



Public Interest Review

**EVALUATION OF A PROPOSED INPATIENT MENTAL HEALTH HOSPITAL IN
SAINT PAUL, MINNESOTA**

11/30/2022

Public Interest Review: Evaluation of a Proposed Inpatient Mental Health Hospital in Saint Paul, Minnesota

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Hospital public interest reviews in Minnesota

Overview of the standard public interest review process

Since 1984, Minnesota law has prohibited the construction of new hospitals or the expansion of bed capacity at existing hospitals without authorization from the Legislature.¹ As originally enacted, the law included specific exceptions to the moratorium on new hospital capacity. More exceptions were added over time—with the statute currently including 33 exceptions. While generally restrictive, the hospital construction moratorium does not limit the use of historically held licensed beds and allows the ability of hospital systems to use closed licensed capacity at different locations under certain conditions.²

The Minnesota Legislature established a procedure for reviewing proposals for exceptions to the hospital moratorium statute in 2004 to aid the Legislature’s deliberations and decision-making on proposed exceptions.³ Under this procedure, hospitals seeking an exception to the moratorium must submit a plan to the Minnesota Department of Health (MDH) for a “public interest review.” The purpose of the public interest review then is to provide the Legislature with an independent, evidence-driven assessment by MDH as to whether, on the whole, the additional beds are or are not in the public interest. In conducting a public interest review, Minnesota Statutes, section 144.552 directs MDH to consider all relevant factors but—at a minimum—the following specific factors are shown in Figure 1:

Figure 1: Public Interest Review General Considerations



¹ [Minnesota Statutes, section 144.551](#)

² For example, the Fairview University of Minnesota Medical Center held 1,700 licensed beds in 2020, but only staffed 767 of these beds. Across all hospitals in 2020, there were 4,823 unused or banked licensed beds with more than half in Hennepin and Ramsey Counties. In addition, Minnesota Statutes 144.551 allows a corporate hospital system to transfer up to 50% of the capacity of a closed facility under certain conditions including limiting increased site capacity by less than 50%, remaining within geographic boundaries, avoid the construction of a new building, and first replacing services from closed beds before using the beds for other purposes (see subdivision 1, (b) (8)).

³ [Minnesota Statutes, section 144.552](#)

- 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 with 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.

For existing hospitals constructing a new facility the following additional criteria apply:⁴

- The ability for the applicant to maintain the current level of community benefit⁵ at the existing facility; and,
- The impact of layoffs at the existing facility including:
 - Transitioning current workers to the new facility;
 - Retraining and employment security for current workers; and,
 - Addressing the impact of layoffs at the existing facility on affected workers

Legislative changes to public interest reviews concerning mental health capacity

On June 2, 2022, [Minnesota Session Laws Chapter 9, House File 2725 \(revisor.mn.gov\)](#) was signed into law. It granted a conditional exception to the hospital construction moratorium to a partnership between Fairview Health Services and Acadia Healthcare to build a 144-bed psychiatric hospital on the site of the former Bethesda hospital in Saint Paul—should the commissioner of health determine that the proposal was in the public interest.

This legislative action represents a deviation from the standard practices related to considering exceptions to the hospital bed moratorium. Most typically, MDH conducts a public interest review of a given proposal and submits the report or an initial findings letter for decision-making by the Legislature. At various times, the Legislature has acted on a proposal to build a facility or expand bed capacity absent a public interest review or approved once the application for a review was submitted. In this case, the Legislature delegated the decision on whether or not to permit the proposed hospital to the commissioner of health following her consideration of the evidence in the public interest review.

⁴ Application materials submitted to MDH from Fairview Health Services and Acadia Healthcare specifically mention that the hospital construction project was intended to replace existing capacity at St. Joseph’s Hospital—which had historically staffed 105 inpatient mental health beds. This means that two additional considerations are required.

⁵ Hospital ‘community benefit’ is defined in [Minnesota Statutes, section 144.699](#), subd. 5.

Thus, while MDH may have suggested changes or different approaches in other reviews, in this review, a yes or no decision formalized the approval without any legislative review or modification.

The legislation that conditionally authorized the exception also included the following requirements for the new hospital if found in the public interest:

- The new hospital must have an intake and assessment area.
- The hospital must accommodate patients with acute mental health needs, whether they walk up to the facility, are delivered by ambulance or law enforcement, or are transferred from other facilities.
- The hospital must comply with new requirements related to exceptions for increased mental health bed capacity from August 1, 2022 to July 31, 2027, including:
 - Using all newly licensed beds exclusively for mental health services.
 - Accepting Medical Assistance and MinnesotaCare enrollees (Minnesota programs funded by the federal Medicaid program).
 - Abiding by the Minnesota Attorney General Hospital Agreement.
 - Having an arrangement with a tertiary care facility or a sufficient number of medical specialists to determine and arrange appropriate treatment of medical conditions.
 - Submitting to the commissioner requested information deemed necessary for the commissioner to conduct the study of inpatient mental health access and quality.
 - Submitting de-identified data to MDH in the format and manner described by the commissioner.

MDH is further tasked with monitoring the new hospital and retains the authority to refuse to grant or renew, suspend, or revoke, a hospital license that would be in violation of the section of Minnesota statutes that includes the requirements above.⁶

Authority to approve other exceptions to the hospital moratorium still rests with the Legislature. However, section 4 of [Minnesota Session Laws Chapter 99, House File 2725 \(revisor.mn.gov\)](#) also created a new process that exempts new mental health beds and psychiatric hospitals built between August 1, 2022 and July 31, 2027 from public interest review. MDH is required to monitor any such exceptions. In addition, section 2 of this law includes enforcement provisions, including the possibility for non-renewal of licenses for hospital beds under this specific exception—if found to not satisfy the conditions in the law noted above during the five-year period. This broad exception, nevertheless, excludes a new psychiatric hospital to be built on the Bethesda hospital site.⁷

⁶ [Minnesota Statutes, section 144.55 subd. 6](#)

⁷ Section 3 of [Minnesota Session Laws 2022 Chapter 99, House File 2725 \(revisor.mn.gov\)](#).

Key milestones and additional context for this review

MDH completed its review on and shared its finding with Fairview Health Services and Acadia Healthcare on September 9, 2022. Subsequently, on September 12, 2022, MDH publicly released its finding that the proposal is in the public interest. Unlike most reviews, the decision was whether, on balance, the new hospital was in the public interest, despite concerns raised by MDH and the public. Like all associated material for the review, the findings letter is available here: [Public Interest Review Letter to Fairview Health Services and Acadia Healthcare \(health.state.mn.us\)](https://www.health.state.mn.us/comm/assessments/20220912/20220912-fairview-acadia-public-interest-review-letter.pdf)

This document serves as an articulation of the available evidence considered as part of MDH's public interest review and the resulting findings.

The proposal for the establishment of a new mental health hospital in Saint Paul, Minnesota

Background

In November of 2021, Fairview Health Services (Fairview) and Acadia Healthcare (Acadia) submitted a letter of intent to MDH to obtain a 144-bed hospital license for the operation of 120 adult inpatient mental health beds. An official notice was then published in the *Minnesota State Register*⁸ as required by [Minnesota Statutes 144.553, Subd. 1](#). When no competing proposals materialized, Fairview and Acadia submitted a joint venture proposal for a new mental health hospital. All materials pertaining to the proposal, including responses to MDH questions and public comments on the proposal are available online.⁹

Overview of Fairview Health Services and Acadia Healthcare

Fairview is a nonprofit integrated health care system based in Minneapolis, Minnesota. It owns and operates nine hospitals, over 80 primary and specialty care clinics, several ambulatory surgical centers, pharmacies, and long-term care facilities within the state. Among their partnerships, Fairview owns part of at least five ambulatory surgical centers that are for-profit, with some of these arrangements going back at least a dozen years. Fairview reported \$6.4 billion in operating revenue in 2021.¹⁰ It is the second largest health care delivery system after Allina Health in the Twin Cities Metro—where six of its nine hospitals are located—with a 26.5% market share. Fairview also extensively partners with the University of Minnesota Medical School and University of Minnesota Physicians under the M Health Fairview agreement, including joint operation of M Health Fairview University of Minnesota Medical Center (UMMC). Currently, Fairview hospitals all operate under the M Health Fairview agreement.

As of 2020, Fairview operated 198 of the Twin Cities Metro’s 684 adult mental health beds (or approximately 29%) with the majority located at UMMC. Since the closure of its psychiatric unit at M Health Fairview Southdale Hospital in 2019 (18 beds) and M Health Fairview St. Joseph’s Hospital in July, 2022 (historically about 105 beds), all of Fairview’s currently operating mental health beds in the Metro are at UMMC.

Acadia is the largest stand-alone behavioral health company in the United States, operating a network of 230 behavioral health care facilities with approximately 10,200 beds in 40 states and Puerto Rico. Acadia operates psychiatric hospitals, specialty treatment centers, residential treatment centers, and outpatient clinics—serving approximately 70,000 patients daily. Acadia does not

⁸ [Minnesota State Register Volume 46 Number 22 \(mn.gov\)](#)

⁹ [Fairview Health Services – Acadia Healthcare Public Interest Review \(health.state.mn.us\)](#)

¹⁰ Fairview Health Services Continuing Disclosure Statement for the Year Ended December 31, 2021.

currently operate any facilities in Minnesota. Unlike Fairview Health Services, Acadia Healthcare operates as a for-profit organization publicly traded on global stock markets since 2011.

After reviewing the initial submission, MDH requested additional information on the proposal on February 3, 2022. It issued a notice of complete application on April 12 after receiving the additional information on February 16.¹¹ The Minnesota Legislature subsequently held hearings on the proposal and passed an exception to the hospital bed moratorium.¹² The language of the moratorium exception pertaining to the Fairview/Acadia proposal differed from typical approaches in the following ways:

1. By making the exception subject to findings from the commissioner’s public interest review, the Legislature, for the first time, delegated its decision-making authority over an exception to the hospital construction moratorium to a state government agency, by basing approval or denial on MDH’s public interest review finding rather than final legislative action.
2. The Legislature required that, following the completion of the construction project, MDH monitor the operations of the facility, “... including by assessing the hospital’s case mix and payer mix, patient transfers, and patient diversions.”
3. The Legislature required that the hospital “... accommodate patients with acute mental health care needs, whether they walk up to the facility, are delivered by ambulances or law enforcement, or are transferred from other facilities.”
4. The Legislature specified that the new facility would also be subject to new oversight provisions for new mental health facilities and beds, pertaining to operating practices, and annual data submission requirements to be established by the commissioner.¹³

In the months following the notice of complete application, MDH solicited feedback and data on bed capacity from other Minnesota hospitals with adult inpatient mental health beds, held a virtual public meeting to give the general public the opportunity to comment, held conversations with emergency medical services providers and other stakeholders, and sought additional clarifying information from Fairview and Acadia about the proposal and how the proposed hospital would meet new requirements set forth by the Legislature.

¹¹ [Minnesota Statutes, Section 144.552 \(c\)](#) requires that MDH issue a finding within 150 days of sending a notice of complete application. The deadline for this finding was September 9, 2022.

¹² [Minnesota Session Laws 2022 Chapter 99, House File 2725 \(revisor.mn.gov\)](#). The discussion and testimony at the Minnesota Legislature is not included in this public interest review.

¹³ [Minnesota Session Laws 2022 Chapter 99, House File 2725, Sec. 4 \(revisor.mn.gov\)](#).

Project description

Application materials submitted by Fairview and Acadia stated that the new hospital would replace and provide additional inpatient mental health and addiction care capacity previously available at St. Joseph's Hospital in Saint Paul.¹⁴ Fairview specifically noted that the 400-bed licensed St. Joseph's Hospital (with about 240 staffed beds) had historically operated 105 inpatient mental health beds that were reduced to 92 beds in 2018, 85 in 2019, 56 in 2020, and down to 40 beds in 2021 through the first half of 2022 before closing on July 1, 2022.^{15,16}

The population identified by Fairview and Acadia includes adults living in the 15-county service area shown in the maps in Figures 2 and 3 that includes Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Mille Lacs, Pine, Ramsey, Scott, Sherburne, Washington, and Wright counties. This area was selected by Fairview and Acadia because it was consistent with the broad geographic area served by St. Joseph's Hospital inpatient mental health services (90% of patients)¹⁷ and includes most of the other Fairview hospitals that have emergency departments, which are assumed to be acting as a primary entry point for the new hospital. The maps include state hospitals operated by the Minnesota Department of Human Services (DHS). These state-run facilities are different from other hospitals in that they often provide care for patients with long-term high acuity needs and often house patients involved in the criminal justice system.

