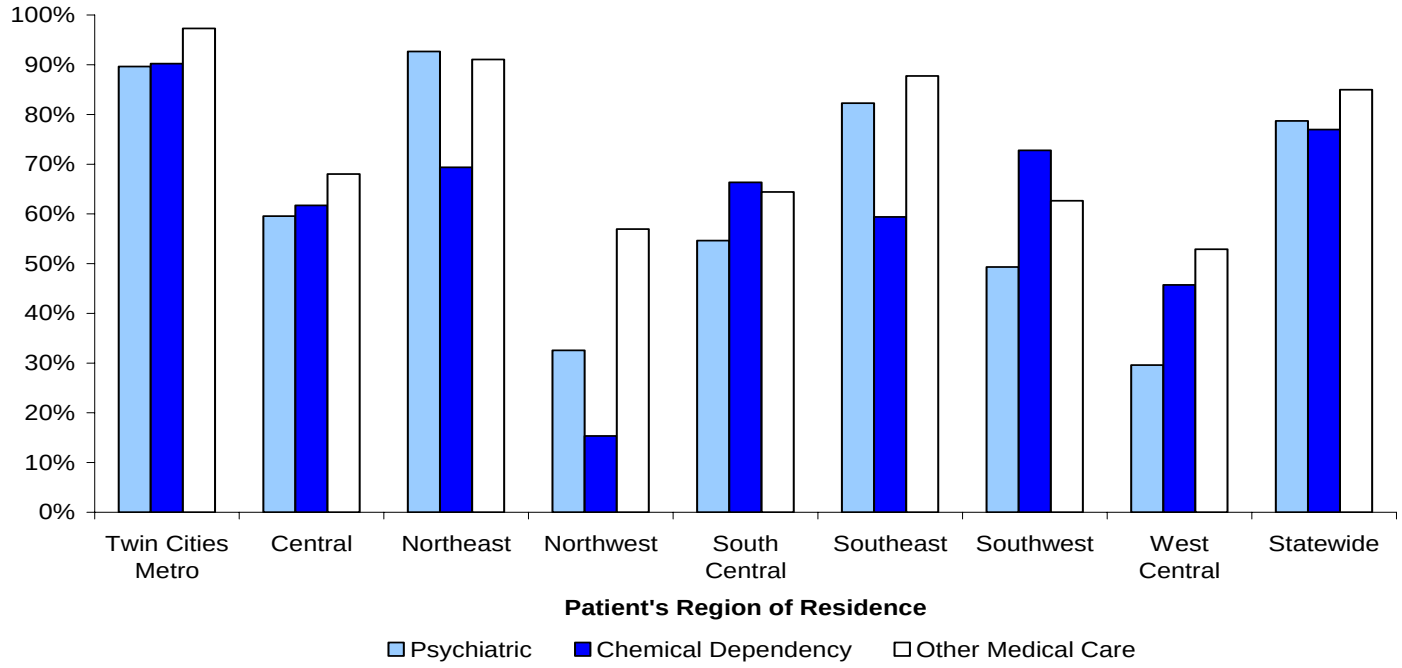
Twin Cities hospitals are also an important source of psychiatric and chemical dependency care to patients from across Minnesota and from other states. In 2006, about 11 percent of psychiatric admissions (nearly 2,000 total) at

Twin Cities facilities and 10 percent of chemical dependency admissions (560 total) were patients from outside of the Twin Cities region.

The fact that patients travel outside of their own region more often for psychiatric and chemical dependency care than for other types of care could be viewed as one indicator of a shortage of capacity for psychiatric and chemical dependency care.[4] However, it does not appear that the main reason why Twin Cities residents travel to receive psychiatric and chemical dependency care is insufficient capacity for these services in the Twin Cities: in 2006, the number of days of inpatient care at *Twin Cities hospitals* (all patients, regardless of where they live) exceeded the total number of days of inpatient care provided to *Twin Cities residents* (regardless of where these patients were hospitalized). This pattern is illustrated for all regions of the state in Figure 3. In this chart, a number higher than 1 means that hospitals in the region provide more days of inpatient care than residents of the region receive; a number lower than 1 indicates that residents of the region use more care than the total number of days provided by hospitals in the region. In 2006, the number of days of care provided by Twin Cities hospitals exceeded the number of days provided to Twin Cities residents by three percent and six percent for psychiatric and chemical dependency care, respectively. The largest mismatches between needed care and care available in a region appear to be in the rural western half of the state (where residents commonly travel to urban areas in North and South Dakota for all care, not just mental health care). Patients who live in the Central region of the state travel to the Twin Cities about 30 percent of the time to receive psychiatric care, 24 percent of the time for chemical dependency care, and 30 percent of the time for other types of care.

Figure 2

Percent of Minnesotans Receiving Hospital Care in Their Own Region

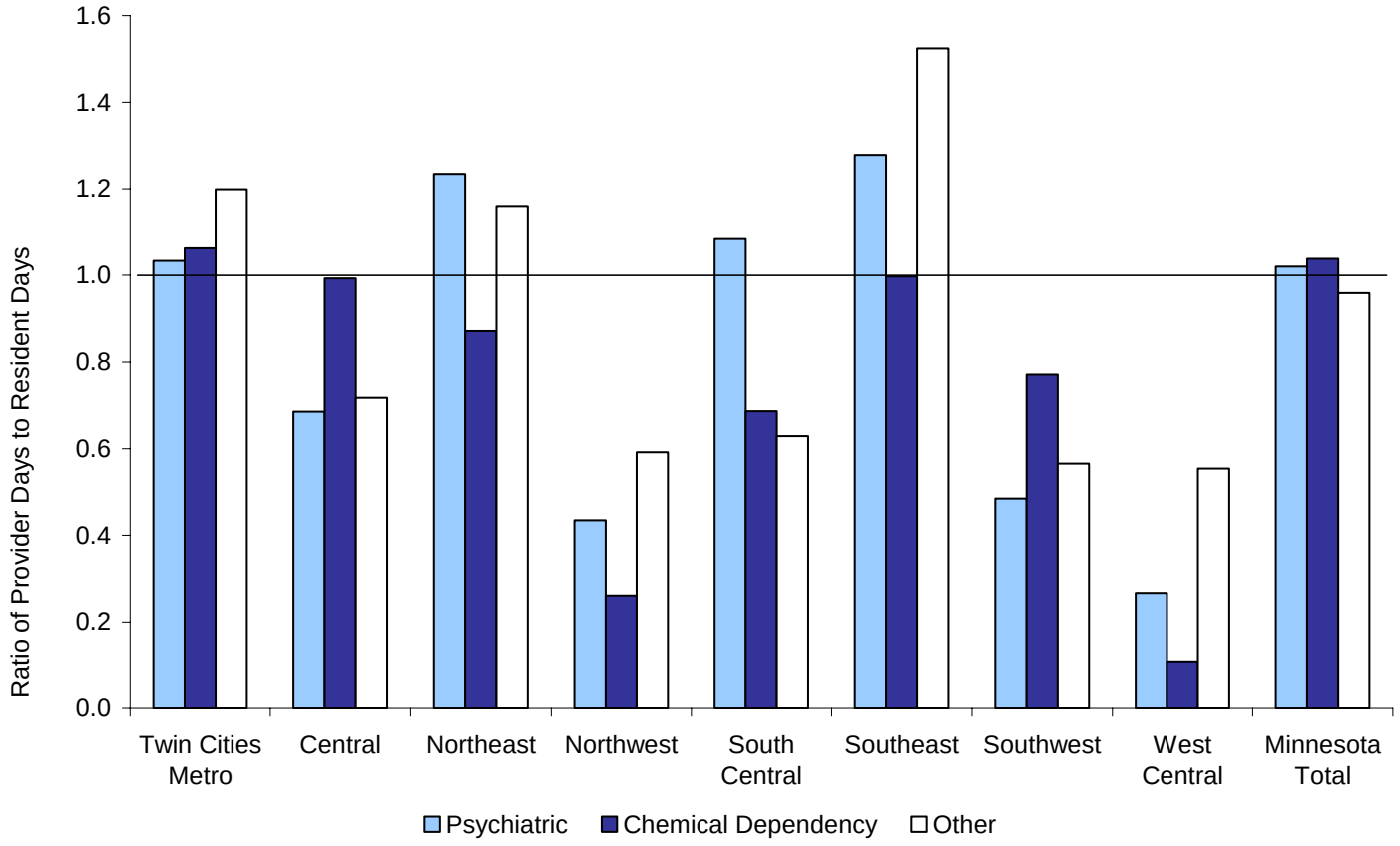


Source: MDH analysis of hospital discharge data and data from state operated facilities; includes travel to neighboring states except Wisconsin.

[4] This analysis of travel patterns is based on 2006 hospitalizations, and existing Twin Cities hospitals have recently added or plan to add at least 32 psychiatric beds in 2008, an increase of 4% to existing inpatient psychiatric capacity in the Twin Cities. In addition, the state operated system of behavioral health care was still transitioning to its new model of small community behavioral health hospitals in 2006 so these data do not reflect the current state operated system.

Figure 3

Ratio of Inpatient Days in Region to Inpatient Days for Region Residents (Community Hospitals Only)



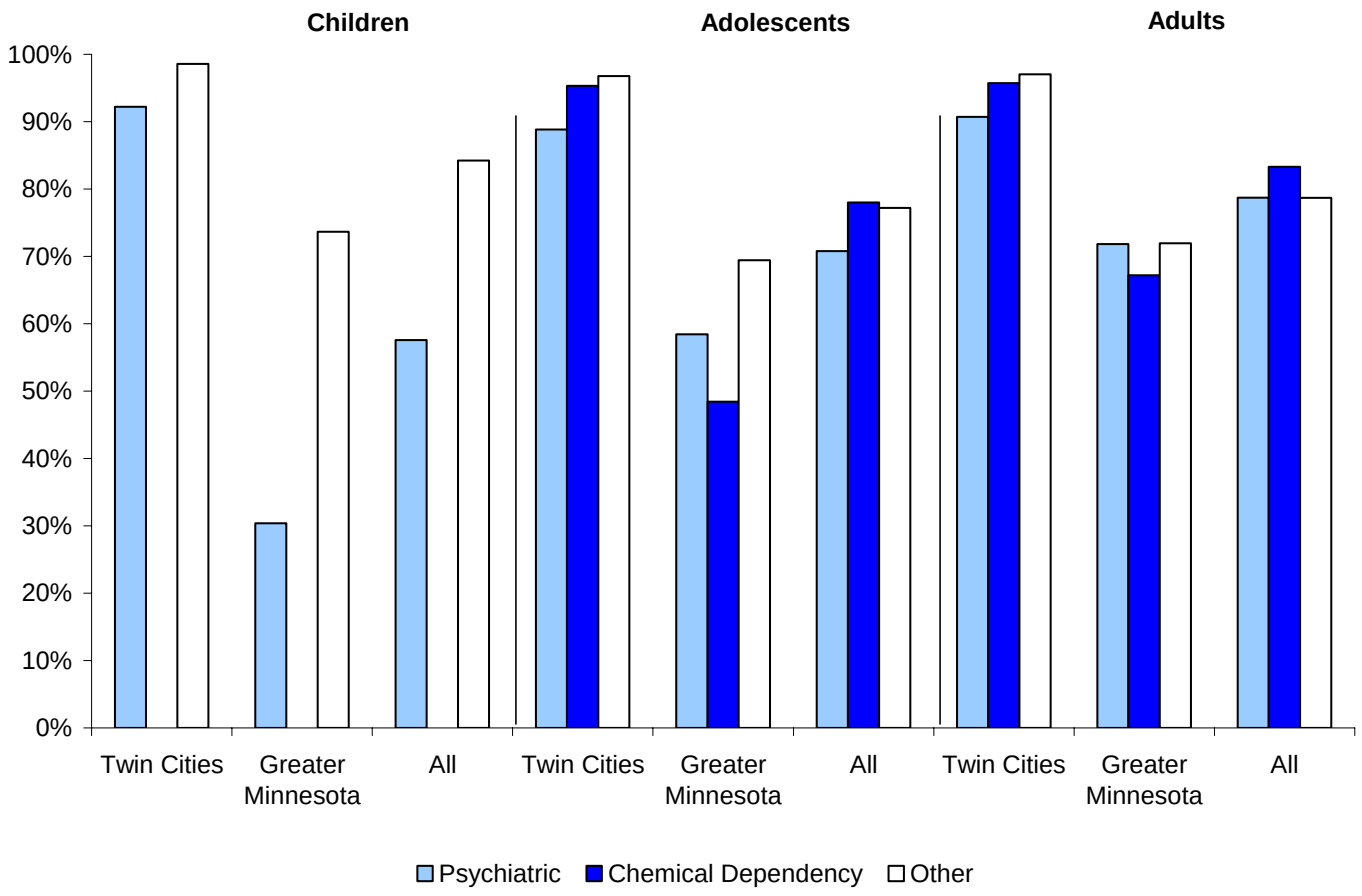
Source: MDH analysis of hospital discharge data (community hospitals only).

Among Twin Cities patients who leave the region for psychiatric care, most are admitted to facilities in neighboring regions: in 2006, 31 percent were hospitalized in Central Minnesota (618 total patients) and 22 percent (444 patients) were treated in the Southeast region. About 150 psychiatric patients from the Twin Cities were hospitalized outside of Minnesota (0.8 percent), including a total of 107 in North Dakota in 2006. Chemical dependency patients from the Twin Cities who are hospitalized elsewhere were treated at facilities that were more scattered throughout Minnesota and neighboring states.

Figure 4 illustrates travel patterns for psychiatric and chemical dependency hospital care compared to other types of care separately by age group. For all types of care, patients from the Twin Cities were far more likely to receive care within their own region than patients from Greater Minnesota. Children and adolescents living in Greater Minnesota were the most likely to travel outside their own region for psychiatric and chemical dependency care, because there is very little hospital capacity in Greater Minnesota for these services.

Figure 4

Percent of Patients Hospitalized in Their Own Region, by Age Group



Source: MDH analysis of hospital discharge data, including surrounding states except Wisconsin. Does not include Minnesota state operated facilities. The number of children receiving chemical dependency treatment is too small to analyze.

If new beds are needed, is the proposed facility the best way to meet this need? One concern about the proposed hospital that was raised in comments submitted to MDH was about the fact that the hospital would only be able to serve patients who are medically stable. In other words, if a patient has conditions requiring medical care in addition to psychiatric or chemical dependency conditions, the patient would need to be treated at another hospital.

MDH's analysis of hospital discharge claims shows that it is common for patients with psychiatric and chemical dependency conditions to have other medical conditions as well. Of over 31,000 admissions for psychiatric care, over 80 percent had at least one non-mental health diagnosis listed. With the information available to MDH, it is not possible to know what portion of this 80 percent of psychiatric and chemical dependency patients would be ineligible to be treated at the proposed Prairie St. John's Woodbury hospital, because it is unknown how many of these other medical conditions were severe enough to require hospitalization.

In response to the concerns raised about the proposed hospital's ability to treat medically complex patients, Prairie St. John's noted that other area hospitals providing psychiatric and chemical dependency treatment do not currently offer "medical-psychiatry" units where patients with medical conditions are treated on a psychiatric unit, and suggested that it would be unfair to hold Prairie St. John's to a stricter standard than other facilities are currently meeting. While it is true that psychiatric patients with medical complications are usually treated on a medical unit rather than a psychiatric unit, they are usually transferred to a psychiatric unit once their medical condition has stabilized sufficiently; when this transfer takes place *within* a hospital (rather than *between* hospitals as would be necessary for Prairie St. John's), continuity of care can be maintained more easily for the patient.

Are there alternatives to adding new beds to the system that would serve patients better? In the process of reviewing this application, MDH received several comments that questioned whether the addition of new hospital capacity is the right solution to the problem of high occupancy rates at existing facilities, delays in patients' ability to receive timely care, and patients' having to travel long distances to receive inpatient psychiatric and chemical dependency care.