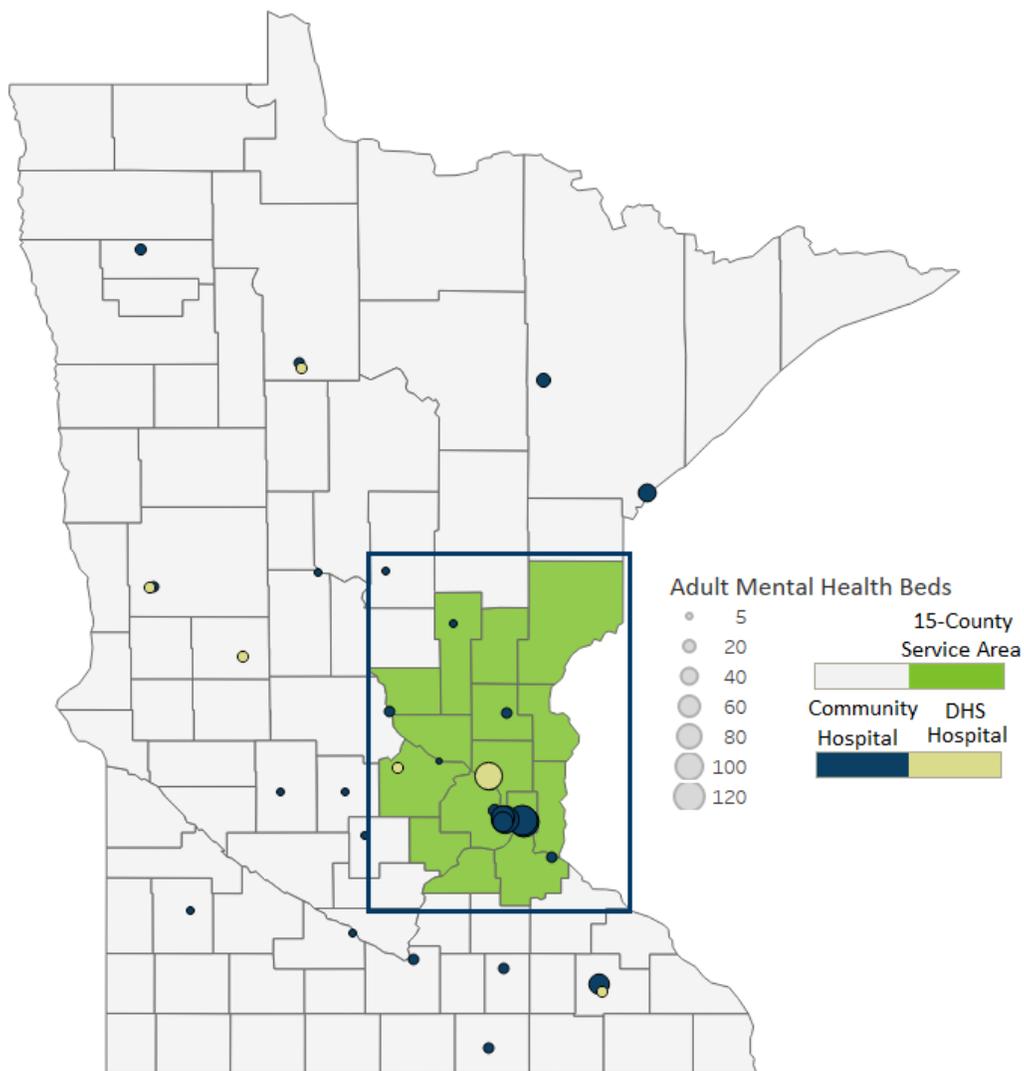
¹⁴ Fairview acquired St. Joseph's Hospital in 2017 in the acquisition of HealthEast Health System that included two other hospitals in the East Metro including St. John's Hospital in Maplewood and Woodwinds Health Campus in Woodbury.

¹⁵ St. Joseph's Hospital closed its emergency department in December of 2020, see: [St. Joseph's ER in St. Paul closes Wednesday morning - StarTribune.com](#).

¹⁶ Fairview also closed an 18-bed inpatient mental health unit at Fairview Southdale Hospital in 2020. Cumulatively, these combined closures of 123 previously available mental health beds are roughly equivalent to the 120 beds that are proposed to be in use at the new hospital (though the requested license is for 144 beds). In addition, St. Joseph's Hospital also had a 32-bed chemical dependency unit until 2020.

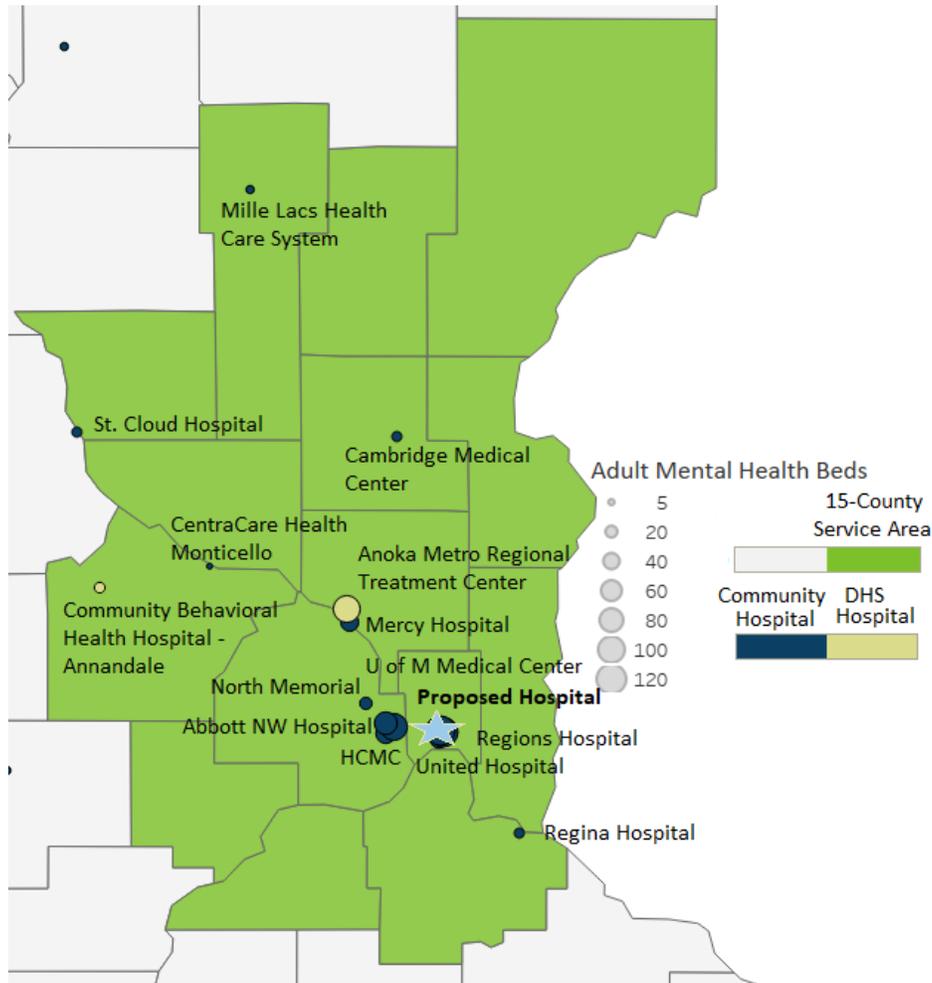
¹⁷ Hospital primary service areas are generally considered to include the area where most (up to the 75th percentile) of patients originate; the secondary service area includes all but the last decile (90th percentile).

Figure 2: Map of the Minnesota Hospitals with Adult Mental Health Beds



Source: MDH analysis of data collected from Minnesota hospitals. 'DHS' is the Minnesota Department of Human Services.

Figure 3: Map of the 15-County Service Area Identified for the Proposed Mental Health Hospital and Service Area



Source: MDH analysis of data collected from Minnesota hospitals. ‘DHS’ is the Minnesota Department of Human Services.

The proposed new hospital under the Fairview/Acadia for-profit joint venture would constitute a freestanding adult inpatient mental health facility with 144 licensed beds (up to 120 staffed beds) on the site of the former Bethesda Hospital at 559 N Capitol Blvd, St. Paul. Due to the proximity to the Minnesota State Capitol, Minnesota law requires approval from the Capitol Area Architectural and Planning Board (CAAPB) to demolish the existing complex and build the proposed new facility. That approval was granted on August 24, 2022.¹⁸

The proposal estimates a cost of \$62 to \$70 million to demolish Bethesda Hospital and construct in its place the proposed new facility with five separate 24-bed inpatient units. These five units would be

¹⁸ For more information on CAAPB documents and public outreach on the proposed mental health hospital, please visit: [Capitol Area Architectural and Planning Board \(mn.gov\)](https://www.capitolareaarchitecturalandplanningboard.mn.gov/).

broadly designated for dual diagnoses of mental health and addiction, mood disorders, thought disorders, geriatric mental health, and general psychiatry. The hospital would also provide non-acute mental health services, including outpatient and partial hospitalization.

Acadia would be the primary operator of the facility in a joint venture arrangement with Fairview and a split ownership of 85% and 15%, respectively. The responsibility for financing would be equivalent to ownership shares. Staffing will be similarly structured with Acadia providing most of the personnel for the facility, while Fairview would provide physician and advanced practitioner services. The agreement includes provisions that the hospital's oversight board will be evenly split between Fairview and Acadia. Three board members from each organization would govern the joint venture.

The proposed hospital represents a different model of care than existing hospitals with adult mental health units in the Twin Cities Metro Area in a few significant ways.

- The facility would not be attached to a general hospital with the full array of diagnostic and therapeutic capability of such hospitals.
- The new facility would not operate an emergency department; rather, the hospital would work primarily with other Fairview hospital emergency departments¹⁹ to accept patients and would operate a 24-hour 'intake and assessment area' to accommodate unexpected patients at the facility.
- As a free-standing hospital exclusively for the provision of mental health care services, not all care at the proposed facility for Medical Assistance patients would be eligible for federal match²⁰ due to the federal Institutions for Mental Disease (IMD) exclusion. This would require the state to cover more costs than at other facilities due to the hospital's size and its free-standing nature.
- The facility would be operated as a for-profit organization without some of the requirements that are in place for nonprofit hospitals, including conducting a community health needs assessment with accompanying implementation strategy, establishing a written financial assistance policy for medically necessary care, complying with limitations for those eligible for financial assistance, and complying with specified billing and collection requirements.²¹

¹⁹ Materials submitted to MDH for the proposed hospital on May 13, 2022 noted that the new hospital would accept patients in a similar manner to the inpatient mental health unit at St. Joseph's Hospital in 2021 where most patients (82%) were admitted from Fairview hospital emergency departments.

²⁰ In Minnesota, the Medicaid program is called Medical Assistance.

²¹ James, J. (2016). *Nonprofit hospitals' community benefit requirements*. Project HOPE. As noted later in this report, legislation that conditionally authorizes the exception for the proposed mental health hospital also includes a provision that the hospital 'abide by the terms of the Minnesota Attorney General Agreement'. This agreement includes requirements for hospitals' billing and collection practices. For more information, visit: [Health Care | The Office of Attorney General Keith Ellison \(state.mn.us\)](https://www.healthcare.illison.state.mn.us).

Freestanding mental health specialty hospital

In their proposal, Fairview and Acadia described the approach of focusing exclusively on mental health care as one way of addressing reimbursement challenges for delivering inpatient mental health care. Specifically, the business model for this facility will not have to support medical equipment and personnel characteristic of a general hospital with an embedded mental health unit. Fairview and Acadia also stated that a share of admitted patients with acute medical needs would need to be served at another hospital with more comprehensive medical facilities and other patients with substantial medical needs might not be admitted.

Nevertheless, the applicants noted that certain acute and chronic conditions would be managed at the hospital along with mental health needs. For example, the facility would be prepared to serve patients with conditions that may include diabetes, hypertension, intoxication, overdose, certain wounds from self-harm, frostbite, heat stroke, dehydration, and diseases of the heart, liver, or kidneys. Each patient would receive a full initial and/or confirmatory laboratory blood/urine/specimen evaluation upon admission to the hospital and receive diagnostic imaging services as necessary. In addition, the hospital would employ or contract with advanced practitioners including physicians, physician assistants, and nurse practitioners, to meet medical needs according to regulations and guidelines from the Centers for Medicare and Medicaid Services, the Joint Commission, and the Minnesota Department of Health.

24-Hour intake and assessment area rather than emergency department

The proposed hospital would have a 24-hour-a-day intake and assessment area to accommodate patients²² who arrive unexpectedly. Therefore, the 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.²³ However, materials submitted to MDH indicated that the hospital would not function as an emergency department and that most patients would not arrive unexpectedly. Fairview and Acadia envision most admissions taking place via transfer from other

²² The Fairview and Acadia letter to MDH dated May 13, 2022 noted that “Every patient who presents to the mental health hospital will receive a medical screening exam (MSE) performed by an appropriate provider to determine whether there is an acute medical or psychiatric emergency and whether they meet admission criteria for inpatient care. Admission criteria involves clinical determination of medical necessity and the capabilities of the hospital to treat the patient’s condition. In the context of mental health care, ‘medical necessity’ refers to symptoms that require hospitalization and does not designate medical conditions beyond mental health diagnoses for mental health units.”