Specifically, there is evidence that 1) many hospital stays may be prevented with more appropriate early intervention, and 2) many hospital stays are unnecessarily prolonged by the lack of appropriate services in the community for patients to be safely discharged. A 2007 study involving all of the Twin Cities hospitals with inpatient psychiatric units found that 40 to 50 patients per month are admitted to the hospital due to a lack of access to less intensive resources, while 240 to 250 patients per month have "non-acute" days in the hospital for other reasons such as a lack of intensive residential treatment beds; the total number of non-acute days was estimated at 2,000 to 2,100 days per month. In total, the study found that with adequate "intermediate resources" approximately 45,000 inpatient bed days could be freed up for other uses, serving up to 2,733 additional patients per year.[5]

Notably, MDH's analysis for this report indicates that 2,576 patients from the Twin Cities region traveled elsewhere to receive psychiatric and chemical dependency care in 2006 – in other words, ensuring that adequate intermediate resources are available could, in theory, eliminate the need for Twin Cities patients to travel outside the region for inpatient mental health care. For practical purposes, however, it is unlikely that this potential will be fully realized in the short term, because it will take time to transform the mental health care delivery system in ways that better serve patients.

In 2007, the Minnesota Legislature passed a comprehensive initiative aimed at transforming the state's mental health care system in ways that improve the availability, quality, and accountability of mental health care within the state. This legislation was the result of years of collaborative work among multiple stakeholders on ways to improve the way that the mental health system serves Minnesotans, and progress toward implementing these reforms was the subject of a recent Minnesota Department of Human Services report to the Legislature.[6] Investments in both child and adult crisis services were a significant part of this initiative.

Factor 2: The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region

The financial impact that Prairie St. John's proposed Woodbury hospital would have on existing hospitals depends on several factors. One factor that will play a role is the types of insurance that their patients have; since Prairie St. John's will accept patients with all types of insurance, its policies about which payment sources to accept will not have an impact on existing hospitals that provide psychiatric and chemical dependency care. However, Prairie St. John's would be ineligible to contract with the Minnesota Department of Human Services for extended psychiatric

[5] HealthPartners, Allina Hospitals and Clinics, and HealthEast Care System, "Psychiatric Patient Flow Study," March 2007.
[6] Minnesota Department of Human Services, "Mental Health Service Delivery and Finance Reform: Case Management Roles and Functions of Counties and Health Plans," February 2008.

hospitalizations as DHS does with other hospitals; the patients who need extended hospitalization are usually the most difficult psychiatric patients to treat and accounted for about 7 percent of inpatient hospital psychiatric days paid for by state public programs in 2006.

Compared to patients who are hospitalized for other conditions, people who are hospitalized for psychiatric and chemical dependency conditions are much more likely to have insurance through Medicaid, as shown in Table 8; an estimated 25 percent of psychiatric admissions and 24 percent of chemical dependency admissions in 2006 were paid for by Medicaid, compared to 12 percent of hospital admissions for other conditions.

Table 8
Hospital Admissions by Payer and Patient's Region of Residence, 2006

	Private / Commercial		Medicaid		Other Public Non Medicaid		Other		All Payers
Psychiatric Admissions									
Twin Cities Metro	7,782	41.9%	4,390	23.6%	4,883	26.3%	1,510	8.1%	18,565
Greater Minnesota	5,334	37.1%	3,892	27.1%	3,696	25.7%	1,458	10.1%	14,380
Outside of Minnesota	626	37.0%	401	23.7%	389	23.0%	277	16.4%	1,693
All Locations	13,742	39.7%	8,683	25.1%	8,968	25.9%	3,245	9.4%	34,638
Chemical Dependency									
Twin Cities Metro	2,648	49.5%	1,205	22.5%	1,013	18.9%	484	9.0%	5,350
Greater Minnesota	982	39.5%	688	27.7%	551	22.2%	266	10.7%	2,487
Outside of Minnesota	120	38.1%	66	21.0%	64	20.3%	65	20.6%	315
All Locations	3,750	46.0%	1,959	24.0%	1,628	20.0%	815	10.0%	8,152
Other Services									
Twin Cities Metro	147,074	49.7%	39,599	13.4%	89,114	30.1%	19,882	6.7%	295,669
Greater Minnesota	127,290	44.9%	28,710	10.1%	104,515	36.8%	23,228	8.2%	283,743
Outside of Minnesota	18,799	47.1%	3,985	10.0%	14,125	35.4%	3,020	7.6%	39,929
All Locations	293,163	47.3%	72,294	11.7%	207,754	33.5%	46,130	7.4%	619,341

Source: MDH analysis of hospital discharge data (community hospitals only)

The fact that the proposed hospital would be unable to treat medically complex patients is an additional factor that means it would attract a patient population that is less complicated than average; the average level of complexity of patients at existing hospitals would likely increase as a result. Because hospitals are typically paid a flat fee per admission based on a patient's diagnosis, an increase in the average level of the medical complexity of patients served by other hospitals would have a negative financial impact on these hospitals.

Factor 3: How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff

Prairie St. John's estimates that staffing the first phase of the proposed hospital will require 71 full-time equivalent (FTE) employees. When the hospital expands to its full proposed capacity of 144 beds, a total of 106 FTEs will be required. Table 9 shows the numbers of each type of professional that Prairie St. John's estimated would be needed to staff the proposed hospital.

Table 9

Proposed Hospital Staffing Needs (Full-Time Equivalents)

	Phase 1 (96 beds)	Phase 2 (144 beds)
Registered nurses (RNs)	24	36
Advanced practice RNs	2	3
Licensed practical nurses	8	12
Social workers	12	18
Activity therapists	8	12
Psychiatrists	6	9
Psychologists	5	7
Pharmacists	3	4
Pharmacy technicians	2	3
Physician assistants	1	2
Total	**71**	**106**

Source: Prairie St. John's submission

While it is impossible to predict the specific workforce shifts that may occur from existing hospitals in the area, several factors are likely to play a role. For example, some people living in the Woodbury area who are currently employed at other hospitals may find it an attractive opportunity to work closer to home; on the other hand, employees who are currently union members may not find the potential loss of seniority by moving to a new employer worth the tradeoff.

Overall, there are significant mental health workforce shortages in Minnesota. Of Minnesota's 87 counties, 70 are designated Mental Health Professional Shortage Areas. Results from a 2007 survey of Greater Minnesota health care employers show that the vacancy rate for psychiatrists (16.8%) was higher than any other physician specialty; respondents to this survey reported that it takes nearly 20 months to fill psychiatry vacancies.[7] Minnesota also has fewer psychiatrists per capita than the national average: there were an estimated 9.5 practicing psychiatrists per 100,000 population in Minnesota in 2005 (compared to 12.1 nationally), and 6.1 child psychiatrists per 100,000 children (compared to 8.0 nationally).[8] As noted earlier, however, the usefulness of these types of comparisons is limited, because the need for services is not necessarily the same in Minnesota as in other states or nationally.

Although the Twin Cities metropolitan area is not designated a mental health workforce shortage area, construction of the proposed Prairie St. John's hospital in Woodbury would create additional competition for existing workforce resources in the Twin Cities and other parts of the state as well. In addition to creating potential difficulties for existing hospitals to serve their mental health and chemical dependency patients, more intense competition for staff would likely drive up wages at all hospitals, contributing to rising health care costs.

In previous reviews of proposals to construct new hospitals, MDH has concluded that because the additional capacity in the proposed new facility was small relative to the total capacity at existing facilities, the proposed new facility would not likely have a large negative impact on existing hospitals' ability to maintain their workforce. If viewed in the context of the hospital system as a whole, the proposed addition of 144 beds to the over 5,700 staffed hospital beds in the Twin Cities metropolitan region represents an increase of only 2.5 percent to the existing

[7] Minnesota Department of Health, Office of Rural Health and Primary Care, "Greater Minnesota Health Professional Demand Survey 2007," December 2007.

[8] 2006 Area Resource File, data from American Medical Association Physician Masterfile. Although this is widely considered the best source of comparative data on physician workforce, it suffers from some of the same limitations as the American Hospital Association survey discussed earlier.

system. Given the highly specialized staffing needs of a psychiatric hospital, however, in this case it is probably more appropriate to view the proposal in the context of its size relative to the existing mental health and chemical dependency capacity of existing hospitals. At a proposed capacity of 144 beds, Prairie St. John's would be the third largest hospital provider of behavioral health services in Minnesota, behind the University of Minnesota Medical Center - Fairview (217 beds) and Anoka-Metro Regional Treatment Center (175 beds). Because the addition of these beds would increase the current number of Twin Cities psychiatric and chemical dependency beds by about 15 percent, its impact on the ability of existing hospitals in the region to maintain their behavioral health workforces would likely be significant.

In conducting its review of this proposal, MDH received several comments from existing hospitals expressing concern that the proposal would have a negative impact on their ability to recruit and maintain staff. Some noted that there is a particularly severe shortage of child and adolescent psychiatrists, as well as a trend toward a preference for practicing in outpatient instead of inpatient settings that is also making it difficult for hospitals to recruit and maintain adequate staff.

Factor 4: The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region

Prairie St. John's currently operates a specialty psychiatric hospital in Fargo, North Dakota. In its application for public interest review, Prairie St. John's stated that it would commit to providing the same level of uncompensated care at the proposed Woodbury hospital that it provides in Fargo.

Like many hospitals, Prairie St. John's charity care policy establishes a sliding scale for free or discounted care. Uninsured patients with family income below federal poverty guidelines ($21,200 for a family of four in 2008) are eligible to receive free care. Discounts are provided on a sliding scale for patients with incomes up to 400 percent of federal poverty guidelines. Prairie St. John's also discounts charges by 25 percent for all self-pay patients, regardless of income.

When reporting on charity care, bad debt, and total uncompensated care, MDH typically uses a measure that adjusts charges to approximate hospitals' actual cost of providing care, in order to provide estimates that are the most meaningful and comparable across hospitals. In 2006, Minnesota hospitals provided a total of about $208 million in uncompensated care, or 2.0 percent of their operating expenses. In the Twin Cities metropolitan area, total hospital uncompensated care in 2006 was $128 million, representing 2.2 percent of operating expenses. As shown in Table 10, charity care represented 1.0 percent of operating expenses at Twin Cities hospitals in 2006, while bad debt accounted for 1.1 percent of expenses.

Table 10
Cost of Charity Care, Bad Debt and Total Uncompensated Care, 2006

	Charity Care	Bad Debt	Total Uncompensated Care
Millions of dollars:			
Minnesota hospitals	$91.2	$116.5	$207.6
Twin Cities hospitals	$60.6	$67.5	$128.1
Prairie St. John's, Fargo	$0.2	$1.6	$1.8
As % of operating expenses:			
Minnesota hospitals	0.9%	1.1%	2.0%
Twin Cities hospitals	1.0%	1.1%	2.2%
Prairie St. John's, Fargo	0.7%	6.2%	6.9%

Charges adjusted by cost-to-charge ratio

Source: Prairie St. John's submission and MDH, Health Care Cost Information System

Compared to averages for Twin Cities and Minnesota hospitals, Prairie St. John's Fargo hospital reports a relatively high level of uncompensated care. In 2006, Prairie St. John's cost of providing uncompensated care was 6.9 percent of its operating expenses. Among Minnesota hospitals, only Hennepin County Medical Center reports a higher level of uncompensated care as a share of operating expenses. Compared to Minnesota hospitals, however, a large share of Prairie St. John's uncompensated care was bad debt – nearly 90 percent, compared to about 56 percent for Minnesota hospitals in 2006. One reason for this difference may be that Prairie St. John's accounts for its self-pay discounts as bad debt, while Minnesota hospitals report these discounts separately and do not count them as uncompensated care. In addition, Prairie St. John's is in the process of re-stating its charity care and bad debt for 2006, since the split between these two categories was not accounted for consistently with earlier years (in 2004 and 2005, bad debt represented 70 percent and 62 percent of total uncompensated care, respectively).

All current Minnesota hospitals have signed an agreement with the Attorney General that standardizes debt collection practices and establishes discounts for uninsured patients with family incomes less than $125,000 per year based on the discount that the hospital provides to its largest private payer. If the Legislature chooses to grant an exception to the hospital construction moratorium to Prairie St. John's, it may wish to consider whether there should be an expectation that Prairie St. John's adopt similar policies. Although it is affiliated with the Catholic Health Association, Prairie St. John's is a for-profit entity that does not have explicit obligations to provide community benefit like nearly all current Minnesota hospitals.

As noted earlier in this report, the proposed Prairie St. John's Woodbury hospital would accept patients from all payer sources; however, because the Prairie St. John's Woodbury hospital would be classified as an IMD, the state would lose federal matching funds on all services (not just inpatient psychiatric or chemical dependency services) provided to Medicaid fee-for-service enrollees between the ages of 21 and 64. Although Prairie St. John's has committed to accepting patients from public programs, because of the loss of federal matching payments the cost to the state will be about twice as high when these Medicaid enrollees receive services at Prairie St. John's compared to other hospitals that are not IMDs.

The proposed hospital would be subject to the same federal requirement to provide emergency stabilizing treatment to patients regardless of their ability to pay that applies to other Minnesota hospitals,[9] although the fact that the proposed hospital would have only limited ability to provide treatment for medical conditions will likely have an impact on the number of cases subject to this requirement. For example, ambulances or law enforcement officials may be less likely to bring patients in crisis to a site with limited medical capabilities when other options are available. In addition, some of the comments that MDH received about this proposal expressed concern about the accessibility of the hospital location for people who must rely on public transportation.

Factor 5: The views of affected parties

In conducting the public interest review of Prairie St. John's proposal, MDH solicited the views of affected parties through a process that included a letter to all hospital administrators in the Twin Cities and all administrators of Minnesota hospitals that offer psychiatric and chemical dependency care, a notice in the State Register, and a public meeting held in Woodbury on January 22, 2008. MDH received numerous written comments on the proposal; copies of the comments submitted to MDH are included in Appendix 2 of this report.

Several themes emerged from the public comments on the proposal:

- Many people shared personal stories of difficulty getting timely and appropriate mental health care, including long waits in emergency rooms, having to travel long distances to be admitted to a hospital, and other

[9] This requirement is referred to as EMTALA, which includes the Emergency Medical Treatment and Labor Act (42 U.S.C. 1395dd) and associated regulations.

frustrating experiences with the mental health care system. In particular, people noted that it can be much more frustrating to find appropriate care for mental health conditions than for other types of medical conditions.

- Comments from rural hospitals reinforced the evidence that patients sometimes travel long distances to receive care. Rural hospital executives noted that they frequently receive patients from the Twin Cities area and get many calls seeking open beds for patients from the Twin Cities.

- As noted elsewhere in this report, hospitals that currently provide psychiatric and chemical dependency services expressed concerns that the proposed facility would have a negative financial impact on them and contribute to workforce shortages, perhaps jeopardizing their ability to maintain their current level of services.

    - Some comments expressed concern about the proposed hospital's participation in Medicaid and its obligation to accept all patients regardless of funding source.

- Several comments emphasized the need for an integrated approach to mental health care, with attention to ensuring that appropriate services are available to reduce the need for hospitalization. Some expressed concern about the proposed hospital's ability to care for medically unstable patients.

- Transporting patients to distant facilities places a strain on the budgets of law enforcement and emergency medical services and diverts resources that are needed elsewhere.

- Finally, MDH received comments that Prairie St. John's is a good corporate and community citizen, and that the proposal would have a positive economic impact on the City of Woodbury.

Section 4: Discussion and Finding

Minnesota's mental health system has undergone significant change over the past several years, with coordinated and comprehensive efforts to make the system more patient-centered, more integrated, and better able to provide patients with the right level of care at the right time and in the right setting. The 2007 Legislature passed a major mental health initiative aimed at improving the availability, quality, and accountability of mental health care within Minnesota. If successful, many of the efforts currently under way will reduce the number of hospitalizations.