²³ This requirement is referred to as EMTALA, which includes the Emergency Medical Treatment and Labor Act (42 U.S.C. 1395dd) and associated regulations. Federal licensing requirements mandate that hospitals without emergency departments must have appropriate policies and procedures in place for addressing individuals’ emergency care needs 24 hours a day and 7 days per week. This includes the following activities of hospitals: appraising patients with emergencies by qualified staff; providing initial treatment on-site with qualified staff; development of policies and procedures in place to transfer emergent patients whose needs exceed the hospital’s capabilities; and arranging transportation while only using 9-1-1 emergency medical services in extraordinary circumstances ([State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals \(cms.gov\)](#)).

locations with emergency departments, rather than patients being brought directly to the facility, including via ambulance or law enforcement.

Increased state funds necessary for certain patients

As explored in greater detail in the following section of this report,²⁴ Fairview and Acadia repeatedly stated in documents submitted to MDH that patients would not be denied access to care based on payment source. This ‘payment blind’ approach is complicated for certain patients who are covered under Minnesota’s Medical Assistance program, as the federal government has a long-standing policy of limiting financial reimbursement to large freestanding mental health hospitals since the 1960s.²⁵

The provision, known as the IMD exclusion, applies to institutions with more than 16 beds that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including substance use disorders.²⁶ This would almost certainly apply to the new facility, which means care for all individuals on fee-for-service Medical Assistance and individuals covered by Medical Assistance managed care with stays of longer than 15 days per month could not be reimbursed with federal dollars. Minnesota has opted to use state funds to finance care for Medical Assistance enrollees requiring care in an IMD facility, resulting in the need for devoting additional state-only spending for certain care at the proposed facility.

The unique approach to designing delivery of inpatient adult mental health care services makes conducting a public interest review challenging. With no other hospitals in Minnesota operating without co-location of a full array of medical services and an emergency room,²⁷ there are no examples against which to test assumptions about patient and payer mix. This significantly limits the ability to accurately assess the contribution of the facility to the local care environment and the impact on other hospitals.

²⁴ Section 3, Factor 4: The provision of care to low-income and nonpaying patients at the hospital will offer details on the expected access for these populations.

²⁵ Most individuals with acute mental disorders were cared for in large public institutions prior to the 1960s, and subsequent efforts were made at the federal and state level to develop a more ‘deinstitutionalized’ approach where a relatively short episode of treatment in a hospital would stabilize severe symptoms, and patients would enter community-based care and rehabilitation post-discharge.

²⁶ Section 1905(a)(B) of the Social Security Act prohibits federal Medicaid payments for patients between age 21 and 65 in an IMD facility.

²⁷ The Minnesota Department of Human Services (DHS) operates seven freestanding psychiatric hospitals in Minnesota without emergency departments; however, these hospitals often provide care for a certain subgroup of patients who can be hard to place in other settings, including those with highly challenging, long-term needs. For example, the two DHS facilities in the proposed service area included the Anoka Metro Regional Treatment Center and the Community Behavioral Health Hospital – Annandale, which had an average length of stay of 102 days and 63 days, respectively, in 2019.

Evaluation of the proposal in relation to statutory review criteria

In this section of the report, MDH assessed if the proposed new 144-bed licensed hospital (with 120 available inpatient mental health beds) meets public interest criteria for each factor specified by Minnesota Statutes, section 144.552, and other relevant considerations.

To examine these questions, we relied on the following sources of information:

- Administrative and survey data collected by MDH
- Hospital discharge data
- Staffing data for inpatient mental health units from the Minnesota Hospital Association
- Emergency medical services data for mental health patients from the Minnesota Emergency Medical Services Regulatory Board
- Hospital quality data from the Joint Commission
- Academic literature and governmental reports

MDH also collected feedback from interested parties through written comments, a public meeting, and interviews, and had informal conversations with medical directors at Minnesota hospitals and Emergency Medical System service providers.

The information that follows was drawn as much as possible from empirical evidence. However, as noted, the proposed hospital differs from existing facilities with psychiatric service capabilities in unique ways. This creates significant uncertainty about the ultimate service and payer mix at the facility and affects MDH's confidence in estimating how the facility would be contributing to the care environment and affecting other hospitals. In addition, other important factors confound a decisive picture of how the proposal fits into the experience of patients and families or caregivers. Those issues are mentioned in greater detail later in this report.

Whether there is a need for the proposed new hospital to provide timely access to care or access to new or improved services

Key Findings:

- Mental health hospitalizations from the proposed service area were predominantly diagnosed with psychoses (69.1%), had high proportion of care covered by Medicaid and presumed uninsured (40.2%), and more than one in five (21.6%) had major or minor medical procedures while in the hospital.
- There is clear evidence that a gap exists between existing capacity for inpatient mental health care and the need for those services. This gap is expected to grow over time due to population growth; yet it will not be completely closed by the proposed hospital.
- On a single day in May 2022, at least 79 mental health patients were on a waitlist for an inpatient mental health bed at hospital emergency departments, and 7.7% of mental health patients had emergency medical services (EMS) transports exceeding an hour—nearly doubling the proportion in 2019 (3.9%) because of the lack of bed availability.

Inpatient mental health services are an essential, and potentially lifesaving, component of health care delivery. Services for patients receiving care in inpatient mental health beds often include clinical evaluation, supervision by trained professionals, medication administration, and other levels of support for a limited time or ‘short stay’ in an environment that is supportive, stable, and safe for the patients who may present with a risk of self-harm or might pose a danger to others. As explained below, there can be several challenges in determining if this specific proposal will meet the needs of the population that would require care by the new hospital. Furthermore, there is no universal agreement on the best way to determine the optimal number of mental health hospital beds for a given population.²⁸

Recent inpatient mental health experience

MDH generated a picture of what inpatient mental health care looked like for patients in the 15-county service area between 2016 and either 2019 or 2020 (depending on available data) by exploring the number of admissions and days in the hospital, patient demographics and co-occurring conditions, services used, and the source of admissions. This four- or five-year span was used to create a stable

²⁸ Drake, R. E., & Wallach, M. A. (2019). Assessing the optimal number of psychiatric beds for a region. *Administration and Policy in Mental Health and Mental Health Services Research*, 46(6), 696-700.

picture of inpatient mental health care before radical changes in bed availability and care needs at Minnesota hospitals in the advent of the global COVID-19 pandemic.²⁹

As shown in Table 1, psychoses represented a majority (69.1%) of mental health inpatient hospitalizations in the service area.³⁰ Psychosis includes many forms of severe and persistent mental illness such as schizophrenia and serious affective disorders;³¹ it was identified by Fairview and Acadia as being the “exhaustive list of all mental illnesses and substance use disorders that will be treated” at the proposed facility.³² The other 30% of hospitalizations for mental health conditions, which would not be treated by the new hospital, included hospitalizations for alcohol or drug abuse dependence, trauma- and stressor-related disorders, and neurocognitive disorders that may present later in life including Alzheimer’s disease and dementia.

Table 1: Distribution of Diagnosis Related Groups and Primary Diagnoses for Adult Inpatient Mental Health Stays in 15-County Service Area, 2016-2020

CMS Diagnosis Related Group	Number of Hospitalizations	Percent of Total
885 - Psychoses	68,880	69.1%
897 - Alcohol/Drug Abuse or Dependence without Rehabilitation	5,184	5.2%
881 - Depressive Neuroses	4,375	4.4%
884 - Organic Disturbances and Intellectual Disability	4,172	4.2%
882 - Neuroses Except Depressive	3,475	3.5%
880 - Acute Adjustment Reaction and Psychosocial Dysfunction	3,317	3.3%
Other CMS Diagnosis Related Groups	10,304	10.3%
All CMS Diagnosis Related Groups	99,707	100.0%

Source: MDH analysis of Minnesota hospital discharge data from 2016-2020.

Another important distinguishing feature of psychoses is that the average length of stay was considerably longer than other acute non-mental health hospitalizations. Figure 4 below shows that

²⁹ [Three Key Trends for Minnesota Community Hospitals in 2020, March 2022 \(health.state.mn.us\)](https://health.state.mn.us)

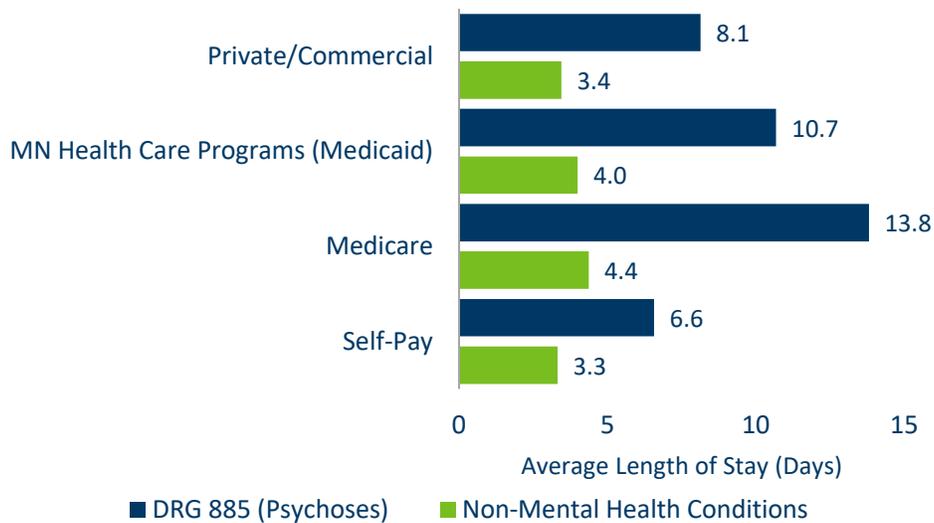
³⁰ Letter to the Minnesota Department of Health dated May 13, 2022. [Notice of Complete Application Response from Fairview Health Services \(health.state.mn.us\)](https://health.state.mn.us)

³¹ Parabiaghi, A., Bonetto, C., Ruggeri, M., Lasalvia, A., & Leese, M. (2006). Severe and persistent mental illness: a useful definition for prioritizing community-based mental health service interventions. *Social Psychiatry and Psychiatric Epidemiology*, 41(6), 457-463.

³² Letter to the Minnesota Department of Health dated May 13, 2022. [Notice of Complete Application Response from Fairview Health Services \(health.state.mn.us\)](https://health.state.mn.us)

this is the case across expected payers. The largest gap observable was for Medicare patients, where those hospitalized for psychoses were in the hospital for nine days longer than other hospitalizations. Similarly, there was a difference of about one week (nearly seven days) for those covered³³ by Minnesota’s Medicaid program, and slightly less (five days) when covered by private or commercial coverage.³⁴

Figure 4: Average Length of Stay of Adult Inpatient Hospitalizations from the Proposed Service Area for Psychoses and Other Conditions by Expected Payer, 2016-2020



Source: MDH analysis of Minnesota hospital discharge data from 2016-2020.

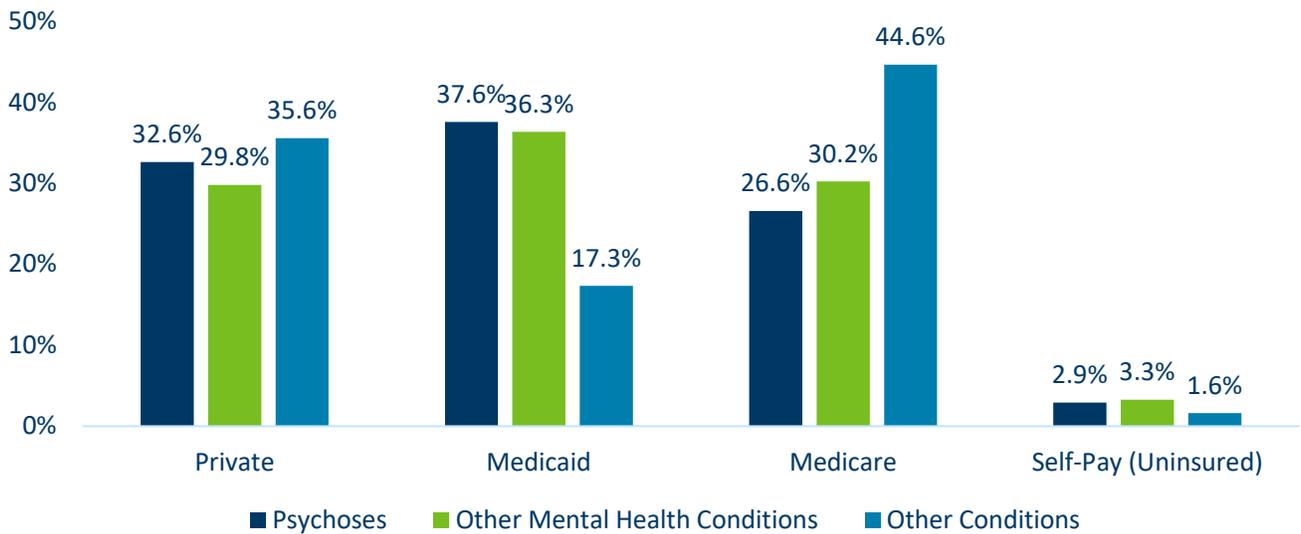
Note: data analyzed were pre-adjudicated claims with payer data based on ‘expected payer’ and not processed claims.