Based on the stories shared by individuals, the data analysis conducted by MDH for this review, and other available information, it is clear that the mental health care system in Minnesota does not always serve patients well. Patients do sometimes have to travel long distances to receive care, they do experience long waits in emergency rooms due to the lack of available beds, and they do not always have access to appropriate intermediate levels of care that could prevent hospitalization and/or the need for an unnecessarily long and expensive hospital stay. The biggest challenge in making a finding about whether an exception to the hospital construction moratorium should be granted is deciding whether the addition of new beds in a specialty hospital is a good solution to these problems.

MDH has based its finding in this review on the following conclusions:

- Although the addition of some inpatient bed capacity could relieve congestion at existing hospitals, available evidence does not indicate that there is insufficient capacity in the Twin Cities:

    - While Twin Cities residents travel outside the region more often for psychiatric and chemical dependency care than they do for other types of care, most (90 percent) are treated at local hospitals;

- Existing Twin Cities hospitals have recently added or will be adding 32 psychiatric beds and 4 chemical dependency beds in 2008, increasing capacity by 4 percent and 3 percent for inpatient psychiatry and chemical dependency, respectively;

- Twin Cities hospitals currently provide more days of inpatient psychiatric and chemical dependency care to patients from other regions than the number of days of care in other regions provided to Twin Cities residents. This fact suggests that if there is a shortage of capacity, it may be best addressed by adding capacity elsewhere. In particular, Twin Cities hospitals care for significant numbers of psychiatric patients from Central Minnesota (representing nearly 5 percent of their psychiatric admissions);

- Strategies to increase the availability of intermediate resources are believed to have substantial potential to free up inpatient capacity for patients who need this level of care. If successful, these strategies would represent a more patient-centered, less expensive solution to the problem of crowding in hospital mental health units;

- The scale of the proposed project is large relative to any documented need for additional inpatient mental health beds in the Twin Cities. Information submitted by Prairie St. John's shows an estimated 3,400 admissions per year at the proposed new hospital after its first year of operation, growing to 5,100 admissions per year after the proposed expansion to 144 beds.

  - Data for 2006 show that about 2,600 patients from the Twin Cities traveled to other parts of Minnesota or out of state to receive psychiatric or chemical dependency hospital care.

  - Additional capacity (32 psychiatric beds and 4 chemical dependency beds) is already being added by existing Twin Cities hospitals in 2008. These new beds could serve an estimated 1,400 additional patients from the Twin Cities.[10] Assuming that current travel patterns are similar to what they were in 2006, this would reduce the number of Twin Cities patients who travel outside the region to receive care from 2,600 to about 1,200.

  - Even if current strategies to increase the availability of crisis services and other intermediate resources fail to reduce the need for hospitalization, Prairie St. John's proposal seeks legislative approval to add capacity in an amount that is as much as three to four times the level of documented need for services in the Twin Cities.[11]

- The inability of the proposed hospital to accept medically complex patients is a concern in terms of its likely negative impact on existing hospitals and its potential impact on continuity of care for patients with medical conditions;

- Compared to adding capacity at an existing full-service hospital, building a specialty psychiatric hospital would have a negative fiscal impact on the state budget; and

- To a significant degree, the current lack of availability of timely and appropriate mental health care appears to be driven by workforce shortages, particularly a shortage of psychiatrists. This is a challenge that is being experienced nationally, not just in Minnesota. The size of the proposed hospital relative to the existing inpatient

[10] Assuming 90 percent occupancy, as Prairie St. John's assumes, average lengths of stay for psychiatric and chemical dependency care as shown in Table 7 for community hospitals, and 90 percent of additional admissions being patients from the Twin Cities.

[11] This is the difference between the 3,400 to 5,100 patients that would be served annually at the proposed hospital and the 1,200 patients that are estimated to travel to other regions after new capacity is added at existing Twin Cities hospitals.

mental health capacity in the Twin Cities is sufficiently large that it would likely have a negative effect on existing hospitals' ability to maintain their staff.

Finding: For the reasons listed above, MDH finds that Prairie St. John's proposal to build a specialty psychiatric hospital in Woodbury is not in the public interest.

Appendix 1: Detailed Tables

Appendix Table 1: Minnesota Inpatient Bed Capacity for Psychiatric Care and Chemical Dependency Services, 2008

Appendix Table 2: Utilization of Psychiatric Services, 2006

Appendix Table 3: Percent of Hospital Admissions - Patient Region by Provider Region for Psychiatric Care, Chemical Dependency and Other Medical Services (2006)

Appendix Table 4: Hospitalization Destination for Minnesota Patients that Travel – Psychiatric Care, Chemical Dependency and Other Services (2006)

Appendix Table 5: Percent of Hospital Patient Days - Patient Region by Provider Region for Psychiatric Care, Chemical Dependency and Other Medical Services (2006)

Appendix Table 1: Minnesota Inpatient Bed Capacity for Psychiatric Care and Chemical Dependency Services, 2008

Community Hospitals

			Psychiatric Inpatient Care		Chemical Dependency Care	
Hospital Name	Hospital City	Region	Currently Staffed	Capacity	Currently Staffed	Capacity
Abbott Northwestern Hospital	Minneapolis	Twin Cities Metro	93	93		
Fairview Southdale Hospital	Edina	Twin Cities Metro	18	18		
Hennepin County Medical Center	Minneapolis	Twin Cities Metro	102	102		
Mercy Hospital	Coon Rapids	Twin Cities Metro	32	32		
North Memorial Medical Center	Robbinsdale	Twin Cities Metro	26	26		
Regina Medical Center	Hastings	Twin Cities Metro	10	10		
St. Joseph's Hospital	St. Paul	Twin Cities Metro	40	40	32	32
Regions Hospital	St. Paul	Twin Cities Metro	96	96		
United Hospital	St. Paul	Twin Cities Metro	60	60		
Unity Hospital	Fridley	Twin Cities Metro	15	15	24	24
University of Minnesota Medical Center - Fairview	Minneapolis	Twin Cities Metro	170	170	47	47
Cambridge Medical Center	Cambridge	Central	14	14	12	12
St. Cloud Hospital	St. Cloud	Central	34	34		
St. Joseph's Medical Center	Brainerd	Central	22	22	7	7
Fairview University Medical Center - Mesabi	Hibbing	Northeast	32	32		
Miller-Dwan Medical Center	Duluth	Northeast	53	53		
St. Luke's Hospital	Duluth	Northeast	22	22		
North Country Health Services	Bemidji	Northwest	12	12		
Northwest Medical Center	Thief River Falls	Northwest	10	10		
Hutchinson Area Health Care	Hutchinson	South Central	12	12		
Immanuel St. Joseph's - Mayo Health System	Mankato	South Central	8	15		
Meeker County Memorial Hospital	Litchfield	South Central	8	8		
New Ulm Medical Center	New Ulm	South Central	10	10	10	10
Winona Community Memorial Hospital	Winona	Southeast	8	8		
Owatonna Hospital	Owatonna	Southeast	10	10		
Austin Medical Center - Mayo Health System	Austin	Southeast	12	12		
Mayo Psychiatry and Psychology Treatment Center	Rochester	Southeast	71	108		
Rice Memorial Hospital	Willmar	Southwest	8	8		
Avera Marshall Regional	Marshall	Southwest	10	10		

Medical Center						
Worthington Regional Hospital	Worthington	Southwest	10	10		
Lake Region Healthcare Corporation	Fergus Falls	West Central	14	14		
Total, Community Hospitals			**1,042**	**1,086**	**132**	**132**
STATE OPERATED FACILITIES						
Anoka Metro State Operated Hospital	Anoka	Metro	175	175		
Community Behavioral Health Hospitals						
Annandale	Annandale	Central	12	16		
Wadena	Wadena	Central	6	16		
Baxter	Baxter	Central	16	16		
Cold Spring	Cold Spring	Central	10	16		
Bemidji	Bemidji	Northwest	8	16		
St. Peter	St. Peter	South Central	16	16		
Rochester	Rochester	Southeast	16	16		
Willmar	Willmar	Southwest	14	16		
Alexandria	Alexandria	West Central	12	16		
Fergus Falls	Fergus Falls	West Central	12	16		
Children & Adolescent Behavioral Health Services						
Willmar	Willmar	Southwest	26	37		
Community Addiction Recovery Enterprise						
Anoka	Anoka	Twin Cities Metro			36	45
Brainerd	Brainerd	Central			60	96
Carlton	Carlton	Northeast			40	40
St. Peter	St. Peter	South Central			36	38
Willmar	Willmar	Southwest			51	92
Fergus Falls	Fergus Falls	West Central			60	90
Total, State Operated Services Facilities			**323**	**372**	**283**	**401**
Total Psychiatric Beds			**1,365**	**1,458**	**415**	**533**

Includes beds that will become operational in early 2008

Source: MDH, telephone survey of hospitals with a psychiatric or chemical dependency unit; Minnesota Department of Human Services

Appendix Table 2: Utilization of Psychiatric Services, 2006

Hospital Name	City	Admissions	Patient Days	Average Length of Stay (days)
Twin Cities Metro Region				
Abbott Northwestern Hospital	Minneapolis	3,062	23,103	7.5
Anoka-Metro Regional Treatment Center	Anoka	675	65,624	97.2
Fairview Southdale Hospital	Edina	922	5,566	6.0
Hennepin County Medical Center	Minneapolis	1,778	29,133	16.4
Mercy Hospital	Coon Rapids	1,016	9,813	9.7
North Memorial Medical Center	Robbinsdale	1,261	8,521	6.8
Regina Medical Center	Hastings	222	2,576	11.6
Regions Hospital	St. Paul	2,481	28,515	11.5
St. Joseph's Hospital	St. Paul	1,211	10,770	8.9
United Hospital	St. Paul	1,899	17,417	9.2
University of Minnesota Medical Center - Fairview	Minneapolis	4,153	39,599	9.5
Total		**18,680**	**240,637**	**17.7**
Central Region				
Brainerd Regional Treatment Center	Brainerd	465	23,673	50.9
CABHS-Brainerd	Brainerd	295	9,865	33.4
Cambridge Medical Center	Cambridge	697	4,443	6.4
St. Cloud Hospital	St. Cloud	1,251	7,418	5.9
St. Joseph's Medical Center	Brainerd	717	4,985	7.0
Total		**3,425**	**50,384**	**20.7**
Northeast Region				
Eveleth	Eveleth	70	3,279	46.8
Fairview University Medical Center - Mesabi	Hibbing	1,027	8,037	7.8
Miller-Dwan Medical Center	Duluth	2,592	15,880	6.1
St. Luke's Hospital	Duluth	985	5,459	5.5
Total		**4,674**	**32,655**	**16.6**
Northwest Region				
North Country Health Services	Bemidji	244	2,531	10.4
Northwest Medical Center	Thief River Falls	435	2,747	6.3
Total		**679**	**5,278**	**8.3**
South Central Region				
CBHH-St. Peter	St. Peter	28	403	14.4
Hutchinson Area Health Care	Hutchinson	675	3,743	5.5
Immanuel St. Joseph's - Mayo Health System	Mankato	635	3,024	4.8
Meeker County Memorial Hospital	Litchfield	158	1,825	11.6
New Ulm Medical Center	New Ulm	341	2,513	7.4
St. Peter Regional Treatment Center	St. Peter	185	7,007	37.9
Total		**2,022**	**18,515**	**13.6**

Southeast Region				
Austin Medical Center - Mayo Health System	Austin	371	2,740	7.4
Mayo Psychiatry and Psychology Treatment	Rochester	2,741	22,690	8.3
Owatonna Hospital	Owatonna	352	2,483	7.1
Winona Community Memorial Hospital	Winona	453	2,053	4.5
Total		**3,917**	**29,966**	**6.8**
Southwest Region				
CABHS-Willmar	Willmar	184	9,015	49.0
Rice Memorial Hospital	Willmar	212	1,676	7.9
Willmar Regional Treatement Center	Willmar	497	18,686	37.6
Worthington Regional Hospital	Worthington	299	1,715	5.7
Total		**1,192**	**31,092**	**25.1**
West Central Region				
Lake Region Healthcare Corporation	Fergus Falls	295	2,379	8.1
Fergus Falls Regional Treatment Center	Fergus Falls	38	1,894	49.8
CBHH-Alexandria	Alexandria	60	1,069	
Total		**393**	**5,342**	**29.0**
TOTAL		**34,982**	**413,869**	**11.8**

CBHH is Community Behavioral Health Hospital
CABHS is Children and Adolescent Behavioral Health Services

Sources: MDH, Health Care Cost Information System; Minnesota Department of Human Services

Appendix Table 3: Percent of Hospital Admissions - Patient Region by Provider Region for Psychiatric Care, Chemical Dependency and Other Medical Services (2006)

Patient Region	Provider Region: Twin Cities Metro	Central	North-east	North-west	South Central	South-east	South-west	West Central	North Dakota	South Dakota	Iowa	Other	Total All Locations
Psychiatric Care													
Twin Cities Metro	90.4%	2.8%	1.2%	**	2.1%	2.4%	0.3%	0.0%	0.6%	0.1%	0.0%	0.1%	**18,565**
Central	23.4%	60.5%	7.0%	0.6%	2.9%	1.6%	0.5%	0.4%	2.6%	0.2%	0.0%	0.2%	**3,665**
Northeast	1.5%	1.2%	95.1%	1.3%	**	0.6%	0.0%	0.0%	0.1%	0.0%	0.0%	**	**3,442**
Northwest	1.9%	5.1%	7.7%	37.8%	**	0.8%	**	1.2%	44.8%	0.0%	0.0%	**	**1,129**
South Central	13.6%	3.4%	1.1%	0.0%	57.3%	17.7%	3.7%	0.0%	0.4%	2.3%	0.0%	0.6%	**1,178**
Southeast	7.6%	0.7%	0.5%	0.0%	2.0%	87.8%	0.6%	0.0%	0.1%	0.5%	0.0%	**	**2,817**
Southwest	4.1%	1.5%	0.2%	0.0%	7.8%	1.7%	41.1%	0.7%	1.3%	41.6%	0.0%	**	**1,120**
West Central	1.6%	3.6%	0.5%	0.6%	**	0.6%	0.2%	29.2%	63.1%	**	0.0%	0.0%	**1,029**
North Dakota	37.5%	**	5.0%	**	0.0%	30.0%	0.0%	15.0%	n/a				**40**
South Dakota	34.1%	0.0%	2.4%	0.0%	**	36.6%	14.6%	**					**40**
Iowa	19.5%	**	0.6%	0.0%	**	74.0%	**	0.0%					**154**
Wisconsin	25.2%	0.7%	66.0%	0.0%	0.6%	7.3%	**	0.0%					**1,028**
Other	72.3%	7.7%	8.8%	**	3.0%	4.2%	1.9%	**					**428**
Total All Locations	**18,767**	**2,985**	**4,605**	**511**	**1,352**	**3,473**	**617**	**354**	**1,383**	**534**	******	**53**	**34,635**
Chemical Dependency													
Twin Cities Metro	95.7%	2.3%	0.2%	0.0%	0.3%	0.7%	0.0%	0.0%	0.5%	0.0%	0.0%	0.1%	**5,350**
Central	27.0%	65.7%	3.1%	1.1%	0.9%	0.6%	0.0%	0.5%	1.1%	0.0%	0.0%	0.0%	**801**
Northeast	6.9%	3.9%	83.9%	0.8%	0.0%	0.6%	0.0%	0.0%	2.8%	0.0%	0.3%	0.8%	**360**
Northwest	4.8%	7.5%	2.7%	28.0%	0.0%	0.0%	0.0%	0.0%	56.5%	0.0%	0.0%	0.5%	**186**
South Central	17.3%	4.7%	0.0%	0.0%	65.3%	8.0%	4.0%	0.0%	0.0%	0.0%	0.0%	0.7%	**150**
Southeast	13.1%	**	**	0.0%	0.3%	85.1%	0.3%	0.0%	0.0%	0.0%	0.0%	0.2%	**572**
Southwest	**	**	0.0%	0.0%	1.4%	0.0%	70.7%	0.0%	2.1%	20.7%	0.7%	0.0%	**140**
West Central	**	2.9%	**	0.0%	0.0%	0.4%	0.7%	21.2%	72.7%	0.0%	0.0%	0.0%	**278**
North Dakota	23.1%	0.0%	0.0%	3.8%	0.0%	7.7%	0.0%	65.4%	n/a				**26**
South Dakota	**	**	0.0%	0.0%	16.7%	0.0%	0.0%	0.0%					**5**
Iowa	**	0.0%	0.0%	7.1%	7.1%	71.4%	0.0%	0.0%					**14**
Wisconsin	55.7%	**	32.8%	0.0%	0.0%	7.6%	0.0%	0.0%					**131**
Other	80.4%	8.7%	4.3%	0.0%	0.7%	0.7%	2.2%	0.7%					**135**
Total All Locations	**5,676**	**714**	**393**	**68**	**129**	**568**	**113**	**83**	**355**	**33**	******	**14**	**8,148**