Figure 5 shows that Medicaid accounts for greater share of hospitalizations for mental health conditions (psychosis and other mental health conditions) than for non-mental health conditions compared to other payers. Medicare’s share of hospitalizations for non-mental health conditions is greater because of the greater likelihood of age-related hospitalizations for chronic conditions and certain procedures.

³³ The hospital discharge data that was analyzed were pre-adjudicated claims with payer data based on ‘expected payer’ and not processed claims.

³⁴ Hospitalizations for mental health, including psychoses, from the service area had longer stays than hospitalizations for other conditions (about 9.5 days overall and 9.5 days when limiting to the mental health unit vs. 4 days for other conditions). The length of stay for psychoses patients above was limited to days in a mental health unit.

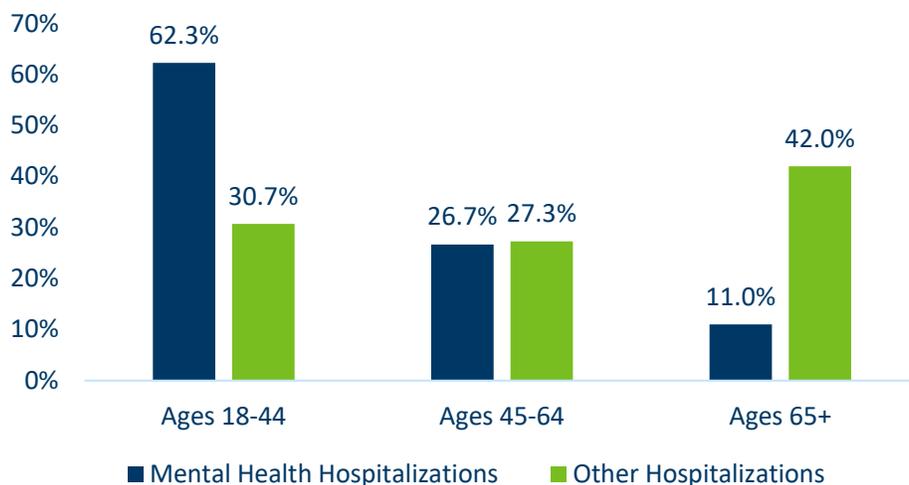
Figure 5: Proportion of Adult Inpatient Hospitalizations from the Proposed Service Area for Mental Health Conditions and Other Conditions by Expected Payer, 2016-2020



Source: MDH analysis of Minnesota hospital discharge data from 2016-2020. Note: data analyzed were pre-adjudicated claims for ‘expected payer’ and not processed claims.

Adult hospitalizations for mental health conditions differ substantially from other types of inpatient care at Minnesota hospitals in terms of age distribution. Figure 6 illustrates that the majority of adults receiving inpatient mental health services from the proposed service area were age 18 to age 44 and most (89.0%) were under the age of 65. The median age for those hospitalized for mental health conditions was age 37. Conversely, the median age for those hospitalized with non-mental health conditions from the area was age 60.

Figure 6: Distribution of Adult Inpatient Mental Health Stays in Service Area by Patient Age, 2016-2020



Source: MDH analysis of Minnesota hospital discharge data from 2016-2020.

The vast majority of hospital stays for mental health conditions (83.6%) had at least one secondary acute condition.³⁵ This proportion was only slightly lower than other hospitalizations, where 88.9% of non-mental health of discharge records had secondary acute diagnoses.³⁶ Advanced diagnostic imaging such as computed tomography (CT) and magnetic resonance imaging (MRI) was a critical part of care for many hospital patients. While the majority of non-mental health hospitalizations (55.0%) had advanced diagnostic imaging like computed tomography (CT) and magnetic resonance imaging (MRI) scan, about one in six mental health hospitalizations (16.4%) required at least some level of advanced radiology including CT, MRI, or nuclear medicine.

Likewise, patients hospitalized for mental health conditions appear to present with similar chronic disease burden as other hospitalized patients. The percent of discharge records for patients with three or more chronic conditions was nearly identical for those with mental health stays (74.5%) compared to all other inpatient stays (73.2%) in the service area. Systematic reviews of the literature have found that physical conditions like hyperthyroidism, various cardiovascular diseases, or other chronic diseases are quite common for mental health hospitalizations.³⁷ In addition to advanced radiology services noted above, most patients receiving inpatient mental health services also require laboratory services for acute and chronic conditions. These services can range from medication management to the evaluation of patients who might have consumed substances at potentially toxic levels. From 2016 to 2020, 88.9% of inpatient mental health records had some form of laboratory services.

Availability of inpatient mental health beds in the service area

Between 2016 and 2019³⁸ there were an average of 18,820 admissions and 223,147 patient days each year for inpatient mental health services. This resulted in an average daily census of 646 patients and an average daily occupancy of approximately 79.3% over this time for community hospitals in the service area.³⁹ This level of occupancy was below a commonly used upper limit of 85% across all

³⁵ Examples include a bacterial infection, poisoning, or an encounter for an injury.

³⁶ MDH analysis of hospital discharge data from 2016-2020 using US Department of Health & Human Services software: [Chronic Condition Indicator \(CCI\) for ICD-10-CM \(beta version\) \(ahrq.gov\)](https://www.ahrq.gov/data-research/chronic-condition-indicator-cci-for-icd-10-cm-beta-version).

³⁷ Šprah, L., Dernovšek, M. Z., Wahlbeck, K., & Haaramo, P. (2017). Psychiatric readmissions and their association with physical comorbidity: a systematic literature review. *BMC Psychiatry*, 17(1), 1-17.

³⁸ As noted above, use of inpatient mental health services dropped precipitously in 2020 during the global COVID-19 pandemic, so these years were used to best reflect *recent* experience in the absence of major pandemic shifts in health care delivery.

³⁹ MDH analysis of Minnesota hospital discharge data from 2016-2019. The occupancy analysis excluded state hospitals operated by the Minnesota Department of Human Services.

hospitals in the area,⁴⁰ but five of the fifteen community hospitals had an average that exceeded this mark during those years, including Regions Hospital, currently the largest provider of inpatient mental health care in the East Metro.

To ensure that the public interest review would be based on the most up-to-date information about the availability of inpatient mental health beds, MDH requested occupancy and staffed bed data from administrators at 29 hospitals with inpatient mental health units for one specific date (May 18, 2022). This bed availability excluded St. Joseph’s Hospital since the facility was operating at a drastically reduced capacity of 40 beds and was winding down operation to close on July 1, 2022. This request generated the following information:

- Hospitals reported 479 staffed community hospital beds⁴¹ dedicated to inpatient mental health.⁴²
- Of these beds, approximately 456 were occupied, for an occupancy rate of 95.2%.
- Only 88.9% of physically available mental health beds were staffed—suggesting that there are factors beyond regulatory limit on beds affecting bed availability.

Lack of needed bed capacity: To achieve what is viewed by some as a customary optimal level of occupancy (85%), 536 beds would have been needed at the time, or about 57 additional beds than what was available (and an even higher number of beds if we were to consider national patterns of mental health bed use).⁴³ Based only on population growth, the need for staffed beds would grow to 617 beds by 2033 (Figure 7), increasing the gap between needed and staffed beds. With existing patterns of hospitalizations, length of stay and discharges, the need for additional beds will not be fully satisfied by the proposed additional capacity of 120 beds at 85% occupancy (102 beds) illustrated by the dotted line in Figure 7.

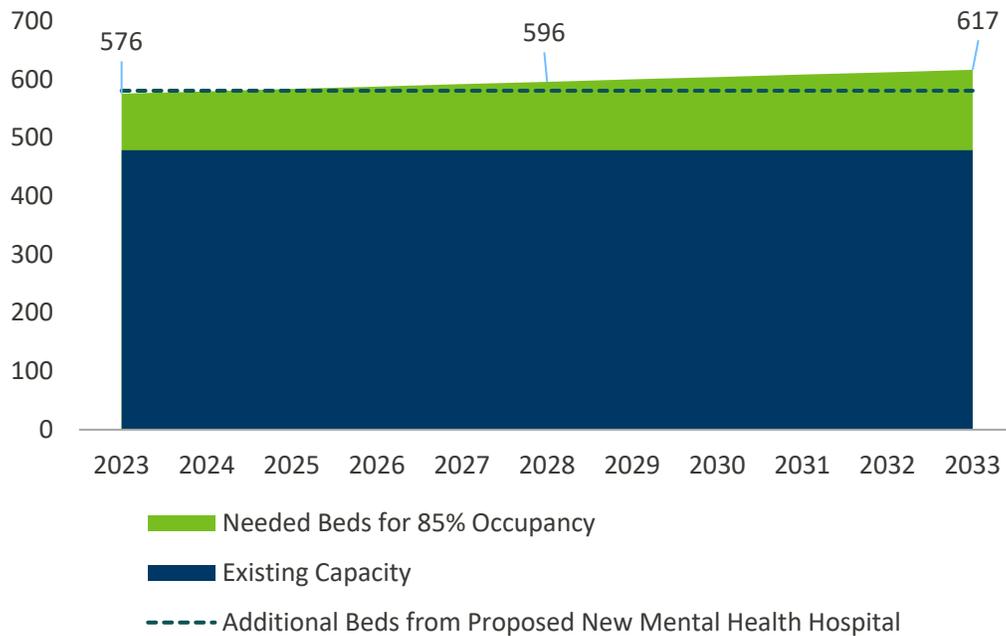
⁴⁰ Green, L. V. (2002). How many hospital beds? *Inquiry: The Journal of Health Care Organization, Provision, and Financing*, 39(4), 400-412. Jones, R. (2013). Optimum bed occupancy in psychiatric hospitals. *Psychiatry On-Line*, 552, 1-9. Ravaghi, H., Alidoost, S., Mannion, R., & Bélorgeot, V. D. (2020). Models and methods for determining the optimal number of beds in hospitals and regions: a systematic scoping review. *BMC Health Services Research*, 20(1), 1-13.

⁴¹ The survey indicated that there were 566 physical mental health beds at hospitals in the service area; however, 87 of these beds were not staffed for various reasons meaning that only 84.6% were staffed and available. More information on staffing can be found on page 47.

⁴² More information on the survey of bed capacity can be found in Appendix B.

⁴³ MDH analysis of data from the National Survey on Drug Use and Health (2020) and the recent paper Hudson, C. G. (2021). Benchmarks for Needed Psychiatric Beds for the United States: A Test of a Predictive Analytics Model. *International Journal of Environmental Research and Public Health*, 18(22), 12205 estimated that between 113 to 122 beds would be necessary in the proposed service area based on national bed use patterns.

Figure 7: Projected Inpatient Mental Health Beds Need for 85% Occupancy for 15-County Service Area



Source: MDH analysis of data from MDH survey of Minnesota hospitals with inpatient mental health beds, Minnesota hospital discharge data, and population projections from the Minnesota Demographic Center.

Excess bed days: Information collected by the survey indicated that approximately 25.1% of patients who were currently using an inpatient bed were unable to be discharged for non-clinical reasons, which was a higher proportion than 19% published in a Minnesota Hospital Association (MHA) publication from 2016.⁴⁴ This means, about a quarter of patient beds could have been available if the following factors had been adequately addressed within the delivery system: inability to be discharged due to administrative or insurance difficulties, lack of appropriate step-down transfer options, or lack of availability in state operated services mental health beds.

Patient boarding in emergency rooms: Nevertheless, even if a significant number of inpatient beds had become available by addressing non-clinical issues, survey data collected from hospitals found that most of these beds would have been occupied by patients on emergency department waiting lists at community hospitals with inpatient mental health units.⁴⁵ This ‘boarding’ at emergency departments is discussed in depth below.

⁴⁴ [Reasons for Delays in Hospital Discharges of Behavioral Health Patients \(mnhospitals.org\)](https://mnhospitals.org/reasons-for-delays-in-hospital-discharges-of-behavioral-health-patients)

⁴⁵ The survey did not include emergency department patients in hospitals without inpatient mental health beds as it was collecting information on mental health bed capacity. Therefore, this documented need likely exceeded available capacity when considering an unknown number of patients waiting at other hospital emergency departments.

We estimate that to maintain an occupancy level of 85% across all beds in the service area and allow just half of the patients on the waitlist from hospitals with inpatient beds to be admitted, a total of 576 total staffed beds would have been needed in 2022 (97 additional beds).

Emergency department boarding of mental health patients

Most emergency department visits for mental health concerns did not result in an inpatient stay. From 2016-2019 only 27.1% of emergency department visits were admitted across all mental health conditions and 39.2% of emergency department visits for psychoses were admitted.⁴⁶ When admissions to inpatient mental health care do occur, they are typically not planned. The most common entry point is the emergency department, where 64.5% of admitted patients originate;⁴⁷ the second most common entry point is from a hospital stay that included other acute health conditions (29.1%), many of whom may have also entered the hospital initially through the emergency department.⁴⁸

When mental health patients are unable to be admitted to an inpatient mental health bed for lack of beds, many remain at the “point of entry” associated with their acute event, the hospital emergency departments. This has a number of consequences discussed below. In our survey, we identified 79 patients on a single day waiting for mental health beds in emergency departments. We believe this represents a substantial portion of the current bottleneck; however, because this count only included emergency departments in hospitals that have inpatient mental health beds, it is still an undercount. Other hospitals can routinely see psychiatric patients in their emergency departments even without dedicated mental health units.⁴⁹

For example, the percent of patients with mental health concerns transported to hospitals without mental health inpatient beds increased from 16.6% from 2017-2019 to 24.3% from 2020-July of 2022.⁵⁰ Similarly, Fairview noted at least 20% of emergency department patients at their hospitals without inpatient mental health beds experience a wait of at least 24 hours for an inpatient mental health bed at another hospital. This unmet need was reaffirmed by hospitals and health care systems, which

⁴⁶ MDH analysis of Minnesota hospital discharge data from 2016-2020.

⁴⁷ This proportion was relatively stable across those five years and was very close to that level (64.2%) in 2020 when Minnesota hospitals were managing a global pandemic and hospitalizations for all mental health issues fell by 13%. About one in ten (10.3%) of hospital emergency department visits from the service area had mental disorder diagnoses in 2019, while only 4.4% did in 2020. More dramatically, most emergency department visits for mental disorders were admitted in 2019 (68.1%), while only 29.1% were admitted in 2020.

⁴⁸ MDH analysis of inpatient discharge data using Chronic Conditions Indicators for ICD-10-CM (beta version) from the US Department of Health & Human Services.

⁴⁹ Data on hospital emergency department boarding from August 11, 2022 to August 31, 2022 at mostly Twin Cities area hospitals found that there were an average of about 72 mental health patients waiting four or more hours to receive care.

⁵⁰ MDH analysis of data from the Minnesota Emergency Medical Services Regulatory Board (EMSRB).

specifically mentioned in public comments and survey responses that patients were often waiting in emergency departments for days and sometimes longer than a full week until a bed could be found.

Emergency department boarding means that patients are not receiving care in a timely manner. While patients may be stabilized in a hospital emergency department, mental health care cannot begin until a patient is in the mental health unit. Furthermore, this setting can be a stressful environment for someone experiencing a mental health crisis.

This strain on space in hospital emergency departments due to boarding can also limit the capacity of hospitals to provide timely trauma care to other patients. We have heard from medical directors their significant concerns that patients waiting for an inpatient mental health bed threatens their mission to deliver trauma care. For example, Regions Hospital is one of the major providers of inpatient mental health services and is also the only Level 1 Trauma facility in the East Metro, with a specialized burn unit. Information submitted by Regions Hospital to MDH indicated that boarding in the emergency department has increased in recent years from about 5% of patients in 2018 and 2019 to 6.5% in 2021 and approximately 8% in the first seven months of 2022.

MDH analysis from the last five years of complete data found that each year an average of 559 psychoses patients from the proposed service area waited in hospital emergency departments for longer than a day to be admitted to an inpatient bed.⁵¹ In addition, the number of psychoses patients leaving the emergency room against medical advice increased in recent years (Figure 8), potentially an indication of the increased practice of ED boarding.

⁵¹ MDH analysis of outpatient hospital discharge data from Minnesota hospitals in the 15-county service area from 2016 to 2020. The extent to which these patients required inpatient care is unknown.

Figure 8: Number of Psychoses Emergency Department Visits Without Admission from Proposed Service Area that Leave Against Medical Advice, 2016-2020



Source: MDH analysis of Minnesota hospital discharge data from 2016-2020. Additional information on this figure can be found in Appendix A: Data Sources and Analyses.

The additional hospital beds at the new hospital would particularly benefit Fairview hospitals that would be the primary source of patients from emergency departments. However, other hospitals within the service area have also emphasized to MDH that beds are consistently near or beyond maximum capacity with long waits for bed placement sometimes stretching as far as weeks. For example, officials from nearby Regions Hospital and United Hospital voiced concern about emergency department volume of mental health patients, and this was among the chief considerations given by health systems endorsing the proposal. Other hospitals and health systems also expressed a need for monitoring by MDH to ensure community access to care that would address emergency department volume at their facilities.

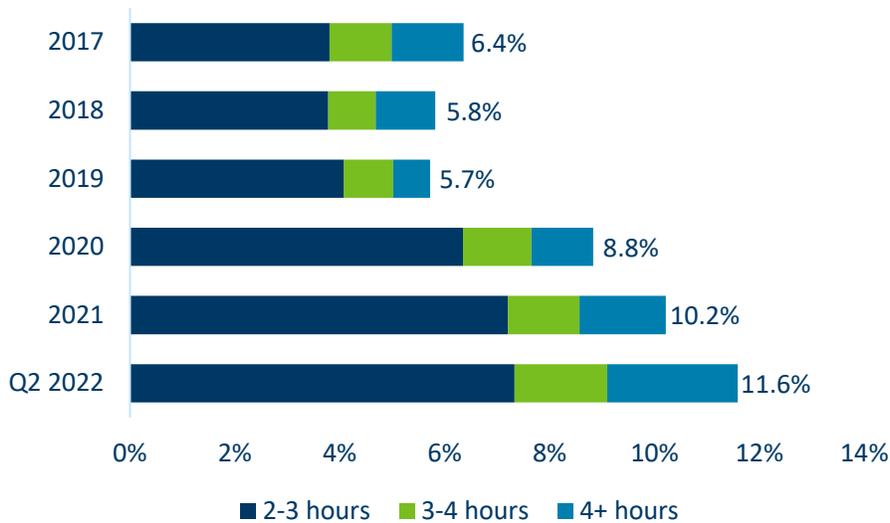
Emergency medical services transportation of mental health patients

The need for additional inpatient mental health capacity was also demonstrated in an analysis conducted by the Minnesota Emergency Medical Services Regulatory Board (EMSRB) for this report. Using data provided by the EMSRB Figure 9 shows that recently 11.6%, or about 1,000 mental health patients from the proposed service area, required emergency medical services (EMS) response times⁵²

⁵² 'Response time' is defined as the time between when an ambulance unit is notified to respond to an incident and when the unit is back in service. This includes the time required for arrival at the scene, transferring care of the patient, and return. EMSRB staff stated that this unit of measurement is the most consistent marker for ambulance resource use.

exceeding two hours—more than double the proportion in 2019 (5.7%). While the enormous pressure on Minnesota hospitals resulting from the COVID-19 pandemic may partially explain these increases, the increased proportion of patients seeing long response times has not abated recently despite lower volume of COVID-19 patients in Minnesota hospitals.

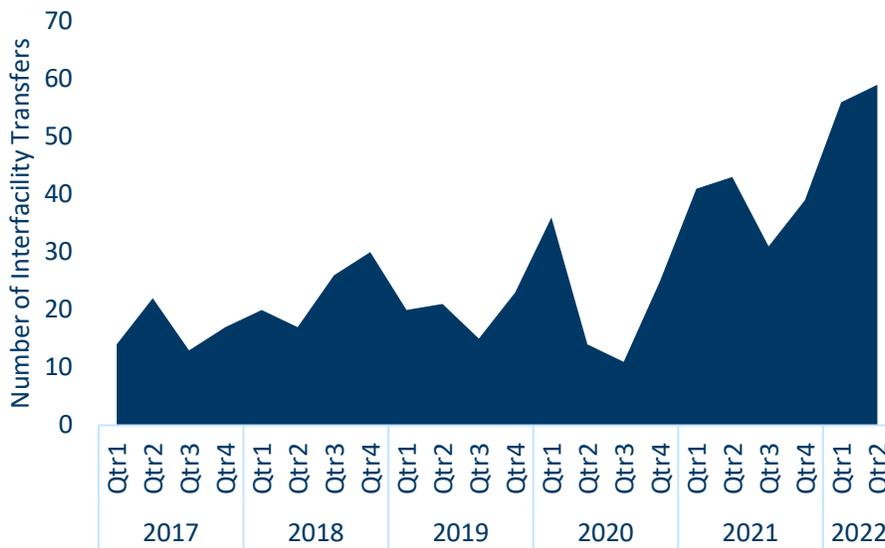
Figure 9: Proportion of EMS Mental Health Response Time for the Proposed Service Area by the Range of Hours, 2017- Q2 of 2022



Source: MDH analysis of EMS data from the Minnesota Emergency Medical Services Regulatory Board, calendar year 2017 through July of 2022. This chart only shows EMS response greater than or equal to two hours. Response time is when the ambulance unit is notified by dispatch, transported a patient, and was back in service.

Moreover, there has been a nearly doubling in the average number of out-of-state transfers for mental or behavioral health services (81 to 154) from the proposed service area in 2021 compared to 2017-2020 and an even higher count in the first half of 2022. Most patients from the service area were transported to hospitals in North Dakota (77.3% in 2021). The average time for these transports was five and a half hours from when an EMS unit was notified until it was back in service. The recent experience in Minnesota shown in Figure 10 illustrates a rise in out-of-state transfers that could at least be partially offset by the existence of the new hospital.

Figure 10: Quarterly Number of Interfacility Transfers for EMS Mental Health Patients Out-of-State for Hospitalization from the Proposed Service Area, 2017- Q2 of 2022



Source: Minnesota Emergency Medical Services Regulatory Board analysis of EMS data from calendar year 2017 through July of 2022.

One of the public comments on the proposed hospital noted that patients traveling long distances create a number of issues for patients.⁵³ For example, patients can be isolated from their support network, often involve challenging and costly transportation arrangements post-discharge,⁵⁴ involve social workers and case management staff that are not familiar with referrals and civil commitment systems, and face an unfamiliar setting that a local hospital that might offer. What’s more, long distances can also pose difficulties post-discharge in achieving a ‘seamless transition with no interruption in services’ to outpatient care that is necessary to reduce the high risk for suicide right after being hospitalized.⁵⁵

Long distance ambulance runs can also result in the inability for EMS to respond to other patients with emergency health care needs during that time they are transporting patients (similar to emergency department boarding noted above). In addition, these transports may result in financial issues for EMS providers if there are limitations on reimbursement for EMS services.

⁵³ [Fairview-Acadia Public Interest Review Letter from Wayne Garrett, August 2022 \(health.state.mn.us\)](https://www.health.state.mn.us/publicinterestreview/letter-from-wayne-garrett-august-2022)

⁵⁴ The proposed hospital would accept most patients through EMS interfacility transfers possibly after an initial ambulance delivery to another hospital emergency department where the patient is initially stabilized. This additional ambulance delivery will add costs compared to a single delivery to a hospital with an available mental health bed, yet it is unclear if these costs would be offset by reduced costs from longer emergency room stays or fewer long-distance EMS transfers.

⁵⁵ [The Surgeon General Releases Call to Action to Implement a National Strategy for Suicide Prevention | HHS.gov](https://www.hhs.gov/newsroom/2022/03/01/surgeon-general-releases-call-to-action-to-implement-a-national-strategy-for-suicide-prevention/)

The financial impact of the new hospital on existing hospitals with emergency departments

Key Findings:

- There is significant uncertainty about the proposed facility's impact on the finances of other facilities because its business and care model would be very different from that of other Minnesota hospitals with inpatient psychiatric care units.
- If the proposed facility were to accept transfers from East Metro hospitals, it could alleviate *some* of the capacity bottlenecks that worsened with the closure of the St. Joseph's hospital and emergency department.
- If the proposed facility were to attract a greater share of the service area's private pay patients and patients with lower complexity, it may negatively affect the payer mix at other hospitals. The analysis predicts the resulting financial impact would be modest for nearby facilities.
- Transparency about the proposed facility's contribution to the delivery of care in the East Metro will be a critical factor to understanding the impact on the operational, regulatory, financial and policy environment for mental health services.

In and of itself, the new facility should not have a significant negative affect on the finances of hospitals in the community, including those with emergency departments. It would be adding new beds and, to the extent that these beds become available for transfers from outside the Fairview system, the new facility would be alleviating some of the documented mental health services bottlenecks that worsened with the closure of the St. Joseph's hospital and emergency department.

At the same time, though Fairview and Acadia have committed to not limiting access to the facility, including by fully complying with the requirement to operate an intake area, the mix of patients admitted to the facility will be affected by key features of the hospital, including the lack of an emergency room, the absence of complex medical services on-site, and the focus on treating psychosis patients from the spectrum of patients with mental and behavioral health care needs.