Other Medical Services													
Twin Cities Metro	97.3%	1.1%	0.1%	0.0%	0.1%	1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%	**295,669**
Central	24.9%	68.0%	2.2%	1.7%	0.5%	1.2%	0.2%	0.7%	0.5%	0.0%	0.0%	0.1%	**82,532**
Northeast	4.5%	1.4%	91.1%	1.1%	0.0%	1.4%	0.0%	0.0%	0.2%	0.0%	0.0%	0.1%	**44,791**
Northwest	0.7%	4.6%	0.7%	57.0%	0.0%	2.5%	0.0%	0.7%	33.4%	0.1%	0.1%	0.2%	**23,049**
South Central	18.5%	3.0%	0.1%	0.0%	64.4%	12.5%	0.8%	0.1%	0.0%	0.3%	0.2%	0.1%	**31,667**
Southeast	11.3%	0.1%	0.1%	0.0%	0.2%	87.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	**50,116**
Southwest	7.0%	3.9%	0.0%	0.0%	4.5%	2.5%	62.7%	1.0%	0.3%	17.2%	0.7%	0.1%	**28,961**
West Central	5.5%	7.1%	0.1%	2.2%	0.1%	1.6%	0.6%	52.9%	29.3%	0.5%	0.0%	0.1%	**22,627**
North Dakota	31.7%	1.6%	0.5%	3.5%	0.1%	33.8%	0.1%	28.5%	n/a				**3,679**
South Dakota	29.7%	1.6%	0.7%	0.4%	0.8%	45.1%	17.7%	4.1%					**1,966**
Iowa	8.2%	0.6%	0.5%	0.1%	6.1%	83.0%	1.4%	0.1%					**6,964**
Wisconsin	44.6%	0.7%	33.8%	0.1%	0.0%	20.8%	0.1%	0.0%					**21,804**
Other	65.0%	7.7%	14.8%	3.0%	1.6%	2.2%	1.3%	1.8%					**5,373**
Total All Locations	**340,923**	**65,601**	**51,556**	**15,949**	**22,927**	**66,822**	**19,302**	**14,426**	**15,109**	**5,372**	**681**	**673**	**619,195**

**Data suppressed because of small cell size
Community hospitals only.

Source: MDH analysis of hospital discharge data

Appendix Table 4: Hospitalization Destination for Minnesota Patients that Travel – Mental Health, Chemical Dependency and Other Services (2006)

HOSPITAL REGION	Greater Minnesota Patients				Twin Cities Metro Patients			
	Hospitalized in Adjoining Region		Hospitalized in Non Adjoining Region		Hospitalized in Adjoining Region		Hospitalized in Non Adjoining Region	
Psychiatric Care								
Twin Cities Metro	1,229	34.8%	135	13.2%	n/a		n/a	
Central	195	5.5%	19	1.9%	511	37.9%		
Northeast	344	9.7%	34	3.3%	n/a		232	52.3%
Northwest	72	2.0%	n/a				**	
South Central	251	7.1%	11	1.1%	392	29.1%	n/a	
Southeast	208	5.9%	113	11.1%	444	33.0%		
Southwest	64	1.8%	18	1.8%			53	11.9%
West Central	36	1.0%	0	0.0%			7	1.6%
North Dakota	663	18.8%	613	60.0%	n/a		107	24.1%
South Dakota	466	13.2%	52	5.1%			16	3.6%
Iowa	**		0	0.0%			n/a	
Other State / Location	n/a		27	2.6%			26	5.9%
All Regions	**3,529**	**100.0%**	**1,022**	**100.0%**	**1,347**	**100.0%**	**444**	**99.3%**
Chemical Dependency								
Twin Cities Metro	317	47.1%	44	23.0%	n/a		n/a	
Central	44	6.5%	**		122	68.9%		
Northeast	30	4.5%	**		n/a		10	18.9%
Northwest	12	1.8%			n/a		**	
South Central	11	1.6%	n/a		17	9.6%	n/a	
Southeast	**		8	4.2%	38	21.5%		
Southwest	8	1.2%	**				**	
West Central	**		n/a				**	
North Dakota	205	30.5%	124	64.9%	n/a		26	49.1%
South Dakota	29	4.3%	n/a				**	
Iowa	**		**				**	
Other State / Location	0	0.0%	6	3.1%			8	15.1%
All Regions	**673**	**97.5%**	**191**	**95.3%**	**177**	**100.0%**	**53**	**83.0%**
Other Services								
Twin Cities Metro	32,098	53.2%	6,364	33.8%	n/a		n/a	
Central	4,481	7.4%	49	0.3%	3,334	50.6%		
Northeast	1,978	3.3%	107	0.6%	n/a		436	5.5%
Northwest	2,368	3.9%	37	0.2%			88	1.1%
South Central	1,782	3.0%	27	0.1%	188	2.9%	n/a	
Southeast	3,948	6.5%	3,261	17.3%	3,073	46.6%		
Southwest	517	0.9%	30	0.2%			79	1.0%
West Central	1,065	1.8%	15	0.1%			131	1.6%
North Dakota	6,728	11.1%	8,260	43.8%	n/a		118	1.5%
South Dakota	4,995	8.3%	292	1.6%			74	0.9%
Iowa	397	0.7%	57	0.3%			97	1.2%
Other State / Location	n/a		339	1.8%			1,355	17.0%
All Regions	**60,357**	**100.0%**	**18,838**	**100.0%**	**6,595**	**100.0%**	**7,950**	**29.9%**

**Data suppressed because of small cell size

Source: MDH analysis of hospital discharge data

Appendix Table 5: Percent of Hospital Patient Days - Patient Region by Provider Region for Psychiatric Care, Chemical Dependency and Other Medical Services (2006)

Patient Region	Provider Region: Twin Cities Metro	Central	North-east	North-west	South Central	South-east	South-west	West Central	North Dakota	South Dakota	Iowa	Other	Total All Locations
Psychiatric Care													
Twin Cities Metro	93.3%	1.6%	0.7%	0.0%	1.4%	1.9%	0.1%	0.0%	0.7%	0.1%	0.0%	0.1%	**169,950**
Central	30.3%	50.7%	6.0%	0.7%	3.3%	2.2%	0.6%	0.6%	5.1%	0.3%	0.0%	0.3%	**22,878**
Northeast	2.7%	1.0%	92.8%	2.0%	0.3%	1.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	**22,666**
Northwest	2.1%	4.3%	4.6%	34.9%	0.2%	1.2%	**	1.8%	50.7%	0.0%	0.0%	0.1%	**9,129**
South Central	20.1%	2.3%	0.7%	0.0%	51.1%	19.5%	2.9%	0.0%	0.5%	2.4%	0.0%	0.6%	**7,675**
Southeast	8.7%	0.4%	0.3%	0.0%	1.9%	87.3%	0.5%	0.0%	0.1%	0.6%	**	0.2%	**19,642**
Southwest	6.5%	0.9%	**	0.0%	9.2%	2.5%	37.0%	0.6%	2.0%	41.1%	0.0%	**	**7,085**
West Central	1.3%	2.5%	0.7%	0.6%	0.4%	0.4%	**	21.1%	72.7%	0.1%	**	0.0%	**8,569**
North Dakota	33.2%	1.6%	1.8%	9.5%	0.0%	45.5%	0.0%	8.4%	n/a				**380**
South Dakota	36.0%	0.0%	0.3%	0.0%	3.6%	44.9%	9.9%	3.3%					**384**
Iowa	24.7%	0.5%	**	0.0%	1.8%	70.8%	1.7%	0.0%					**1,464**
Wisconsin	31.2%	0.3%	57.1%	0.0%	0.8%	10.4%	0.2%	0.0%					**5,863**
Other	79.4%	3.2%	8.6%	1.3%	2.2%	3.7%	0.7%	0.6%					**3,907**
Total All Locations	**175,605**	**15,671**	**27,978**	**3,970**	**8,318**	**25,111**	**3,434**	**2,286**	**13,435**	**3,385**	******	**394**	**279,592**
Chemical Dependency													
Twin Cities Metro	94.9%	3.3%	0.1%	0.0%	0.2%	0.5%	**	0.0%	0.9%	0.1%	**	0.1%	**30,514**
Central	24.4%	70.8%	1.7%	0.8%	0.7%	0.7%	0.0%	0.3%	0.6%	0.0%	0.0%	0.0%	**5,670**
Northeast	12.3%	9.7%	62.6%	1.8%	0.0%	1.3%	0.0%	0.0%	10.0%	0.0%	**	2.3%	**1,639**
Northwest	3.6%	9.4%	1.9%	18.6%	0.0%	0.0%	0.0%	0.0%	65.9%	0.0%	0.0%	0.5%	**1,160**
South Central	17.5%	14.7%	0.0%	0.0%	53.8%	10.3%	3.6%	0.0%	0.0%	0.0%	0.0%	**	**702**
Southeast	15.6%	1.9%	0.3%	0.0%	**	81.8%	**	0.0%	0.0%	0.0%	0.0%	**	**2,079**
Southwest	2.7%	**	**	0.0%	**	0.0%	65.3%	0.0%	3.3%	27.1%	**	0.0%	**550**
West Central	1.6%	2.8%	0.0%	**	0.0%	0.3%	0.4%	8.7%	86.3%	0.0%	0.0%	0.0%	**2,322**
North Dakota	70.6%	0.0%	0.0%	3.2%	0.0%	4.0%	0.0%	22.2%	n/a				**126**
South Dakota	33.3%	38.1%	0.0%	0.0%	**	0.0%	0.0%	0.0%					**16**
Iowa	13.0%	0.0%	0.0%	1.9%	0.0%	85.2%	0.0%	0.0%					**54**
Wisconsin	59.2%	7.0%	29.8%	0.0%	0.0%	3.9%	0.0%	0.0%					**795**
Other	86.6%	6.6%	2.7%	0.0%	**	0.1%	2.8%	0.1%					**874**
Total All Locations	**32,411**	**5,628**	**1,428**	**303**	**482**	**2,074**	**424**	**247**	**3,250**	**167**	**6**	**81**	**46,501**

Other Medical Services													
Twin Cities Metro	97.1%	0.8%	0.2%	0.0%	0.1%	1.2%	0.0%	0.0%	0.1%	0.0%	0.3%	0.1%	**1,084,215**
Central	30.2%	61.9%	2.2%	1.8%	0.4%	1.8%	0.1%	0.7%	0.7%	0.1%	0.0%	0.1%	**290,071**
Northeast	5.6%	1.2%	89.8%	1.2%	0.0%	1.7%	0.0%	0.0%	0.3%	0.0%	0.1%	0.1%	**170,121**
Northwest	7.2%	0.5%	0.7%	48.0%	0.0%	3.5%	0.0%	0.6%	38.9%	0.1%	0.1%	0.4%	**89,217**
South Central	22.6%	3.2%	0.1%	0.0%	55.9%	16.6%	0.7%	0.1%	0.0%	0.4%	0.2%	0.1%	**111,795**
Southeast	12.0%	0.1%	0.1%	0.0%	0.2%	87.0%	0.0%	0.0%	0.0%	0.1%	0.3%	0.2%	**171,238**
Southwest	11.1%	4.3%	0.0%	0.0%	4.0%	3.4%	53.1%	0.9%	0.5%	21.6%	0.8%	0.3%	**102,180**
West Central	8.9%	7.9%	0.1%	1.7%	0.1%	2.2%	0.5%	46.8%	31.2%	0.4%	0.0%	0.2%	**85,500**
North Dakota	44.6%	0.9%	0.3%	1.9%	0.1%	37.2%	**	15.0%					**19,316**
South Dakota	34.1%	0.7%	0.3%	0.1%	0.5%	50.4%	11.3%	2.7%					**9,878**
Iowa	10.2%	0.3%	0.3%	0.1%	3.6%	84.6%	0.8%	0.1%		n/a			**34,381**
Wisconsin	45.3%	0.3%	31.9%	0.0%	0.0%	22.4%	0.0%	0.0%					**97,797**
Other	70.0%	4.8%	16.4%	2.0%	1.2%	1.6%	0.7%	1.3%					**25,776**
Total All Locations	**1,299,857**	**207,961**	**197,468**	**52,799**	**70,332**	**261,061**	**57,754**	**47,363**	**65,183**	**23,617**	**4,909**	**3,181**	**2,291,485**

**Data suppressed because of small cell size
Community hospitals only.

Source: MDH analysis of hospital discharge data

Appendix 2: Public Comments on the Proposal

Health Care Provider Organization Comments

Douglas County Hospital
East Metro Adult Crisis Stabilization Program
Fairview Health Services
HealthEast Care System
Hennepin County Medical Center
Hutchinson Area Health Care
Mental Health America of North Dakota
Minnesota Chapter, American College of Emergency Physicians
Minnesota Medical Association
Monticello-Big Lake Community Hospital
Regions Hospital
Rice Memorial Hospital
Riverwood HealthCare Center
Worthington Regional Hospital

Other Comments

Charlene Myklebust, Psy. D.
City of Fargo
City of Woodbury
Deborah Simmons
Diane Preston
Donna-Gail Wilcock
Eleanor Daly
Judith and Todd Johnson
Mary Hertaus
Minnesota Pipe Trades Association
Todd Johnson, RN

Douglas County Hospital

111 - 17th Avenue East, Alexandria, MN 56308 ● (320) 762-1511 ● TDD (320) 762-6100 ● www.dchospital.com

February 20, 2008

Julie Sonier, Director
Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Ms. Sonier:

I am writing in support of Prairie St. John's request to build a psychiatric hospital in the Twin Cities. Prairie St. John's has been an excellent partner in our mission to provide the patients we serve with the highest quality medical care possible. Prairie St. John's does an excellent job accepting transfers from our facility of psychiatric patients.

Prairie St. John's contribution to the care of psychiatric patients in Minnesota and North Dakota is substantial. We are very fortunate to have them as a member of our medical community, and we believe they will make an excellent contribution in the Twin Cities as well.

Sincerely,

William G. Flaig
Administrator
WGF/lib

cc: Torrey Westrom, State Representative
Bill Ingebrigtsen, State Senator

An Equal Opportunity Employer

East Metro Adult Crisis Stabilization Program (EMACS)

Established in 2002, the EMACS Partnership is a private/public partnership.