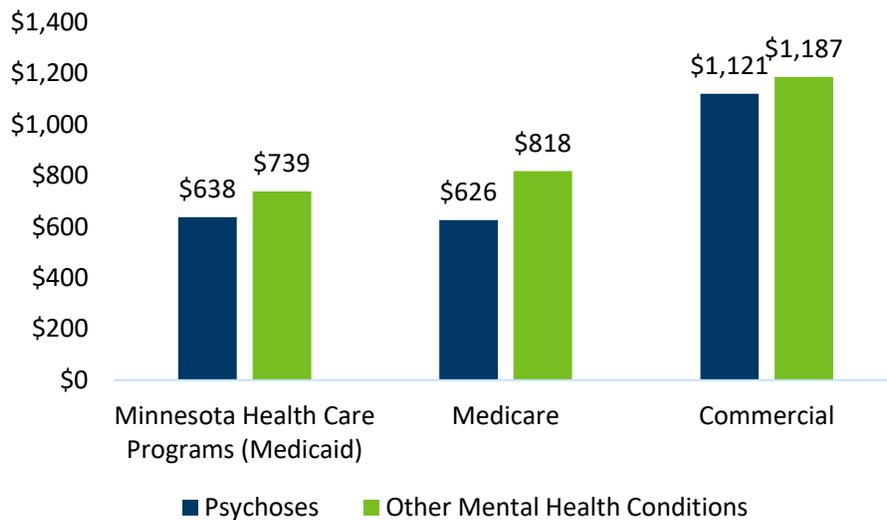
There are two potential ways in which the operations of the facility might create adverse financial impact on existing hospitals serving patients from the proposed service area, including those with emergency departments:

1. If the proposed facility were to attract a greater portion of East Metro private pay patients, other hospitals would experience an adverse payer mix with a greater share of lower-reimbursed patients (typically those covered by public payers such as Minnesota's Medicaid program and Medicare or the uninsured).
2. Similarly, if the proposed facility were to attract a greater share of lower-complexity patients, in part because of the lack of an emergency room and co-located medical care, other facilities would

have to absorb a greater share of these patients and devote additional resources to provide care (staff and medical equipment) in an area of care that is already reimbursed at lower rates.⁵⁶

As illustrated in Figure 11, the differences in median paid amounts per day⁵⁷ were around 76% to 79% higher for commercially insured psychoses patients than Medicaid and Medicare, respectively, and 45% to 61% higher for other mental health conditions. As discussed earlier, commercial patients represent fewer than one third of psychoses patients, so it would be unlikely that the proposed hospital’s patient population be restricted to only commercial patients. However, as nearly all patients are expected to be transfers, the new facility will have more control over their patient population than hospitals with an emergency room.

Figure 11: Median Allowed Amounts per Day for Selected Diagnosis Related Groups by Major Category of Payer for Minnesota Residents, 2019



Source: MDH analysis of Minnesota All Payer Claims Database (MN APCD) data for calendar year 2019 (Extract 24).

With the proposed hospital drawing most of its patients from Fairview hospitals, the magnitude of any impact of the new beds on non-Fairview hospitals is likely to be limited. To the extent that the hospital takes fewer patients with public coverage or without health insurance, any adverse impact will mostly fall on Fairview hospitals, though other hospitals may also see small increases in patients with public

⁵⁶ Horwitz, J. R., & Nichols, A. (2022). Hospital Service Offerings Still Differ Substantially by Ownership Type: Study examines service offerings by hospital ownership type. *Health Affairs*, 41(3), 331-340.

⁵⁷ Medicaid and commercial payers have been seen to mirror the reimbursement approach that Medicare uses where payments are made for hospitalizations on a per diem basis where the first day of care generates the highest payment and includes additional payment for treatment in the hospital’s emergency department. See *Ibid.*, Shields, M. C., Stewart, M. T., & Delaney, K. R. (2018).

coverage or no health insurance. It is also possible that by drawing patients from Fairview emergency departments in hospitals without mental health beds, the share of public program patients at Regions and United hospitals could decline.⁵⁸

Further, to the extent that the new hospital reduces emergency department boarding, hospitals may experience a financial benefit. A study from 10 years ago found that length of stay in emergency departments was over three times longer for psychiatric patients than non-psychiatric patients, preventing an average of 2.2 bed turnovers and a cost to the department of \$2,264 per patient.⁵⁹ The prevalence of psychiatric boarding, and the expectation that more inpatient mental health beds will help relieve it somewhat, was among the chief considerations given by health systems endorsing the proposal.

With the planned lower levels of staffing, discussed further below, the new hospital may try to limit patients that require more staff resources, and will have some control over this through transfer requests. First, the facility will only accommodate psychoses patients, meaning the facility will have a narrower range of patients than other inpatient mental health units in the region; psychoses patients are also generally less resource intensive than those with other mental health conditions. In addition, without comprehensive medical capabilities at the site, some patients would be too medically complex to be treated. These factors could plausibly result in a lower acuity patient population than other facilities, making a lower staffing ratio more tenable to manage safety or quality of care. It is, therefore, possible that many patients with higher clinical complexity would not receive care at this hospital.⁶⁰ The specific population that we expect to be admitted would be low to moderate clinical complexity (one and two on a four-point severity scale, 60.1% of all psychoses patients).^{61,62}

⁵⁸ We do not anticipate that all mental health patients in areas that had been served by St. Joseph's Hospital's emergency department from the past would be served by the new hospital due to the gap between closure in 2020 and eventual opening in 2023 or 2024; much of the change in where patients go for emergency care due to closure has already happened.

⁵⁹ Nicks, B. A., & Manthey, D. M. (2012). The impact of psychiatric patient boarding in emergency departments. *Emergency Medicine International*, 2012.

⁶⁰ This determination was based on the assumption that patients at higher levels of clinical complexity might not meet the definition of 'medically stable' patients indicated in proposal materials, and from interviews with emergency medical services medical directors operating in the area. However, it is possible that all psychoses patients will be accepted after receiving additional information on how the hospital would provide medical service such as diagnostic imaging, certain intravenous therapy, and laboratory services.

⁶¹ As noted above, the proposed hospital would exclusively provide care to psychoses patients (CMS DRG 885).

⁶² MDH analyzed Minnesota hospital discharge data 3M All-Payer Refined Diagnosis Related Group (APR-DRG) severity levels from 2016 through 2019 to investigate patient volume from the proposed service area for three separate APR-DRGs that comprised 99.1% of CMS DRG 885 - Psychoses.

The financial impact on existing facilities for both aspects discussed here – a hypothetical adverse payer-mix and an adverse mix in patient complexity – should be modest, for two reasons.

1. For existing nearby hospitals, mental health services account for a comparatively small portion of overall hospital revenue.⁶³
2. The reimbursement for the federal Medicare program, that is closely followed by other payers, incorporates several patient-level factors related to complexity such as diagnoses, comorbidities, patient age, patients who receive electroconvulsive therapy, and patient length of stay. These should help moderate a mix in patient complexity.

A recent report analyzing these and other updated adjustment factors on historical data concluded that freestanding for-profit mental health hospitals in urban areas would see a slight reduction in payment rates after considering historical clinical complexity and resource use (-0.38%) while urban non-profit hospitals with mental health units would see an increase of 1.41%.⁶⁴ These calculations for the Centers for Medicare and Medicaid Services at the national level suggest that a similar dynamic could occur locally in Minnesota and that the new hospital might also see a patient population who are less complex and require fewer resources than surrounding hospitals.

Ultimately, how the facility will affect the financial status for other hospitals in the East Metro and surrounding service area is highly uncertain. It depends on staffing progression at the facility and the labor market overall, internal Fairview patient transfer decisions, admitting practices at the proposed facility, and adjustment by the EMS operators and providers to the new realities in the health care market. While there is insufficient data to predict behavioral responses by all involved actors and data on the current care environment is too lagged to draw firm inferences, MDH will monitor patient and payer mix, transfers and patient flow as the hospital begins delivering services to inform operational, regulatory and policy decisions in the service area.

⁶³ Inpatient mental health and chemical dependency services were 4.3% of total operating revenue for Regions Hospital and 2.2% of operating revenue for United Hospital in 2021 according to hospital annual reports. These figures are based on charges adjusted by a cost-to-charge ratio for each hospital.

⁶⁴ [Technical Report: Medicare Program Inpatient Psychiatric Facilities Prospective Payment System: A Review of the Payment Adjustments \(cms.gov\)](#). This national estimated change in total payment from this technical report also includes assessing several facility level adjustment factors, including a wage index based on labor costs, rural location status, teaching status, patients admitted through the hospital emergency department, limited payments with extraordinarily high costs (outliers). The estimate also includes control variables that included occupancy rates, low volume, and the presence of electroconvulsive therapy.

How the new hospital will affect the ability of existing hospitals to maintain staff and the impact of the new hospital on existing workforce

Key Findings:

- It is unclear how the proposed facility will impact other hospitals' ability to maintain staff because the proposed facility is characterized by an unusually lean staffing plan, and it is unknown how many former staff at Fairview mental health units that closed recently would be employed at the new hospital.
- The current labor market conditions for hospital staff are challenging as a result of the global pandemic in terms of cost and staff shortages. For mental health staffing, these challenges build on top of longstanding struggles.
- The large volume of vacancies in relevant fields may pose a challenge for staffing the proposed facility, and a large number of new openings could further strain the ability of other health systems to hire and retain staff in a tight labor market for highly specialized positions.
- Fairview was found to have made a good faith effort to avoid layoffs with previous closures; however, there was also anecdotal evidence that a portion of the workforce was negatively impacted by these changes.

The proposed facility's staffing plan calls for 200 full-time equivalent employees (FTE). Half of FTEs would be evenly split between nurses and mental health technicians.⁶⁵ The facility would also employ social workers, psychiatrists, nurse practitioners and/or physician assistants, and a number of additional administrative and other support staff. The proposed facility is scheduled to maintain one security staff on duty at all times. Some of the medical staff could be available through contractual arrangements and their ongoing availability on site is not clear.

The list below shows the numbers of FTEs for each type of personnel that would staff the proposed hospital:

- Registered Nurses (55)
- Mental Health Technicians (55)
- Social Workers (15)
- Recreational Therapy (6)
- Outpatient Clinicians (3)
- Psychiatrists/Physician Assistants/Nurse Practitioners (10)

⁶⁵ Currently, Fairview psychiatric beds are typically staffed by "psychiatric associates," a position requiring a four-year degree. Some mental health technician jobs do not require a college degree, and it isn't clear what the educational requirements for this type of position at the new hospital would be.

- Intake/Admissions Clinicians (14)
- Medical Records/Health Information Management (5)
- Quality Improvement/Performance Improvement (1)
- Utilization Review (6)
- Administration/Support Staff (25)

We note later in this document that the proposed staffing plan of 200 FTE for 120 hospital beds has a much higher ratio of patients to staff in comparison to Minnesota or national norms or practices. This complicates an assessment on how the actual staffing might impact other hospitals. In addition, as mentioned above, Fairview closed about 123 inpatient mental health beds in the last few years. The recently closed St. Joseph's Hospital retained a slightly higher sized staff (212 FTE) for their 40 inpatient mental health beds – a ratio of five staff per bed compared to just over 1.5 staff per bed proposed for the new hospital. At the time the new facility will be staffed, it is unlikely that the previous St. Joseph's staff are available to transfer to a new organization, primarily because of the time that would have passed since their previous job ended. In addition, these workers would face loss of seniority and current union contracts, something that may discourage staffing of the new facility with existing Fairview staff.

Nonetheless, we anticipate that since the advanced practitioners will be provided by Fairview, many of these personnel would be from Fairview's pool of employees rather than coming from other hospitals, or they would be attracted through national recruitment based on information provided to MDH. Acadia also operates in more than one dozen states and has experience recruiting staff at hundreds of other facilities across the country. Acadia noted in application materials that it intends to use national recruitment teams that are part of the organization as well as relationships with schools of nursing and academic institutions to staff the hospital.

Be that as it may, Minnesota has been facing significant challenges in mental health staffing across the state, something that worsened as the result of the pandemic. A recent report by MDH on pandemic-induced workforce exits, dissatisfaction, and shortages found that there have been dramatic increases in vacancies, nurses are working longer hours and leaving the profession, and burnout is rising across all occupations staffing hospitals, factors that apply to the mental health work force as well.⁶⁶ Given the existing labor market challenges related to supply and the cost associated with attracting and retaining qualified staff, the proposed facility will potentially staff up more slowly than anticipated and require different approaches, some of which might affect retention in the market.

⁶⁶ Minnesota Department of Health, Office of Rural Health and Primary Care. ["Minnesota's Health Care Workforce: Pandemic-Provoked Workforce Exits, Burnout, and Shortages."](https://health.state.mn.us) (health.state.mn.us).

Mental health workforce trends

Mental health professionals working in Minnesota hospitals are in short supply. Four out of five Minnesota counties (80%) are designated mental health shortage areas by the federal government, including Ramsey County where the new hospital would be located.⁶⁷ According to recent data, there are 14.1 board-certified psychiatrists per 100,000 residents in the proposed service area—with about one in four practicing in hospitals (2.7 psychiatrists per 100,000).^{68,69} Similarly, workforce data show that there were approximately 6.6 psychologists that work in hospitals per 100,000 in the proposed service area—which was only nine percent of the psychologist workforce.⁷⁰

The Minnesota Department of Employment and Economic Development’s Job Vacancy Survey indicated that occupations within the category of health care practitioners and technical staff had nearly 19,800 vacancies in the fourth quarter of 2021, the third highest number of vacancies for any job category. A second category, health care support occupations, had over 18,000 vacancies. Additionally, the largest recent increase across all health care occupation vacancies was for mental health and substance abuse counselors, where for every 100 open positions, 26 remained unfilled.⁵⁷ There were also 94 vacancies for psychiatrists, 402 openings for psychiatric technicians, and 5,587 vacancies for registered nurses across the state.⁷¹ More recent data from the Minnesota Hospital Association also highlights more individuals moving to part-time schedules.⁷²

The difficulty in hiring mental health professionals, specifically, was emphasized by health system representatives in meetings with MDH. One provider working in the Twin Cities metro area commented that they had 45 mental health positions open including mental health associates, registered nurses, RN case managers, psychologists, and program specialists. They further shared that some practitioner roles had stayed open for a year or longer, with multiple openings remaining constantly as employees retired at a rate faster than candidates could be hired. Broadly speaking, there is some skepticism in the community that the operators of the new facility would be able to staff

⁶⁷ US Department of Health and Human Services, Health Resources & Services Administration Shortage Designation. Accessed online August 10, 2022 at <https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation>.

⁶⁸ MDH analysis of data on actively licensed psychiatrists from December 14, 2021 and population estimates from the US Census Bureau for 2021.

⁶⁹ This compares to 11.6 board-licensed psychiatrists per 100,000 residents nationwide, based on 2019 data from the Area Health Resource File and US Census Bureau.

⁷⁰ Minnesota Department of Health, Health Care Workforce Data Portal. Accessed online August 10, 2022 at <https://www.health.state.mn.us/data/workforce/hcwdash/index.html>

⁷¹ MDH analysis of Minnesota Department of Employment and Economic Development Job Vacancy Survey data from fourth quarter 2021.

⁷² Minnesota Hospital Association, 2022 Workforce Report, updated October 25, 2022. Accessed October 25, 2022 at <https://public.tableau.com/app/profile/david.haverberg3725/viz/Workforce2022/Report?publish=yes>.

up along the plans that they indicated they would be pursuing to open the hospital in late 2023 or early 2024.

Employment impacts on Fairview workforce

Since the proposed facility involves replacing existing capacity at St. Joseph’s Hospital, Minnesota statutes also require MDH to evaluate how the proposal impacts workers at the closed facility.⁷³ This includes whether Fairview would be transitioning staff to the new facility, what retraining and employment security would be available, as well as to what extent layoffs might have affected these staff previously employed at St. Joseph’s Hospital. Fairview submitted statements to MDH that they are working closely with former St. Joseph’s Hospital employees to assist in placing them in comparable roles across their system. They noted that dozens of workers have already applied for and been accepted to new roles within the system, while a smaller number voluntarily resigned, decided to retire, or elected a voluntary layoff. Fairview stated that no involuntary layoffs occurred, and that even those workers who elected a voluntary layoff would receive priority in accessing newly available positions. Fairview stated that with over 2,900 open positions across the Fairview system they are confident that the remaining individuals can be placed in a comparable role.

Minnesota Nurses Association (MNA) and Service Employees International Union Healthcare Minnesota & Iowa (SEIU), representing nurses and psychiatric associates working in the Fairview system, disputed some of these claims. However, it was difficult to find definitive data about whether workers were able to find equivalent compensation due to job losses resulting from Fairview inpatient mental health service line closures connected to the proposed establishment of a new facility.

MNA stated that over half of nurses who obtained subsequent employment at an MNA-represented facility worked now under different arrangements, including the number of hours⁷⁴. SEIU indicated that workers were not rehired from recently closed Bethesda Hospital. Both MNA and SEIU also stated that workers who changed roles due to unit or facility closures often lost seniority and benefits due to working under a different collective bargaining agreement.

⁷³ [Minnesota Statutes, section 144.552\(d\)\(2\)](#)

⁷⁴ Many hospital employees typically work less than a 40 hour work week or 1.0 “full time equivalent” - FTE. Workers may have gone from jobs offering 1.0 or 0.8 to positions offering only 0.6 or 0.4 for example.

Provision of services to low-income and nonpaying patients, and the ability of existing hospitals to maintain the current level of community benefit

Key Findings:

- The authorizing legislation mandates that low-income patients covered by Medicaid will be accepted.
- The proposed facility is also expected to use similar charity care policies as in use at other Fairview Hospitals and abide by the Attorney General’s agreement.
- The proposed facility is not expected to substantially change community benefits provided at Fairview hospitals, and some reductions in community benefit due to the closure of St. Joseph’s Hospital may be partially offset by initiatives at the former site of St. Joseph’s.
- The proposed facility would create future state budget outlays due to limits on federal match for certain Medicaid patients that is estimated to be approximately \$2.4 million per year.

Legislative requirements for new hospital

The legislation authorizing the new hospital mandates that the hospital accept low-income patients enrolled in public programs funded by Medicaid and requires that the new hospital abide by the agreement between Minnesota hospitals and the Minnesota Attorney General on collection practices and on billing practices that guarantee the uninsured receive best-payer discounts.⁷⁵ In its proposal, the new hospital would also extend the same charity care policies and discounts to uninsured or underinsured patients as Fairview. As required, MDH will monitor these commitments, in addition to care practices and delivery patterns.⁷⁶

Charity care policy

Like many hospitals, Fairview’s charity care is based on a sliding income scale, providing discounted or no-cost care for certain patients and their families. For example, uninsured patients with family income up to 200% above the federal poverty guidelines (\$55,500 for a family of four in 2022) are eligible to receive free care. Additionally, uninsured patients with family incomes from 200% to 300% (up to \$83,250 for a family of four in 2022) receive a discount of 50% of gross charges on the balance after the uninsured discount. Uninsured discounts are limited to households with incomes below \$125,000 who receive medically necessary treatment.

⁷⁵ [Minnesota Session Laws Chapter 99, House File 2725 \(revisor.mn.gov\) Sec. 4.](#)

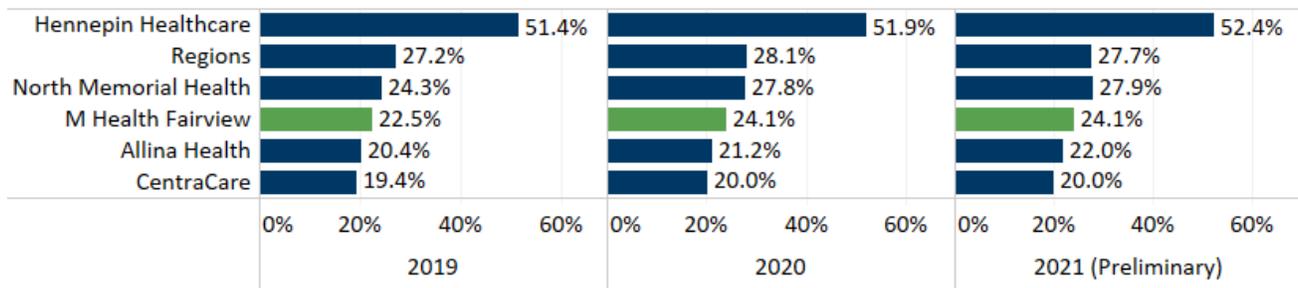
⁷⁶ [Minnesota Session Laws Chapter 99, House File 2725 \(revisor.mn.gov\) Sec. 3.](#)

Providing care to Minnesotans covered by public programs, or without coverage

Research on for-profit freestanding facilities without emergency rooms in California suggest they are more likely to serve privately insured patients.⁷⁷ It is possible that the same pattern could emerge in Minnesota even though materials supplied to MDH reiterate admission decisions at the new hospital would not be made based on payment source. As it currently stands, the Fairview system has comparable rates of patients who are covered by Medicaid or who are uninsured to four other facilities or health systems that operate hospitals with inpatient mental health beds in the proposed service area (see Figure 12).

As shown earlier in Figure 5, less than one third of mental health inpatients have private health insurance, therefore, it would be difficult to operate this type of facility without having patients with public programs. Nonetheless, as noted above, MDH is required to monitor the percent of patients covered by public programs, or without coverage, at the proposed facility and assess to what extent that meets the requirements laid out in law.

Figure 12: Average Percent of Minnesota Public Program (Medicaid) and Self-Pay Hospital Admissions for Health Systems and Hospitals with Inpatient Mental Health Beds in the Service Area, 2019 to 2021*



Source: MDH analysis of Hospital Annual Reports from 2019-2021. Data from 2021 is preliminary. Based on all admissions. Additional information on this figure can be found in Appendix A: Data Sources and Analyses.

Community benefit at existing Fairview hospitals

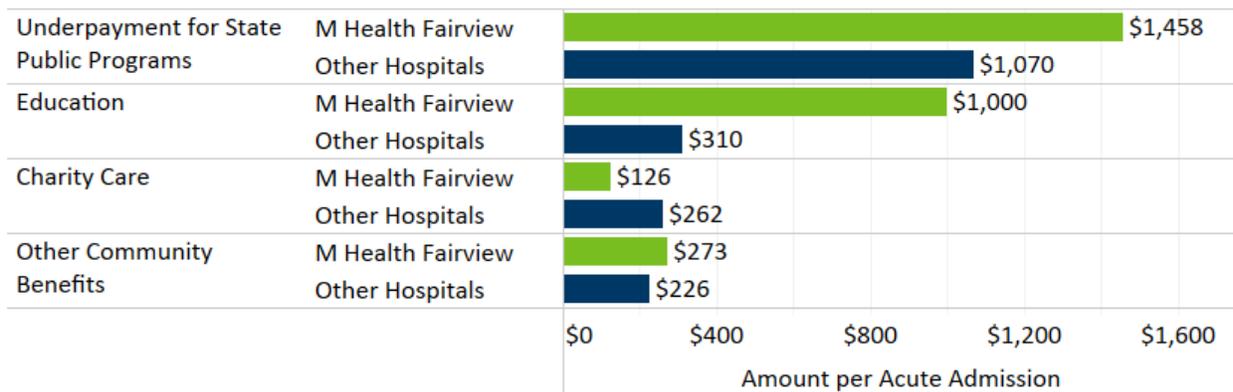
One of the additional factors MDH is required to assess when a proposed new hospital is replacing existing capacity is how the existing levels of community benefit would be maintained.⁷⁸ Figure 13 illustrates that among health systems and hospitals that provide inpatient mental health care, Fairview exceeds the average hospital in terms of categories of community benefit per acute admission, but

⁷⁷ Sachs, R. M. (2020). *Essays on Health Care Markets and the Safety Net* (Doctoral dissertation). [SACHS-DISSERTATION-2020.pdf \(harvard.edu\)](#)

⁷⁸ Hospital ‘community benefit’ is defined in [Minnesota Statutes, section 144.699](#), subd. 5.

particularly in two areas: (1) As we have noted elsewhere,⁷⁹ the majority of community benefit expenditures are dedicated to providing care to patients covered by state health care programs (Medicaid) and that is also the case for Fairview (about \$1,460 out of approximately \$2,800 of estimated community benefit per admission). (2) A large portion of the remaining benefit was provided in education expenses for about \$1,000 per acute admission.

Figure 13: Amount of Community Benefit (Estimated \$ Dollars) per Acute Care Admission for Fairview Hospitals and Other Hospitals in Service Area with Inpatient Mental Health Beds, 2016-2020



Source: MDH analysis of Hospital Annual Reports from 2016-2020. Additional information on this figure can be found in Appendix A: Data Sources and Analyses.

The closure of St. Joseph’s Hospital that accompanied this proposal included the loss of an emergency department that was a critical access point for the community; however, St. Joseph’s Hospital represented a small share of overall Fairview community benefit expenditures (8.1%) from the most recent five years of complete data. We further expect that the new hospital would accept state public program and nonpaying patients as noted above. Finally, Fairview has taken several steps to repurpose the St. Joseph’s Hospital facility as a federally qualified health center and a space for other community-based services to address social determinants of health, such as food insecurity, that are part of hospital community benefits.

Loss of federal matching funds

Federal statute commonly known as the ‘IMD exclusion’ has largely prohibited the use of federal matching funds under the Medicaid program from being used to reimburse hospitals (and other facilities) for Medicaid beneficiaries while they are inpatients or residing in hospitals, nursing facilities, or other facilities with more than 16 beds that are primarily engaged in providing diagnosis, treatment,

⁷⁹ [2016-2018 Hospital Community Benefit Spending in Minnesota, March 2022 \(health.state.mn.us\)](https://health.state.mn.us)

or care to patients with mental disorders.⁸⁰ Over the years, policy changes have allowed federal matching funds for monthly capitation payments made to a health plan for beneficiaries in an IMD, but whose hospitalizations do not exceed 15 days in a month for patients covered by Medicaid managed care⁸¹—which is the predominant payment mechanism for Medicaid in Minnesota.