It is composed of:

- Ramsey, Dakota and Washington counties
- Blue Cross/Blue Shield, Medica Health Plans/United Behavioral Health, HealthPartners, and UCare Health Plans
- State of Minnesota Department of Human Services Adult Mental Health and State Operated Services
- Regions, HealthEast and United Hospitals
- National Alliance for the Mentally Ill (NAMI), MN
- Ramsey County Adult Advisory Council
- Mental Health Association of Minnesota

EMACS provides community based crisis assessment, crisis intervention, crisis stabilization, rapid access psychiatry, and health care navigator services.

Mission

Mission of EMACS is to provide individualized, community based, mental health crisis stabilization services through an innovative public-private partnership.

Values

Values include a strong belief in and commitment to maintaining a vehicle for its membership to identify, discuss and seek resolution to mental health systems issues.

Focus

EMACS continues to focus its efforts to:

- Serve all people, despite ability to pay and payer status
- Provide the "Right Service at the Right Time" reducing utilization of costlier levels of care such as inpatient services
- Work in East Metro hospital emergency rooms
- Alleviate the psychiatric bed shortage through diversionary services (pre and post admission)
- Reduce prolonged hospital stays by improving community resources (i.e. transitional housing, short term intensive case management, emergency psychiatric services, and patient drug and funding assistance)

Note: Although the Minnesota Department of Human Services is a voting member of EMACS, as a State agency DHS has a formal process for responding to proposals of this type and, therefore, is abstaining from this matter.

EMACS
Study and Planning Process
2007-2008

INTRODUCTION

East Metro Adult Crisis Stabilization (EMACS) functions as a mobile crisis assessment and stabilization program in Ramsey, Dakota, and Washington Counties. The program seeks to resolve gaps in services including hospital beds. The EMACS Leadership Team represents counties, State DHS and SOS, hospitals, health plans, and consumers.

DHS awarded to EMACS a crisis infrastructure grant in 2006. The goals are to further develop and integrate the mental health crisis structure. Health Care Navigators and rapid access psychiatry are examples of needed services to strengthen the mental health infrastructure. An over-arching goal is the construction of a seamless mental health service system to include defining hospital bed and residential treatment service needs.

Efforts to move forward on the grant goals led to the establishment of a sponsor workgroup. This sponsor group convened a comprehensive group of providers, health plans, counties, State, hospitals and consumer groups that serve individuals experiencing a mental health crisis.

The mission is to further evolve an integrated community based mental health system in the East Metro. This is being achieved, in part, by engaging in a planning process to determine the adequacy of services and assess resource utilization across a continuum of care. The focus is on the services necessary to support individuals from the initial crisis incident through stabilization. The group is to assess the current system and suggest improvements based on current gaps, the area's changing demographics, and mental health trends.

The first meeting on June 27, 2007, brought over 40 representatives from counties, SOS, state services, DHS, non-profit providers, hospitals, Detox, health plans, and consumer groups together. The result was a commitment to an aggressive, time-limited study and evaluation process.

PROCESS

A broad consensus and a heightened interest in developing a single, comprehensive plan for improving the East Metro Adult Mental Health Continuum of Care emerged out of the large group meeting. Four workgroups were created to further develop a work plan:

- *Acute Inpatient Care* focused on determining how existing beds were being utilized, if any additional inpatient capacity was necessary, and how to improve the patient flow in to and out of the Inpatient Care System.
- *Community Services* focused on determining what community services exist, what is necessary, and how they could be integrated to provide for a better continuum of care
- *Housing* focused on the housing needs of individuals moving through the initial crisis to stabilization

Note: Although the Minnesota Department of Human Services is a voting member of EMACS, as a State agency DHS has a formal process for responding to proposals of this type and, therefore, is abstaining from this matter.

- *Resource/Data* served as a central repository for data from all the work groups and made this information available to the workgroups to help inform their work

OUTCOME

Through a consensus process, each of the four work groups identified the primary focus areas to improve the system.

- *Acute Inpatient Care*:
    - Reducing non-acute days in existing inpatient units by improving access to community resources at time of discharge
    -
    - Shortening wait time in the Emergency Departments by improving access to existing services and creating additional community capacity.
    - Improving continuity of care by addressing community-to-hospital and hospital-to-community transfer of clients and information
    - Increasing the number of specialty beds that would be available to serve
        - MI-CD patients (intoxication and enhanced risk)
        - MI-Medically Complex
        - Behavioral Crisis in need of structured services
- *Community Services;*
    - Consolidating and integrating existing community crisis services into a centrally located Crisis Center that could work closely with the spectrum of services - both community and inpatient.
- *Housing:*
    - Short-term transitional housing for individuals who no longer need acute level of care
    - Long term supportive housing, both scattered site and site-based, that offers a spectrum of intensity of services
    - Integration of the existing housing resources available and improving access to supportive services

ACTION STEPS

Currently there are three work groups tasked with designing change in the mental health care continuum:

- *Crisis Center* group will focus on the services that are to be consolidated, integrated and located within a 24/7 Crisis Center that includes mobile crisis
- *Community Services* group will focus on the support services to be consolidated, integrated, and developed in the East Metro community to prevent the need for hospitalization and provide options for support when discharged
- *Fiscal and Policy* group will work on the fiscal notes, legislative and policy changes that will need to occur to allow this system integration and consolidation to take place

These groups committed to work through March 2008 to actively plan the next steps, including structural and financial details, and then develop an implementation schedule.

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Study and Planning

Community Need

- Inadequate crisis beds with programming (approximately 75 unnecessary admissions/year in East Metro)
- Inadequate detox for dual diagnosis (138 unnecessary admissions/year in East Metro)
- Inadequate immediate access to outpatient psychiatry (24 unnecessary admissions/year in East Metro)
- Increased housing with programming (would save 4,500 bed days/year in East Metro allowing existing beds to serve 500 more patients/year in East Metro)
- Increased dual diagnosis treatment (would save 1,620 bed days/year allowing existing beds to treat 180 more patients/year in the East Metro)
- Increased capacity of nursing homes able to work with mental health as well as patients/year in the East Metro)
- Increased access to services for the uninsured/underinsured

Meeting this community need translates to finding a way to sustain

- Increased outpatient emergency evaluations 24/7
- Increased outpatient crisis stabilization services
- Increased access to psychiatrists and advanced practice providers (such as CNS, NP, PA) 7 days/week
- Increased capacity of housing w/support services
- Increased services for patients with both mental illnesses and chemical dependencies (outpatient, intensive outpatient with lodging and inpatient)
- Increased inpatient psychiatric beds for patients with medically complex problems and medical co-morbidities
- Health Care Navigators to get patients appropriately enrolled in insurance programs

For further information, please contact:

Tina Isaac
651.554.6337
tina.isaac@co.dakota.mn.us

Note: Although the Minnesota Department of Human Services is a voting member of EMACS, as a State agency DHS has a formal process for responding to proposals of this type and, therefore, is abstaining from this matter.

FAIRVIEW
Fairview Health Services

2450 Riverside Avenue
Minneapolis, MN 55454-1395
Tel 612-672-6300

January 8, 2008

Julie Sonier
Director of Health Economics Program
Minnesota Department of Health
Box 64882
St. Paul, MN 55164-0882

Dear Ms. Sonier,

Fairview is an integrated health care provider headquartered in Minneapolis and serving Minnesota residents across the eastern third of the state. In partnership with the University of Minnesota, we are committed to medical research, education and patient care. Fairview Behavioral Services is the largest behavioral health care provider in this area. We have 306 total beds in the Minneapolis/St. Paul Metropolitan community. We provide a full continuum of counseling services, intensive outpatient, day treatment and partial hospital programs. We also provide specialty care for gambling, chemical dependency treatment for the deaf and hard of hearing and mental health services for pastors from across the country. Fairview understands well the need for improvement to the behavioral health care system. It is our depth of experience in providing care and partnering with others in the private and public arenas that directs our energy toward creative, new models of improvement rather than the tried and failed systems of the past.

Fairview is concerned the proposed 144 bed acute psychiatric hospital in Woodbury directs much needed resources to the wrong end of the care continuum. We believe improved access to service should first be directed toward intervention at early stages of illness and toward specialty services appropriate to the diagnosis. Minnesota would best be served by a system of behavioral care which provides access to the right care in the right setting by the right provider at the right time for each patient in need.

In response to the public notice, I would like to address four issues.

Whether the new hospital is needed to provide timely access to care or access to new or improved services.
Mental health and chemical dependency services can be timely, high-quality and cost effective when the right care is available in the right setting by the right provider at the right time. Initially, it may appear adding additional beds would provide greater access for patients. We believe that is untrue and may, in fact, exacerbate the overall vulnerability of the behavioral health care infrastructure in the state.

Current statistics are staggering:

- 80% of psycho-pharmaceutical medication is prescribed by non-psychiatrists.
- 92% of the elderly receive behavioral health care in primary care settings by providers not specifically trained in behavioral health.
- Only 1 in 4 patients referred to a specialist for behavioral health care receives that care.
- 38 Minnesota counties have no psychiatrist.

This is just a sampling of facts we believe demand a fundamental change in the care model structure and not the reprise of old solutions, such as increasing patient beds, that have repeatedly failed patients. Acute care general psychiatric beds, even when developmentally assigned by age, are often poor interventions for patients with autism, reactive attachment disorder, borderline personality disorder and many others. It is the inadequate provision of care alternatives at earlier stages of illness that created the demand for a level of service that is the most expensive and generally not the most appropriate care for a given diagnosis.

Providing more effective, integrated care at the primary care level could move Minnesota into a leadership role, creating a best practice model of care for mental health and chemical dependency services and reducing the demand for inpatient admissions. A model based on levels of integrated care is in patients' best interest. Such an innovative care delivery model would provide better, safer care for patients and improve patient outcomes. Creating a primary behavioral health care model will have large population impact. Minnesota, consistent with the entire country, lacks providers – clinically trained psychiatrists, clinical nurse specialists, psychiatric nurse practitioners and chemical dependency counselors. An integrated health care provider team would increase access for patients faster, caring for patients before they reach crisis stage and need inpatient care.

When a tragic circumstance grabs local headlines the discussion often turns to bed availability even when that was not a determinate in the situation. Unfortunately, solutions which are higher quality, community based, less expensive and frequently preventative in nature are discounted.

The potential financial impact of the new hospital on existing acute-care hospitals that have emergency departments in the region.

Fairview is concerned the proposed 144 –bed behavioral services hospital in Woodbury will have a negative impact on behavioral health care in Minnesota. We believe it will draw providers from existing programs, cause a negative financial impact on existing programs, potentially close some of those programs; and reduce the overall services available to Minnesotans in need of behavioral health care. As a nonprofit healthcare

provider, Fairview treats patients regardless of their ability to pay. We have recently opened a special Behavioral Emergency Center on the University of Minnesota Medical Center, Fairview's Riverside campus to more appropriately serve behavioral patients in crisis. Fairview has done the right thing for patients and the community with this model of care while absorbing reduced financial performance. With this model, we are able to:

- Deliver specialty mental health assessment and intervention service within the emergency room and use network scheduling to community providers to determine and access appropriate patient treatment.
- Use beds for patients who truly require constant supervision and a locked, secure environment.
- Discharge patients who do not require a locked setting in order to receive care within their community on a next-day basis.
- Provide crisis intervention and stabilization in a space uniquely designed for this purpose separate from other emergency room functions.

Using this new approach, our inpatient units are admitting patients with the highest levels of acuity, adding staff to ensure safety, caring for more chronically mentally ill patients, experiencing longer lengths of stay as these patients proceed through the commitment process and wait for community or state services which often don't adequately exist. Innovative new care models such as this one must not be undermined by expansion of the wrong services. We believe support of Prairie St. John's proposal will:

- Increase to existing programs the number of referrals who are uninsured or have hit their maximum mental health/chemical dependency benefit. Prairie St. John's currently has partial outpatient services in Minnesota. In our experience, their referrals to our programs currently fall into these categories of uninsured or at benefit limits. Their referrals share the characteristics of high acuity, high risk and lack of insurance.
- Increase the number of government pay patients which is already 53% of our total charges.
- Greatly jeopardize our ability to maintain the beds and programs we currently have – the largest set of services in the state.

How the new hospital will affect the ability of existing hospitals in the region to maintain existing staff.

Prairie St. John's proposal indicates 6 new psychiatrists and 65 additional health care staff would be required to open phase one of the project; and a total of 9 psychiatrists and 97 staff would be required by the end of phase two. The most common reason we divert a behavioral health patient is the lack of a psychiatrist to staff a patient bed, not the lack of an actual, physical bed. Consequently, the staff needed for a new facility, threatens existing programs because:

- A serious shortage of psychiatrists currently exists in Minnesota, particularly in child and adolescent psychiatry and those dedicated to serving patients in a hospital setting which is higher risk and negatively impacts the physician's life style.
- Psychiatrists moving to outpatient practice continues to erode current staff.
- Retirement of psychiatrists also erodes staff. Many of Minnesota's psychiatrists are nearing retirement.
- Prairie St. John's is already recruiting both physicians and team members from existing programs.

Again using innovative methods, Fairview has employed seven psychiatrists over the past year to offset attrition. To achieve this, we recruited from across the nation. We don't believe it will be possible to replace these psychiatrists if they are hired away by the new facility. These hospitalists are critical to ability to serve patients as they guarantee consistent bed staffing and, therefore, bed availability. However, we continue to have unmet provider needs in many child and adolescent areas as well as in our chemical dependency programs. Continued erosion of our staff will further limit our ability to accept patients and keep programs open and beds staffed.

Extent to which the new hospital will provide services to nonpaying or low-income patients, relative to the level of such services provided by existing hospitals in the region; and view of affected parties.
According to information from your office, the proposed Prairie St. John's facility will not be a medical assistance provider for adults. Prairie St. John's calculated its charity care at $345,137 or 1.4% of its operating budget. However, what constitutes this calculation may not be consistent with Minnesota charity care guidelines.

The Minnesota Department of Health, the Minnesota Attorney General's office and the Minnesota Hospital Association recently defined charity care guidelines for Minnesota health care organizations, eliminating bad debt from that definition. It is not clear that Prairie St. John's, a for-profit organization headquartered outside Minnesota, follows those same guidelines.

Additional restrictions on patients who would receive care in this new facility pose significant risk to existing community programs.

- Page 5 of the proposal addresses the community need for chemical dependency detoxification facilities. The proposal states that these services will only be provided within general medical limitations. Therefore, addicts, severe alcoholics and patients with multiple medical diagnoses would not be treated at this proposed facility. Rather, they would be referred to existing community programs.

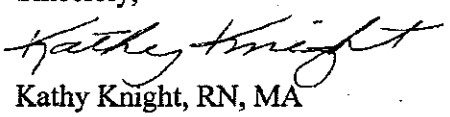
- Many with addictions, severe alcoholism and patients with dual chemical dependency and medical diagnoses are only eligible for consolidated funds, a government program with very limited reimbursement.
- Patients requiring longer term or residential care due to the severity of their illness will not be accepted. Availability of behavioral longer term care is a serious current gap in service that this proposal fails to address.

Summary
Minnesota residents needing mental health and chemical dependency services drive Fairview's concern about Prairie St. John's proposal to expand inpatient behavioral beds in the Twin Cities metropolitan area. We believe it is fundamentally a flawed approach to the access concerns in behavioral health care. We also believe it will draw providers from existing programs; cause a negative financial impact on existing programs, potentially close some of those programs; and reduce the overall services available to Minnesotans in need of behavioral health care – patients afflicted with mental illness and/or chemical dependency.

We believe a better public policy would be to strengthen our behavioral health care infrastructure by calling on local experts who daily face patients in need and who understand the intricacies in providing the best possible care for Minnesotans. We believe innovative approaches to treating patients with the right care in the right setting by the right provider at the right time is a better alternative than building a new facility directed at the highest and most expensive level of care. Integrating behavioral care into the primary care model in patients' home communities increases access to mental health care by trained personnel who can complement the family practice and internal medicine physicians in providing care for the whole patient.

Thank you for giving Fairview the opportunity to respond to this proposal. We welcome the opportunity to be part of a community wide effort to move new, innovative care models forward. If you have questions or would like additional information on our comments, please contact me directly at 612-273-1184 or kknight1@fairview.org.

Sincerely,



Kathy Knight, RN, MA
Vice President, Fairview Behavioral Services
Fairview Health Services

HealthEast Care System

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651-232-2300
Fax 651-232-2315

Hospitals
- St. John's Hospital
- St. Joseph's Hospital
- Woodwinds Health Campus
- Bethesda Hospital

Clinics
- Family Medicine
- Internal Medicine
- Pediatrics

Medical Home Care
- Home Care
- Hospice Care

Outpatient Care
- Urgent Care
- Digestive Care
- Pain Care
- Optimum Rehabilitation/ Physical Therapy
- Radiology Care
- Surgery Centers
- Vascular Center

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January 8, 2008

Julie Sonier
Director, Health Economics Program
Division of Health Policy
Minnesota Department of Health
P.O Box 64882
Saint Paul, MN 55164-0882

RE: Hospital Interest Review—Prairie Saint John

Dear Ms. Sonier:

I am writing on behalf of the HealthEast Care System regarding the application by Prairie St. John (PSJ) for a new 144-bed mental health hospital in Woodbury. Currently St. Joseph's Hospital staffs 36 inpatient mental health beds and 28 chemical dependency beds. We have plans to add 4 additional Mental Health and Chemical Dependency beds in 2008. We fear that a new facility will fracture the current system due to the severe staffing shortage of mental health practitioners, especially psychiatrists and chemical dependency counselors in Minnesota. As a result, existing programs, like ours, that serve a higher percentage of elderly, disabled (Medicare) and poor (enrolled in Minnesota government health care programs) will be not be able to operate at current levels.

Below is a table depicting the current mix of patient days by payer served by St. Joseph's in fiscal year 2007 as compared to the planned mix of patient days per Prairie St. John application to the Minnesota Department of Health. As you can see, the business model of PSJ plans on serving a much lower percentage of Medicare and MA patients. PSJ indicates they will serve MA patients, however, it is unclear whether they can be a licensed provider by DHS to provide services to Minnesota government health care enrollees.

Types of Payer	St. Joe's MH	St. Joe's CD	Prairie St. J
Medicare	36	14	15
MA/GA/MnCare	30	45	25
Private	31	40	60
Un-ins/charity	3	1	
Private pay			10
Total Gov.	66	60	40

St. Joe's based on inpatient days for FY 2007 % patient days for 2007 PSJ, submitted in MDH response

PSJ indicated that 6 new psychiatrists and 65 additional health care staff would be necessary to open the facility during phase one, and 9 psychiatrists and 97 staff for phase two. PSJ states in its application that it is successful in recruiting psychiatrists and other staff nationally. We are aware that PSJ has recruited Minnesota psychiatrists that are currently staffing existing MH/CD programs. In fact, we have been informed that a team of psychiatrists that we worked for two years to recruit has recently signed a contract with PSJ. One physician also provides services to our CD unit three days a week and we are concerned that he will not be available if a new facility is opened. In addition, we currently have openings for a psychologist, social workers, and several chemical dependency counselors.

PSJ has indicated that they will not admit patients with general medical conditions. As a result, we expect that we will be referred patients with higher acuity/risk factors that will put an additional strain on our unit which will be exacerbated if we continue to lose staff. Also, if the balance of payers shifts for St. Joseph's and other current providers to more government payers and uninsured, it will seriously impact our ability to maintain the current level of services. Finally, the location in Woodbury, is not easily accessible for patients that rely on mass transit or live in low income housing or other residential or transitional facilities; these patients will not be able to access the PSJ programs or hospital due to lack of personal transportation.

The impact of new behavioral hospital will also significantly impact Woodwinds hospital, located in Woodbury. The emergency services capacity at Woodwinds was not designed to meet the emergency services needs of a 144 bed behavioral health hospital that will attract patients from across the Twin Cities service area. Obviously, this significantly increased demand would have a negative impact on meeting the emergency services needs of our primary service area. Similarly, for inpatient services, there will likely be a significant increase in the demand for medical transfers into Woodwinds from the PSJ facility. Woodwinds' hospital capacity is already challenged to meet the increasing demand for inpatient medical services from the primary service area as evidenced by recent bed expansions in 2006 and again in 2008. The increased demand created by the PSJ facility will compromise Woodwinds' ability to meet the inpatient demand of the primary service area.

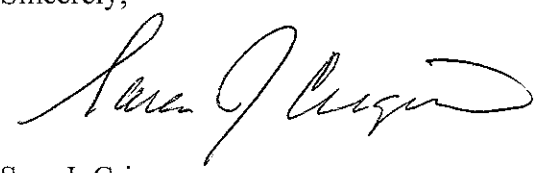
HealthEast has been meeting with other mental health and chemical dependency stakeholders in the East Metro area over the last several months to study and make recommendations regarding our current systems and practices with the goal of improving MH/CD services in a cost effective manner. A study was undertaken to determine whether there are sufficient MH/CD beds in the areas. Sg2, a national consulting firm, looked at utilization trends across the county for comparable metropolitan areas. In comparing the Twin Cities to Madison, Denver, San Diego, and Seattle, they determined that there was no need for additional beds in the Twin Cities.

The East Metro group has developed several recommendations that will improve care to the MH/CD population without building a new facility. The group proposes establishing a centralized Mental Health Crisis Center in the East Metro area that improves the system by centralizing access, expanding psychiatric resources and triaging care. The basic principle: Improve services and maximize resources by providing the right service at the right time. The group also made recommendations to enhance and expand community services, and increased housing and detox options. They identified the need to improve medication access and adherence which requires expanded community outreach as our patients access their care at a variety of locations, including primary care clinics. A summary of the recommendations is attached.

In summary, we urge the State to seriously consider other proven and more cost effective options for improving mental health and chemical dependency services in Minnesota. The Prairie St. John for-profit business model, service capabilities, and suburban location are clearly established to achieve a favorable mix of payers and patients. This reallocation of existing business in the market will only serve to erode the financial performance of existing providers and worse, only serve to further fragment the behavioral care to all patients by stretching existing professional services over additional sites in the market.

Thank you for inviting us to respond to this application process. We believe this decision could have significant implications to the care of mental health and chemically dependent patients in our communities. We strongly encourage the State to consider the research and recommendations of the local expertise on the East Metro Planning Group for solutions to improve our behavioral care system. The creation of more beds is not a solution but rather a bigger band-aid on a serious problem facing members of our community. We appreciate your consideration of our position on this matter.

Sincerely,



Sara J. Criger
CEO, St. Joseph's Hospital
Vice President, HealthEast Behavioral Health Services
651-232-3611

Hennepin County
Medical Center

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January 8, 2008

Julie Sonier, Director
Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Julie,

Thank you for the opportunity to respond to the Prairie St. John's proposal.

Hennepin County Medical Center and our Hennepin Faulty Associates practice plan have a longstanding commitment to the provision of mental health services, and in fact provide an extensive array of services, including our acute psychiatric service, inpatient beds partial hospitalization and outpatient programs. We are quite aware of the challenges associated with meeting the mental health needs of our Minnesota residents.

Upon reviewing the Prairie St. John application and related materials posted on the MDH web site, we would express these perspectives:

1. We concur with the perspective that the need for mental health professionals, inpatient facilities, and community based programs is greater than the current supply.

2. The proposed project is clearly oriented to providing additional inpatient beds. The other points on the continuum (a representative list is included on p. 14 of the application) receive minimal emphasis, and residential facilities-- one of the region's greatest needs--are clearly excluded from the project.

3. The project envisions minimal service to adults who receive Medical Assistance. Attracting a commercial payer mix to the Prairie facility will result in more Medical Assistance volume in the general acute care hospitals, which likely represents lower reimbursement for most facilities. The application refers to Federal regulation that guided Medicaid populations away from stand-alone psychiatric facilities. It may be instructive to reacquaint interested parties with the rationale for that direction.

4. The Prairie facility, because of minimal medical capabilities, will by definition have a patient population with comparatively minor co-morbidities.

5. Prairie projects that the conditions of the patient population to be seen will in the main be those with depression and anxiety. While these can be difficult conditions for some patients, there is a greater need for inpatient facilities that can accommodate patients with serious and persistent mental illness.

6. The Prairie project proposes a 24/7 Needs Assessment operation. It is not clear to what extent such a facility would divert patients from the existing general acute hospital emergency rooms; in fact, it may represent a source of additional referrals to those sites.

7. The Prairie project does not reference ways or means by which it will increase the supply of health care professionals in the area, other than to say it will conduct nation-wide searches for additional professional staff. Without assuming responsibility for financing or programming for the education of additional mental health professionals, we would have concerns that the project will more likely create upward pressure on human resource costs. It is already difficult to cover those costs for the facilities that are seeing a more acutely ill patient care population, and that see a high volume of uninsured and Minnesota public assistance patient volume.

We appreciate the opportunity to comment, and look forward to the public hearing on January 22.

Sincerely,

Lynn M. Abrahamsen
Chief Executive Officer

CC Michael Popkin, MD, Chief of Psychiatry
Michael Harristhal, Vice President, Public Policy
Mary E. Davidson, Intergovernmental Relations
Hennepin Healthcare System Board of Directors
Hennepin County Board of Commissioners

Julie Sonier - Comments regarding Prairie St. John's Hospital proposal

From: "Buboltz, Marilyn A"
To:
Date: 1/8/2008 4:56 PM
Subject: Comments regarding Prairie St. John's Hospital proposal
CC: "Wells, Mary E" , "_HAHC - Inpatient MHU - RN Managers" <_HAHC-InpatientMHU-RNManagers@hahc-mn.org>

Julie,
Our hospital had received your letter indicating the process that is occurring through the Department of Health due to the proposal submitted by Prairie St. John's to build a new psychiatric hospital in Woodbury. Our hospital in Hutchinson has a 12 bed Inpatient Mental Health Unit and approximately 30% of the patients admitted to our unit are transferred from the metro counties.

The management team and I plan to attend the meeting on the 22nd to hear more about the proposal. After reading the proposal we do have questions that may be clarified at that meeting.
The changes in the State Operated Services and the closing of the Regional Treatment Centers have created some complications for our Community Hospitals Mental Health Unit. We're not sure if the Prairie St. John's proposal will be an answer to those issues. There are two easily identified gaps that have been created by the closure of the Regional Treatment Center and they are 1.) facilities that can manage patients with a high risk of violence and 2.) facilities that will accept medically complicated patients.
Adequate reimbursement is an issue for Mental Health Units. We do have questions/concerns regarding Prairie St. John's Payor Mix data and the fact that they will not accept Medicaid patients due to federal regulations. We would like to hear more about their intake process in acceptance of underinsured and uninsured patients. We would assume they would be governed by EMTALA regulations considering they would be certified as a "specialty" hospital. (An area for clarification)

Thank you for including Hutchinson Area Health Care in your request for this proposal review.

Sincerely,

Marilyn Buboltz
Hutchinson Area Health Care
Division Director
Community Care Programs & Services
Phone: 320-234-4664
FAX: 320-234-4652
Email: mbuboltz@hahc-mn.org

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Mental Health America of North Dakota
Susan Rae Helgeland
Executive Director

November 9, 2007

Dear Commissioner Magnan:

I am writing as executive director of Mental Health America in ND (MHAND) to support Prairie St. John's efforts to build a specialty health hospital in Woodbury, Minnesota. MHAND is a 501© 3 non profit organization. Our mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

I have known and worked with Prairie St. John's hospital in Fargo, North Dakota since 1997. I am also a member of their Institutional Review Board. They are an excellent corporate and community citizen for our city and state. They are also a significant partner and contributor in community advocacy projects for people with mental illness and their family members.

I believe that Prairie St. John's will make an excellent addition to the psychiatric care community in Minnesota. If you need further information from me please call me at 701-391-8824 (cell). My cell phone is the best way to reach me.

Sincerely,

Susan Rae Helgeland, MS

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Minnesota Chapter

American College of Emergency Physicians®

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February 14, 2008

Julie Sonier, Director
Health Economics Program
Minnesota Department of Health
P.0. Box 64882
St. Paul, MN 55164-0882

Dear Ms. Sonier:

This correspondence is being forwarded on behalf of the Minnesota Chapter, American College of Emergency Physicians (MNACEP), and deals with one of the more serious challenges to our healthcare delivery system - the ability to respond to the acute psychiatric needs of our residents.

Admitting patients with acute psychiatric illness to an impatient psychiatric bed in this state has become increasingly difficult in recent years, and often results in "boarding" patients in hospital emergency departments for extended periods of time. It is not unheard of for a psychiatric patient to spend more than a day waiting for an open bed.

The challenges in meeting the needs of mentally ill patients are not new and a resolution will not be easily forthcoming. However, MNACEP believes that appropriate incentives to encourage a new generation of mental health professionals, appropriate facilities, adequate funding, and a strong out-patient support system may help the healthcare system deal with our serious mental health challenges.

MNACEP supports the addition of in-patient psychiatric beds as proposed by Prairie St. John's Hospital. However, we feel strongly that a number of important conditions should be first satisfied:

1) Prairie St. Johns' must accept all patients regardless of ability to pay or source of payment

2) The proposed institution must provide 24-hour access for acute psychiatric evaluation and admission;

3) The facility should have a staffing strategy that is not detrimental to other Minnesota hospitals, which are already facing serious professional psychiatric staffing challenges; and,

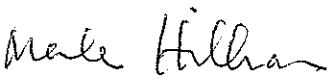
4) Prairie St. John's should endeavor to create a model for providing an integrated medical and psychiatric health care delivery system for those patients in need.

If these conditions are not met, MNACEP is concerned that the Prairie St. John's facility will not improve access for the very patients with acute psychiatric needs who we are currently struggling with and could even exacerbate an already brittle situation. The potential for so-called patient "cherry-picking", i.e. securing the most attractive patients, leaving the full service hospitals to deal with only the most difficult management and dispositional patients, is a very real fear among the healthcare provider community.

We do not believe that simply adding inpatient beds is the solution to this complex problem. Rather, a viable solution must be the result of an operationally integrated response as a key component of the entire healthcare delivery system in Minnesota.

Thank you for your attention to this important matter. Should you have any questions, please do not hesitate to contact me.

Sincerely,



Merle Hillman, MD
President
MNACEP

MMA
Minnesota Medical Association

Physicians working for a healthy Minnesota

January 17, 2008

Ms. Julie Sonier
Director of Health Economics Program
Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882

Dear Ms. Sonier:

On behalf of the nearly 11,000 members of the Minnesota Medical Association, we write to express our concerns regarding the current proposal by Prairie St. John's to build a psychiatric hospital in Woodbury.

In 2007, the MMA Board of Trustees authorized the creation of a Psychiatric Bed/Patient Diversion Task Force to address access issues to mental health services in order to identify statewide solutions to the problem of access to psychiatric services. The task force is comprised of physician members from psychiatry, emergency medicine, family practice and internal medicine.

Both the Psychiatric Bed/Patient Diversion Task Force and the MMA Board of Trustees have reviewed the Prairie St. John's Application as well as the supplemental information on the Minnesota Department of Health website; and although we support and encourage an increase in inpatient psychiatric beds, we cannot at this time support the Prairie St. John's Proposal unless the following conditions are met:

- **Prairie St. John's must accept all patients regardless of insurance status or type**

  According to their proposal, due to their standalone psychiatric facility status, they will be unable to accept Adult Medicaid patients. This constitutes a significant percentage of the patients with inpatient needs who are frequently found among those spending hours in the emergency room awaiting a bed. Without this capability at Prairie St. John's, other hospitals in the region will be forced to take a disproportionate share of uninsured and/or publicly funded patients with greater risk of financial insolvency and bed closure.

- **Prairie St. John's must provide 24-hour emergency access for psychiatric evaluations and admission**

  Although Prairie St. Johns has stated that they will provide a Needs Assessment department staffed 24 hours, 7 days a week, this is very different than a psychiatric emergency room. Ambulances and families with psychiatric emergencies will not be directed to Prairie St. John's since they have no emergency room capacity. They may also be exempted from EMTALA laws as a result. This does little to alleviate the backlog in existing emergency rooms.

1300 Godward Street NE, Suite 2500 • Minneapolis, MN 55413 • ph 612/378-1875 or 800/342-5662 • fx 612/378-3875
E-mail mma@mnmed.org • Internet www.MMAonline.net

- **Prairie St. John's must make provisions for availability of medical services for psychiatric patients with stable medical illness at the Prairie St. John's facility and for acute care psychiatric services to patients with unstable medical illness in collaborative adjacent medical facilities.**

  Prairie St. John's will be unable to admit patients with unstable medical co-morbidities. Their policy states that patients who are medically unstable will be transferred to an appropriate facility for care. Since patients with psychiatric illness commonly have active and concurrent medical diseases, this is a major drawback. Acute care hospitals in the region will continue to have the sole responsibility to care for psychiatric patients with significant medical co-morbidities.

The MMA understands the scope of the problem of psychiatric bed availability and its impact on emergency and general medical resources. However, we also realize that open beds that do not have the capability to take the breadth of patients who need admission hurts rather than helps the issue of access to psychiatric services. Although Prairie St. John's would add beds, the constraints of the facility would mean that existing facilities in the metro area would be adversely affected by having to take the most ill and low income patients entering the system.

Thank you for the opportunity to respond.

Sincerely,

Robert K. Meiches, M.D., MBA
Chief Executive Officer

Roger G. Kathol, M.D.
Co-Chair, MMA Psychiatric Bed/Patient Diversion Task Force

Steve P. Sterner, M.D.
Co-Chair, MMA Psychiatric Bed/Patient Diversion Task Force

From: "Lynn Olson" <lolson@mblch.com>
To: <Julie.Sonier@state.mn.us>
Date: 12/28/2007 1:05 PM
Subject: Prairie St. John's Inpatient Hospital Proposal

Dear Ms. Sonier,

As a long-time health care worker and advocate, I read with interest the proposal by Prairie St. John's to locate a psychiatric facility in Woodbury.

Quickly my background: I am currently Chief Operating Officer at Monticello-Big Lake Community Hospital in Monticello, MN. Prior to that I served for six years as CEO of Ottumwa Regional Health Center in Ottumwa, Iowa which had a 22 bed inpatient psych unit. Prior to that I was CEO at Regina Medical Center in Hastings, MN where I set up a 10 bed gero-psych unit. I served on the Policy and Advocacy Committee for the Minnesota Hospital Association for several years and currently serve on an MHA Outpatient Facilities Task Force that is looking at the proliferation of ambulatory facilities and the cost to the system of duplication of such facilities. I also lobbied (successfully) to get additional funding from the State of Iowa for the University of Iowa's psychiatric residency training program to get more providers educated for rural areas during my time in Ottumwa.

My concern is who the proposed inpatient facility will serve. Having worked in both suburban and rural hospitals, I have seen the acute need for psychiatric services in rural and ex-urban communities, with a frustratingly concurrent over-supply of psychiatrists and facilities in more upscale suburbs. The State of Minnesota has tried to meet some of the need by establishing a network of 16-bed mini hospitals around the state. These have helped but generally are not available to take evening, night, and weekend emergency cases; resulting in hospitals like ours having to deal with psych patients without the facilities or staff to meet the need.

Several months ago I met with a representative from Prairie St. John's and asked them about the services they planned to offer. The informed me of their offices in Plymouth and Woodbury and that they were only planning on offering day treatment and other outpatient services. I specifically asked if they would be interested in working with us at that time to set up an inpatient unit to help us meet the challenges we are facing, as well as our neighboring hospital in Buffalo, with managing psych patients who come to our Emergency Rooms. I was told they had no plans to establish in inpatient facility at that time.

I have several questions. Will the proposed hospital take all payers (i.e. Medicare/Medicaid) or simply take commercial insurance or private pay patients? Will it be open to take emergency admissions? Will there be psychiatrists on call to admit patients in crisis?

It is clear from the data I've seen that we need more psychiatric beds in Minnesota. The State of Minnesota recognized this in awarding the new hospital in Maple Grove to North Memorial/Fairview and requiring it to contain psychiatric beds; which I'm assuming will be required to take emergency admissions. My concern with putting another facility in

Woodbury, 20 minutes away from Maple Grove, is whether it will likewise serve all payers and be available for emergency admissions, or will they limit themselves to an attractive payer mix and hours of admission. We shouldn't use up precious resources (psych nurses, psychiatrists) to provide limited services to limited populations. If the proposed hospital will take all comers and be open to 24-hour a day, seven day a week admissions I would whole-heartedly support it. But if it is to be limited to certain payers and hours of admission, I think resources could be put to better use elsewhere.

Thank you for your time.

Sincerely,

Lynn W. Olson
Chief Operating Officer
Monticello-Big Lake Community Hospital

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Regions Hospital®

January 8, 2008

Julie Sonier, Director
Health Economics Program
Minnesota Department of Health
P.O. Box 64882
St. Paul, MN 55164-0882

Dear Ms. Sonier,

The purpose of this letter is to provide written comments on behalf of Regions Hospital related to Prairie St. John's application/proposal to build a psychiatric specialty hospital in Woodbury. We have based our comments on the application posted on the Minnesota Department of Health (MDH) website and the areas MDH is required to consider. In addition, we have also added questions or comments that we think would be helpful for MDH to explore in the proposal evaluation. This letter will be submitted electronically on January 8, 2008.

Summary comments on the need for psychiatric beds in the east metro:

We believe there is a need for more inpatient capacity that is fully integrated with the continuum of care for persons with mental illness. This includes community, primary and outpatient care, crisis intervention and stabilization, inpatient care, and community based services. Regions Hospital is expanding our inpatient capacity from 80 to 96 beds in February 2008 to better serve persons with mental illness. This follows a 2006 expansion of services and in our emergency department to provide more care and crisis services.

Any new expansion of inpatient capacity in the east metro should serve all persons, regardless of payer source. This includes full participation in serving persons who are enrolled in state public programs. Allowing one institution in the market to accept private pay patients without all other publicly funded patients will change the payer mix of the other institutions. This would ultimately harm access to behavioral health services in the community because the other institutions will have a higher and more disproportionate share of publicly funded and uninsured patients.

There should be an investment in community based, intermediate options for care. Our East Metro Roundtable on Mental illness in 2006 brought together 25 policy makers, public and private providers and community agencies to outline strategies to address pressing needs. This work has resulted in additional support for the East Metro Adult Crisis Services Stabilization team, which Regions supports, and the formation of a new Psychiatric Medication Access program, a collaborative of the east metro hospitals and the St. Paul/Bigelow Foundations. These community based programs demonstrate an ongoing commitment to addressing capacity

in the east metro area that complements inpatient services. In addition, Regions operates Hovander House, Safe House and Safe Alternatives, which provide less restrictive, community based options for persons with mental illness and chemical dependency disorders.

Any new inpatient bed expansion for mental health services should serve persons with medically complex conditions. This is a growing need in this community and one of the reasons Regions Hospital is expanding our unit to better serve persons with co-existing medical problems. We also believe that medical care should be integrated completely with psychiatric care and should not be separate or distinct. For example, in the last year we have had several patients with very extended lengths of stay related to complications from kidney failure and their need for dialysis treatment. We have also seen an increase in patients with complications from Diabetes. This type of treatment requires close coordination and integration of all care provided to these patients.

1. **Does the Prairie St John's hospital proposal for psychiatric beds provide timely access to care or access to new or improved services?**

   An analysis of Regions Hospital behavioral health data demonstrates the need for more intermediate levels of care in order to have discharge options in a timely manner. In addition, our inpatient units are running at full capacity, and the need is driven by an increase in uncompensated care, longer lengths of stay due to lack of available community based resources, as well as those patients with medically complex care needs. In the absence of longer term options to change the patient flow dynamics beginning with prevention, crisis intervention and appropriate housing/intermediate care options, we believe additional inpatient capacity is needed, but not in a specialty model. The specialty model will not provide the full range of care needed by persons with mental illness.

   A significant and growing need in the metro area is for resources that are less restrictive and community based such as supportive housing, case management and supportive outpatient/transitional services. This is both a short and long term issue that will require the commitment of providers and policy makers to work together to improve access. A single specialty hospital will not solve this issue.

   While the proposal calls for additional inpatient beds, we do not see in the proposal any description of how medical personnel will integrate in the facility, or whether the facility will be able to take admissions 24/7/365. If admissions cannot be taken on evenings and weekends, timely access will be compromised. In addition, the location of the hospital in the suburban east metro will make it more difficult to serve a patient base that is low income, uninsured or publicly funded. Police and ambulance are less likely to transport to that area rather than the central metro area. Families and patients will have more difficulty accessing the facility for service and follow up care due to limitations in public transportation availability in that area.

   While the proposal also requests licensed beds for substance abuse treatment, there does not appear to be a lack of adult inpatient/residential beds for treating adult substance abuse patients in the metro area. There is, however, a lack of detox resources and funding in the

community for adult substance abuse patients and adult substance abuse patients with medical/psychiatric co-morbidities. This lack of resource impacts the metro area emergency departments and inpatient mental health beds and is one source of the strain on capacity.

Medical co-existing conditions

Prairie St. John's indicates that patients with unstable medical conditions will not be admitted to the Prairie St John's hospital. That gap will need to continue to be filled by the other metro hospitals in the east metro. Patients that become medically unstable during their stay at Prairie St John's will presumably be transferred to nearest full service ER and hospital with a continuum of psychiatric and general medical care. This raises transition of care and care coordination concerns, as well as transport costs. The proposal does not address these issues.

Prairie St John's indicates patients with medical conditions that can be treated with *routine* nursing care can be admitted. A limited lab and lack of imaging equipment will severely limit these patients from receiving care. We would assume based on the proposal that the following clinical care would be restricted or excluded from admission or continued psychiatric care at Prairie St John's hospital.

- MRSA
- CDIF
- Dialysis
- IV's
- Transfusions
- Telemetry
- Seizures
- Withdrawal symptoms
- Delirium tremens.
- Psychiatric and medical conditions that require extensive diagnostic lab work or imaging

In addition, the proposal does not contain information on staffing of medical personnel to perform routine medical care in order to evaluate the capacity.

2. **How will the Prairie St John's specialty hospital affect the ability of existing hospitals in the region to maintain existing staff?**

We do have a concern is that this model of a psychiatric hospital proposal will negatively impact Regions and other metro area hospitals' ability to recruit and retain clinical staff. The Prairie St John's hospital proposal does not identify a staffing strategy or plan that would enhance supply of clinical staff in the metro area, including psychiatrists, mid-level providers and other members of the clinical team. Our concern is that it would take existing providers, already in short supply, and result in shortages at the full service hospitals. As far as we know, the organization does not have a track record of recruiting and retaining staff in the metro area.

3. **The extent to which the Prairie St John's hospital will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region.**

We assume based on the proposed structure for the hospital and information in the proposal that it will not allow Medicaid patients to access care (e.g.22-64). This raises several concerns:

- The other metro hospitals accept all patients, whether they are uninsured or have insurance (Medicaid, Medicare and Commercial).
- Prairie St. John's will not care for a significant pool of patients that tend to have complicated treatment and significant discharge challenges.
- Represents over 40% of the patients in Regions ED and Inpatient Mental Health
- Raises questions on what happens to patients who present to Prairie St John's with Medicaid or Medicaid pending or those who are dually-eligible for Medicaid and Medicare.
- Given the extent to which the proposal may limit access for patients on Medicaid, and the lack of emergency, crisis and medical services, we doubt there will be any significant charity care provided at this proposed site, and project that it will have no impact on redistributing charity care or Regions Hospital's charity care provision.
- The provisions for self pay are not delineated in the proposal, or whether the proposed hospital would follow the Attorney General guidelines related to discount for self pay rather than their stated guidelines.
- It is not clear in the proposal how the hospital would handle follow up care for persons who do not have the ability to pay, or who would require financial assistance for outpatient services following the hospitalization.

We believe firmly in our point that hospitals should accept all patients (private, public pay and the uninsured). In the absence of full participation in government programs and serving those who do not have the ability to pay, MDH could consider whether to recommend that the hospital would need to commit to a targeted charity care level that would be either through direct services or contribution to a pool for charity care that would be proportional to Regions Hospital's contribution to charity care. These funds would be available to providers to care for persons without the ability to pay.

4. What is the financial impact of the Prairie St John's hospital on existing acute-care hospitals that have emergency departments in the region?

The proposed hospital will not have an impact on lessening admissions to the other metro hospital emergency departments. In addition, to have less than a full service Emergency Department is less than current community standard.

Our understanding is that the proposed hospital would have a Need Assessment department, but not an emergency department. Without an emergency department, it is unclear that the

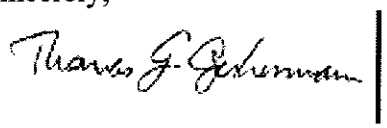
hospital would see persons who need security, clinical 1 to 1 staffing, or intoxicated patients. It is also unclear whether admissions would be available 24/7. In order for the other hospitals to have any relief in emergency department visits, patients with these issues would need to be seen at Prairie St. John's.

The proposal identifies in 2006 that Prairie St John's had 12% of net revenues of uncompensated care (charity care, bad debt, and administrative adjustment). It appears that $345,137 is charity care or 1.38% of net revenue. In contrast, Regions Hospital provided $14.8 million in charity care (actual costs of charity care) in 2006, or 3.78% of net revenue. Further loss of commercial patients to another hospital will have a negative impact on Regions Hospital as well as all east metro hospitals. We do not predict that the addition of a hospital will relieve the charity care provided at Regions.

As you are aware, Regions is actively planning for the future of health care services on our campus, with our 2009 expansion, and we are committed to continuing our service as the east metro safety net provider of behavioral health services. This will be challenging as the population increases and the need for care increases in many service lines. We are equally committed to helping the community develop resources and to be active in the long term public policy changes needed to better serve persons with mental illness in appropriate levels of care. I will be planning to attend the public meeting on the proposal on January 22, 2008 at the Woodbury Central Park Indoor Amphitheater in Woodbury.

Thanks for the opportunity to comment on the proposal. If you have any questions about our comments, please feel free to contact me at (651) 254-3988.

Sincerely,



Tom Geskermann
Vice President for Behavioral Health
Regions Hospital

Julie Sonier - Letter of Support

From: "Haglund, Doreen"
To:
Date: 1/7/2008 8:38 AM
Subject: Letter of Support

January 7, 2008

Julie Sonier, Director
Health Economics Program
MN Department of Health

Dear Ms. Sonier:

This letter is written in support of approval for a new psychiatric hospital in Woodbury, MN. Rice Memorial Hospital in Willmar, MN has an 8-bed behavioral health unit, the Rice Institute. Many times these beds and others in the area are occupied by patients from the Twin Cities. It is our opinion that more beds are needed in the Twin Cities in order to provide timely access to care.

There is a waiting list for psychiatric beds, and Rice would not anticipate any negative financial impact with additional services in Woodbury.

Thank you for soliciting public interest review comments regarding this issue of an exception to the hospital bed moratorium.

Sincerely,

Maureen Ideker, RN
Associate Administrator/Chief Nursing Officer
Rice Memorial Hospital

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February 21, 2008

Ms. Julie Sonier
Director of Health Economics Program
Minnesota Department of Health

Dear Ms. Sonier:

I am writing this letter as requested by Mr. John Ryan, Special Project Liaison with Prairie St. John's Hospital regarding the ongoing need for additional inpatient mental health services in Minnesota.

As the CEO for Riverwood Healthcare Center, I am aware of the ongoing issues faced by our Emergency Room physicians who transfer patients from Riverwood to an appropriate inpatient location for various mental health issues. There is definitely an access problem in Minnesota that requires staff including time from our providers to identify a location in Minnesota that will accept patients. Often, numerous calls are required and precious time wasted that could be dedicated to other pressing emergency situations in order to secure a bed and make the appropriate transfer. With the state closing it's facilities the stress is even greater on the limited locations that are available.

I would encourage you to seriously consider approving the moratorium exception that is being requested by Prairie St. Johns. If I can provide you with additional information, please feel free to contact me.

Sincerely,

Michael Hagen, Ed. D.
Chief Executive Officer
cg

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Julie Sonier - RE: Prairie St. John's moratorium request

From: "PLATT,MELVIN"
To:
Date: 2/7/2008 4:11 PM
Subject: RE: Prairie St. John's moratorium request

I have been contacted by a representative from Prairie St. John's psychiatric hospital to comment about the need for additional beds in the metro area. While I do not have actual statistics in front of me, I do know that we have had a huge number of calls from hospitals within the metro area requesting placement of patients in our unit here at Worthington Regional Hospital. The unfortunate situation that occurs is that most of the time the patients do not qualify for psychiatric care but rather detox or chemical dependency care, which we do not provide at our hospital. This then becomes a difficult situation for the admitting physician as he tries to determine the appropriateness of the admission. I truly believe there is a need for additional services in the metro area, but those services need to be all encompassing to include additional detox and chemical dependency programs that will deal with those patients who require those services. I cannot comment on the need for additional psychiatric beds since most of the calls from the metro area do not qualify for admissions to a acute psychiatric ward.

I would encourage the Mn. Department of Health to carefully review the request from Prairie St. John to insure they are willing to provide the appropriate level of care based on the need in the area served. Detox and chemical dependency inpatient services are badly needed. Is there a need for more acute psychiatry.

Thank you for listening.

Melvin J. Platt, Chief Executive Officer
Worthington Regional Hospital
1018 6th Ave.
Worthington, MN. 56187
Telephone 507-372-3110
Fax: 507-372-3240
email: plattm@sanfordhealth.org

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From: Char K Myklebust <CKMyklebust@district287.org>
To: <Julie.Sonier@state.mn.us>
Date: 1/13/2008 7:16 PM
Subject: Support for Prairie Saint Johns

Dear Ms. Sonier -

I am writing in support of Prairie Saint Johns request to provide inpatient psychiatric care in Minnesota.

As the former mental health supervisor in a large metropolitan consortium of school districts, I have been dismayed at situation after situation involving young people with significant mental health needs who were turned turned away from hospitals. Youth and families are forced to endure lengthy waits - sometimes 8 weeks - to see psychiatrists; even when symptoms have risen to the point of suicidal ideation and threats.

Thanks to you and others who are called upon to consider Prairie Saint Johns' request to add this much needed service to the continuum of mental health care in Minnesota.

Sincerely,

Dr. Charlene Myklebust, Psy.D.
Director of Social Emotional Learning
Intermediate District 287 (13 suburban Hennepin County school districts)
1820 Xenium Lane North
Plymouth, MN 55441

CITY OF Fargo

Mayor Dennis R. Walaker
200 3rd Street North
Fargo, North Dakota 58102
Phone (701) 241-1310
Fax (701) 476-4136

November 13, 2007

Dr. Sanne Magnan
Minnesota Commissioner of Health

Dear Commissioner Magnan:

I am writing in support of Prairie St. John's efforts to build a mental illness and chemical addiction treatment hospital in Woodbury, Minnesota. Prairie St. John's Hospital in Fargo, North Dakota has been an excellent health provider in our community. They are also a good corporate and community taxpayer for our city and state.

Since 1997, Prairie St. John's has operated a freestanding psychiatric hospital in Fargo providing much needed services to our citizens. They also have a positive history of providing uncompensated care to Minnesota and North Dakota citizens who desperately need mental healthcare but cannot afford to pay for their services.

I believe Prairie St. John's will make an excellent addition to the psychiatric care community in Minnesota, as it has in North Dakota.

Sincerely,

Dennis R. Walaker
Mayor

DRW:sf
wwpsj

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CITY OF Woodbury

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January 8, 2008

Julie Sonier
Minnesota Department of Health
Health Economics Program
85 East 7th Place, Suite 220
St. Paul, MN 55101

Re: Application for New Hospital (Prairie St. John's)

Dear Ms. Sonier:

The City of Woodbury has been working for some time on the creation of a medical campus district in Woodbury. The concept for a medical campus district arose from the recent update of the city's commercial comprehensive plan. The Comprehensive Plan Task Force felt that the area by the Woodwinds Health Campus and Hospital presented a unique opportunity for a concentration of medical-related uses and associated professional jobs anchored by the hospital. A market study, by the McComb Group supported this idea, and found that:

- Woodbury has less medical office space, fewer hospital beds and a lower physician market share than would be expected based on its trade area size. The large trade area and population per bed suggests that more beds can be supported.
- Physician offices and employment have grown about 8 percent annually.
- Having a supply of developable land makes it possible for medical offices to locate near hospitals and expand as their business grows.
- The demand for hospital beds and medical office space is inter-related. Developable sites in medical centers provide hospitals and medical specialty groups the opportunity to expand in a cooperative manner as the health care needs of their trade areas increase.

The request by Prairie St. John's to build a psychiatric hospital facility in Woodbury is consistent with the City's plans to create a medical campus district in this vicinity. The use is consistent with the City's vision. The facility as it has been described to us would involve 80 beds, which would provide in-patient care for mental health needs. It would also include an out-patient care component as well. Prairie St. John's currently has an out-patient facility in Woodbury and has been a good corporate citizen of Woodbury.

Partners in Healing
of Minneapolis

Principal Partners

David Alter, PhD, LP
Licensed Psychologist, ABPP, ABPH

Deborah S. Simmons, PhD, LMFT
Licensed Marriage and Family Therapist

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Past President, American Holistic Medical Association

Associates

Glenda Cedarleaf, MSW, LICSW
Licensed Independent Clinical Social Worker

Tamara Taylor, L.Ac.
Licensed Acupuncturist/Herbalist

Patricia Enstad, MS, CMT
Certified Massage Therapist

Alana Riss Fine, PhD, LP
Licensed Psychologist

Kathy Jennings, CTP
Certified Trager Practitioner

February 4, 2008

Julie Sonier, Director
Health Economics Program
Division of Health Policy
Minnesota Department of Health
PO Box 64882
St. Paul, Minnesota 55164

Dear Ms. Sonier:

I am writing in support of the application by Prairie St. John's to add new inpatient psychiatric and chemical dependency beds in Woodbury.

As a Ph.D. mental health provider for the last 13 years, I am all-too-familiar with the shortage of beds for mentally ill children, adolescents and adults in the Metro area. Demand for hospital services is growing, but availability is shrinking. Health East has eliminated its child psychiatric unit at St. Joseph's hospital and other hospital systems have not increased their capacity. Regions Hospital is adding 10 inpatient beds, but they are also adding 10 psychiatric beds in their emergency department, which is an acknowledgement that they and other Metro hospitals cannot admit psychiatric patients for the care they need. The need is particularly critical for children and adolescents.

Minnesota's mental health system is failing to meet the needs of patients. The current system requires admission of patients hundreds of miles and hours of driving away from family, friends and support systems. This is the single most ineffective approach of treatment.

Again, as a clinician who must deal with the aftermath of the failure of the current mental health system to provide the services needed to prevent further suicides, murders and pain by patients and their families, please find that the Prairie St. John's application is in the public interest.

Sincerely,

Deborah S. Simmons, PhD, LMFT

A Center for Holistic Health
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Julie Sonier - hospital

From: "Diane Preston"
To:
Date: 1/31/2008 7:39 PM
Subject: hospital

Dear Ms. Sonier;
I am a nurse at Woodwinds Hospital and just wanted to let you know my concerns. I am very concerned about the lack of inpatient psychiatric beds in the Twin Cities, esp. in the Woodbury area. I am supporting Prairie St. Johns to go ahead with the building of the psychiatric hospital in Woodbury as planned. I know there is a critical shortage of psych inpt. beds in the area. Many times these psych patientss are trying to get admitted on medical floors but often there is no space available. Even when they are admitted, the care is not what it should be . These patients deserve to have the treatment that Prairie St. Johns is proposing with the building of this new hospital. Thank you for anything you can do to facilitate this.

Diane Preston, R.N.

Julie Sonier - new mental health facility in St Paul...

From:
To:
Date: 1/30/2008 10:19 AM
Subject: new mental health facility in St Paul...

Dear Ms. Sonier,

I am horrified to hear that a group is trying to put another mental health facility in the Twin Cities!
Minnesota's approach to mental health is not leading to improved conditions for those with mental health problems. A number of the victims of these facilities are walking Nicollet Mall in a daze dressed in rags and talking to theirself. I have seen this and decided to do everything I can to prevent anyone who pushes the use of psychotropic drugs on children or who condones shock treatment or any other crime against mankind from getting in an office of anykind. Building another mental hospital just continues this unsuccessful approach, and will lead to more ruined lives.

I beg you to please make a surprise visit to one of these facilities in our state and demand to see what is being done to people there. Demand an investigation, get statistics, get written statements from those whose lives have been ruined by electric shock treatments. Demand to see how many of our youth have died from suicide while under the care and treatment of a psychiatrist. Anyone who would condone this approach has not looked for and confronted the truth about it.

Thank you for listening,
Donna-Gail Wilcock

Start the year off right. Easy ways to stay in shape in the new year.

From: eleanor1204
To: Julie.Sonier@mn.state.us
Date: 2/9/2008 9:48:52 AM
Subject: Need for Psychiatric beds

Dear Ms. Sonier,

I am writing in support of the Prairie St. John's proposal to build a Psychiatric Hospital In Woodbury. For the last two yeas one of my granddaughters has been having severe mental problems These included having delusions when she was hearing voices and threatening other members of the family with a butcher knife. On three occasions there were no Psychiatric beds available in the metro. One time the family was told to get all dangerous articles out of the home and the hospital would call when a bed was available. That took three days.

The last time she was in a crisis she was transported to Fargo. You can imagine the increased mental strain for a child to be placed so far from her family. In addition, it is a great strain for the family to have to miss work to get back and forth to Fargo. The bright side of the picture is that with adequate help at Fargo and follow-up at Prairie St. John's, she is doing well, and has had no outbursts. It is too bad that a family must go to such extreme steps to get adequate mental help for their child. We need more beds available locally.

Sincerely, Eleanor Daly

Eleanor Daly
1745 Graham Av. #336
St. Paul, MN. 55116-3287

Apparently I have an incorrect e-mail address.

To: Julie Sonier, director
Health economics program
Mn. Dept of Health

1/26/2008

Dear Julie,

We are writing to express our support for the psychiatric/chemical dependency hospital being proposed in Woodbury, MN. We are residents and taxpayers in Woodbury. We are both nurses. I work in the local community hospital that does not have any psychiatric beds. When people come to the E.R. seeking help for their crisis/mental health issue, they wait for hours with no psychiatric care, only to be transferred upstairs to a med-surg bed which absolutely does not meet their need, since there is no psychiatric care. They frequently wait for days only to pay for an ambulance transport when a psychiatric bed becomes available, in many instances - hours away. Patients seeking help are often suicidal and sometimes homicidal. It seems to me they deserve immediate help. It is a shame that we add insult to injury by not providing the help they need. Do we need the blood of these people and/or their loved ones on our hands before we do something.

Prairie St Johns has proposed a solution to Minnesota's deficit of psychiatric beds. It is incomprehensible to us that they are being met with resistance when there is such an obvious need.

We need psychiatric beds and at least the leaders of prairie St Johns wantto and are willing to help with the mental health crisis. Please encourage the Legislature to approve the proposed hospital. Sincerely, Judith A. Johnson
Todd Johnson

Julie Sonier, Director
Health Economics Program
Minnesota Department of Health
PO 64882
St. Paul, MN 55164-0882

1/30/2008

Julie
I am in support of having an inpatient physchiatric unit in Prairie St. John's
In Woodbury.

I feel there is a GREAT need for this facility to be built in this community.

I have experienced first hand the frustration of not having help available.

Please strongly consider seeing this through and building the facility
for inpatient physciatric help to the community.

Mary Hertaus
Mary Hertaus

MINNESOTA PIPE TRADES ASSOCIATION

Affiliate of the United Association
Composed of Journeyman and Apprentices of the Plumbing and Pipe Fitting Industry
Of the United States and Canada
State Federation of Labor – A.F.L.-C.I.O.

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Pipefitters
Local #455

Virginia
Plumbers and Pipefitters
Local #589

Road Sprinkler Fitters
Local #669
District 28

January 11, 2008

Julie Sonier, Director
Health Economics Program
Minnesota Department of Health
PO Box 64882
St. Paul MN 55164-0882

Dear Ms. Sonier:

I am writing to voice the support of the Minnesota Pipe Trades Association for the proposal by Prairie St. John's to build a hospital in Woodbury to provide care to patients suffering from a crisis in their mental or chemical health.

The current mental health system is in crisis. Patients in St. Paul needing care are transported to Fargo because there are no beds in St. Paul. Patients in Rochester are transported to Duluth because there are no beds in Rochester. Patients in Brainerd are transported to Willmar because there are no beds in Brainerd. Patients have even been transported to Winnipeg because there are no beds in Minnesota or a neighboring state.

This is wrong. Patients suffering from serious mental illnesses should receive care close to home where their families and loved ones are. The proposed Prairie St. John's hospital will begin to address some of the shortages patients face when seeking the care that may save their life. If this hospital is built, Minnesota will still be underbedded compared to other states. But the problem will be less and more patients will receive care close to home.

On behalf of the thousands of families in the Minnesota Pipe Trades Association, I encourage your support for this proposal which is so desperately needed for our members, their families and the public.

Thank you,

Tom Hansen

Thomas Hansen, President
Minnesota Pipe Trades Association

TH:km

Julie Sonier - Prairie St. John's Hospital

From: Todd Johnson
To:
Date: 1/27/2008 8:18 PM
Subject: Prairie St. John's Hospital

Dear Julie,

I fully support Praire St John's proposal to build a specialty psych/chem dep hospital in Woodbury. These are the reasons why.
My name is Todd Johnson. I have been a nurse for 15 years and have vast experience in multiple settings from nursing homes to critical care. I live in Woodbury and have personal and professional experience in chemical dependency and mental health. My most recent experience was when my nephew was admitted to Region's Hospital, through the ER against his parent's wishes. They kept my nephew in a locked unit for one week with no psych eval for several days.There was no ongoing psychiatric help. My nephew and family were upset and frustrated at the lack of compassionate care and asked for my support. We met with the administrator of Region's hospital and received no satisfaction from his response to our concerns. We had to fight the system to get my nephew transferred to a place where he actually recieived appropriate care and treatment. My sister transported him to Prairie St John's in Fargo, ND. She had to drive 4 hrs each way and pay for a hotel multiple times because there were no other open beds in the twin cities. My nephew recieved great care at this facility and he was able to return home with appropriate outpatent services, in a short time. (the psychiatrist at Region's had recommended my nephew be placed permanantly in a state institution, based on the only (30 minute) eval done at Region's in a week. I currently work in home care and have seen community resources being exhausted by new immigrants. I see other clients who were born here and worked their whole lives here, have retired and are unable to recieve some of these community services.
What upsets me is that these corporations that oppose Prarie St John's are more concerned about money then about the solution that Prairie St John's provides to the desperate need our community has for more psychiatric beds.
Thank you very much for your time and consideration.

Todd Johnson

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