The Minnesota DHS currently pays for any services provided to fee-for-service beneficiaries while in an IMD and capitation payments made for managed care beneficiaries who are in an IMD for more than 15 days in a month through a 100% state funded program. This program would allow many patients to be served by the new hospital to be covered by state programs administered by DHS once the hospital is accredited by the Joint Commission.⁸² We estimate that, at maximum, 45.2% of Medicaid patients at the new facility would either be covered under a fee-for-service arrangement or be Medicaid managed care patients with stays beyond 15 days, for which the state would incur full expenses (without a federal match); the additional, state-only expenses are estimated to be approximately \$2.4 million per year.⁸³

⁸⁰ There are exceptions that apply to people over the age of 64 and under the age of 21.

⁸¹ H.R.6 - 115th Congress (2017-2018): Support for Patients and Communities Act. (2018, October 24). <http://www.congress.gov/>.

⁸² [Minnesota Administrative Rules, Part - 9505.0045](#).

⁸³ This assumes that the average occupancy of the 120 staffed beds would be 85% and the average length of stay would be 10.6 days (based on hospital discharge data of psychoses hospitalizations that had an expected primary payer of Medicaid for patients from the service area 2016-2019), there would be 13,987 patient days and about 1,316 hospitalizations. This also assumes that the new hospital would have the same distribution of fee-for-service (FFS) Medicaid of 34.2% from 2016-2019 as Fairview Hospitals calculated from hospital discharge data for expected primary payer. Additionally, one of every six (16.7%) Medicaid managed care psychoses hospitalizations are assumed to have a length of stay of longer than 15 days based on hospital discharge data. The estimated dollar amounts are derived from median allowed amounts for psychoses patients of \$7,907 from the Minnesota All Payer Claims Database data for calendar year 2019.

The views of affected parties

Key Findings:

- The most common theme among comments and feedback MDH received was support for an increase in staffed mental health beds in the East Metro. This view was almost uniformly expressed by patients and family members.
- There were mixed views from other hospitals and health systems. All saw a need for additional beds, yet some were concerned that patients from the immediate area, particularly those covered by Medicaid, would not be served by the proposed facility, and look to MDH to monitor that access is provided to the community.
- At the same time, there was considerable opposition to the facility, as proposed, from organized labor, advocates for patients with mental illness, psychiatrists, and from providers that work at Fairview.
- Among participating individuals not in support of the proposal, the most common concern was that the facility would not serve all patients in need, because of the facility's limited medical capabilities and lack of an emergency department.
- There were also concerns among some about whether a for-profit entity would "fit into the Minnesota health care culture," how the lack of a charitable mission would affect other Minnesota hospitals, and that the need to generate a profit might affect provider safety and quality of care.
- Multiple social services organizations expressed support for Fairview as a trusted community partner.
- Some individuals expressed support for the proposed facility as a place to care for underserved populations with mental health needs.

MDH took the following steps to invite the views of affected individuals, organizations (including other hospitals), stakeholders, and other interested people:

1. Presenting an overview of the public interest review to the Minnesota State Advisory Council on Mental Health and Subcommittee on Children's Mental Health on May 5, 2022.
2. Posting an official notice in the *Minnesota State Register* requesting public comments on May 16 and May 22, 2022.
3. Sending letters to Minnesota hospitals with adult inpatient mental health units on May 23, 2022.

4. Hosting a virtual public meeting on June 9, 2022, after issuing a press release, posting information on the MDH website, and reaching out to various contacts.⁸⁴

All public comments regarding this specific proposal following the submission of the plan to MDH were posted on our website,⁸⁵ and are compiled in Appendix C, available with this report. In addition, a summary of the comments received as part of the virtual public meeting are posted on the MDH website.⁸⁶ Public comments and testimony to the Legislature about specific hospital bed moratorium exceptions, or the hospital moratorium in general, are not included in the public interest review process.

In total, MDH received 67 written public comments from a variety of perspectives, including other health systems operating in the region (4), community organizations (10), providers (27), unions (2), and patients and family members (24).

Health systems including Allina Health, CentraCare, HealthPartners, Hennepin HealthCare, and North Memorial Health submitted comments which expressed support for an increase in staffed mental health beds. The support of these health systems was qualified, however, with substantial concerns over the lack of an emergency department, about whether the proposed facility would equitably treat acute patients and those with public insurance or no insurance, the lack of co-located comprehensive medical services, and the challenge of staffing the proposed new beds given existing staffing challenges in the community.

For example, Allina Health broadly expressed support for the proposal; earlier concerns regarding the lack of an emergency department were eased by monitoring and reporting requirements established by the legislature. CentraCare offered a comment generally in support, but also noted that more inpatient beds are of limited use if a bottleneck remains in long-term outpatient placement. HealthPartners saw a potential increase in available mental health beds as a positive development for patients in the East Metro yet emphasized that the loss of beds at St. Joseph’s Hospital was a huge blow to the community, and that the proposed new facility could only hope to restore community

⁸⁴ To access public comments, please visit the following website: [Fairview Health Services - Acadia Healthcare Public Interest Review \(health.state.mn.us\)](https://www.health.state.mn.us/fairview/health-services-acadia-public-interest-review). MDH also held a number of informal conversations with medical directors in the Metro Area and representatives of the EMS system to gain additional insights into the proposal.

⁸⁵ Publicly available documents that resulted from legislative hearings were added to the MDH website: [Fairview Health Services - Acadia Healthcare Public Interest Review \(health.state.mn.us\)](https://www.health.state.mn.us/fairview/health-services-acadia-public-interest-review); however, since these comments on the proposal were not directly sent as part of the public interest review process they are not included in this document. Documents included in this category include the following letters to legislative committees: Mental Health Minnesota dated February 21, 2022; Allina Health dated March 8, 2022; Chelsea Schafter dated March 9, 2022; and, Office of the Ramsey County Attorney dated May 4, 2022.

⁸⁶ A summary of this meeting can be found online here: [Public Meeting Summary – Fairview Health Services and Acadia Healthcare Proposed Mental Health Hospital, June 9, 2022 \(health.state.mn.us\)](https://www.health.state.mn.us/fairview/health-services-acadia-public-interest-review).

benefit if it was ensured that public crisis access was maintained through enforcement of requirements to maintain 24/7 public access.

Likewise, Hennepin Healthcare submitted a statement indicating they welcomed additional investments in mental health in Minnesota but specified that they hope any new facility would be required to treat all acute patients regardless of insurance and admit patients on a 24/7 basis with the state monitoring compliance. North Memorial Health submitted a statement expressing support for increased mental health capacity and concern that the proposed facility may be able to avoid caring for patients based on insurance since it will not be a general acute care hospital. They also expressed concern that staffing is already difficult for existing mental health beds, and that they hope this will not exacerbate these challenges at other facilities. They stated that they hope Fairview will try to minimize the time in which St Joseph's beds are closed but new beds are not yet open, for the benefit of the community.⁸⁷

Fairview's University of Minnesota Medical Center, a member of the Fairview family of facilities, stated that limited mental health bed capacity is leading to long stays in emergency departments, placing stress on patients and staff, and sometimes delaying care even for non-psychiatric patients. Their statement indicated that increasing mental health capacity will improve outcomes across entire health systems. This sentiment was echoed by the Metro Health and Medical Preparedness Coalition, a group of organizations who facilitate integrated planning, response, and recovery activities for events or emergencies with public health and medical implications in the Metro Area, which noted that medical beds are currently being used for mental health patients due to overflow, limiting capacity outside the area of mental health. Marshall County Social Services issued a statement highlighting the difficulty of placing mental health patients in rural Minnesota, commenting that even from 162 miles away, they believe increased capacity from the proposed hospital in Saint Paul would help relieve strained services throughout the state.

Social service organizations including Catholic Charities of St. Paul and Minneapolis and Sanneh Foundation also submitted statements in support of the proposal, citing the need for more mental health services, and Fairview's status as a trusted community partner. Catholic Charities of St. Paul and Minneapolis stated that they see a great deal of unmet need for mental health services in the East Metro and believe the proposed hospital will provide appropriate care for this largely underserved population. The Sanneh Foundation submitted a statement praising Fairview as a trusted community partner and stating that the proposed stand-alone mental health facility with Acadia Health will positively impact the community.

Some other community and patient advocacy organizations submitted statements more skeptical of the proposed hospital's benefits, or in outright opposition to the proposal. While Guild Services, an

⁸⁷ This letter was dated June 23, 2022 which was about one week before St. Joseph's closed on July 1, 2022.

organization that provides mental health services in the East Metro, acknowledged the need for more mental health beds, they expressed concern that the lack of an emergency department or comprehensive medical facilities would result in reduced access for uninsured or homeless patients, and that the proposal fails to address the need for social support services.

The National Alliance on Mental Illness, an organization advocating for patients affected by mental illness, submitted a statement opposing the proposed facility over concerns that a stand-alone psychiatric facility would have insufficient resources for non-psychiatric medical needs, the lack of an emergency department would lead to lack of accessibility particularly for marginalized groups and those with the most acute needs, and the potential effects on other area hospitals who already provide psychiatric care. The Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities submitted a statement identifying the model of a stand-alone psychiatric hospital with no emergency department as problematic for patient accessibility. The Office recommended that a moratorium exception only be made for facilities which can provide quality care while accommodating the mental and physical needs of a diverse population.

Patients and family members issued largely supportive public comments, frequently citing the long wait times for mental health admissions in current circumstances or positive experiences with Fairview mental health services. Alternatively, nurses and other frontline mental health workers, many of whom identified as currently working for Fairview, submitted a large number of comments to MDH (27 written statements), with the most common sentiment being concern over the closure of other Fairview mental health beds elsewhere. Individuals identifying as mental health staff also expressed concern over low staffing ratios at the proposed facility, union contracts from other Fairview facilities not carrying over, and patient access to the facility regardless of acuity or payer.

Some individuals, the Minnesota Nurses Association (MNA), and the Service Employees International Union Healthcare Minnesota (SEIU) criticized the for-profit business model of the proposed facility and asserted that Acadia Healthcare has a track record of fraud, unsafe facilities, and poor quality of care. MNA and SEIU also raised concerns that the proposed facility would not actually increase total capacity in the region or state, since it is accompanied by equal or greater closures at other Fairview facilities. MNA and SEIU additionally raised a concern that the health care financing system undervalues mental health and other basic health care services and that supporting this project would reinforce a failed model.

The Minnesota Psychiatric Society (a local branch of the American Psychiatric Association representing physicians and psychiatrists) submitted a letter in opposition to the new hospital. The group expressed concerns that, despite a clear need, the proposed hospital would not properly meet community needs and place existing facilities at a disadvantage primarily through the lack of an emergency department and ability to select patients. These dynamics were seen as resulting in a less stable environment for mental health beds at other hospitals.

Additional factors impacting the review

While there are statutory considerations that MDH must address in the public interest review process outlined on page five, there also exists additional factors that are relevant to this review, as it represents a departure from how most inpatient mental health care is currently provided in Minnesota. With such a substantial change in the status quo, along with new legislation that is intended to increase inpatient mental health beds throughout the state (MN Statutes 144.551, Subd. 1a), we also consider the following points: 1) access to physical health services and the impact on emergency departments; 2) staffing levels; 3) for-profit hospital care; and 4) broad issues with the mental health continuum of care.

Key Findings:

- Most admissions at the new facility will be patients who were transferred from other facilities or hospital emergency departments, but the facility will be expected to also arrange treatment for admitted mental health patients who have other medical needs.
- The proposed staffing levels at the new facility also represents a substantial departure from both current inpatient mental health unit staffing levels in Minnesota, and other psychiatric hospitals nationwide.
- The proposed hospital will be primarily operated by a for-profit entity, rare in Minnesota. This business model can lead to different incentives in how care is provided that potentially affect quality of care, though evidence remains mixed.
- There is a gap in knowledge about barriers to care and inefficiencies in inpatient mental health care in Minnesota that must be overcome to better understand access restrictions.

Access to services for physical health and access points to care

As a freestanding facility, patients will not have access to the full array of medical services they would have at a general acute care hospital. This concern was raised by mental health advocacy organizations such as Mental Health Minnesota, National Alliance on Mental Illness Minnesota, as well as the Minnesota Office of Ombudsman for Mental Health and Developmental Disabilities. However, legislation authorizing the exception to the hospital construction moratorium, should the Commissioner of Health find it in the public interest, included a provision that requires the hospital to

“have an arrangement with a tertiary care facility or a sufficient number of medical specialists to determine and arrange appropriate treatment of medical conditions.”⁸⁸

To meet this requirement, materials supplied to MDH indicate that the new hospital would rely on direct and contracted services at the facility as well as rely on medical specialties at Fairview hospitals and clinics. For example, the hospital would employ or contract with advanced practitioner staff, including medical doctors and physician assistants, from a variety of medical specialties. Fairview and Acadia expect these providers will have a minimum of eight to ten clinical encounters per day at the hospital according to information supplied to MDH from Acadia and Fairview.

Likewise, basic laboratory services would be offered on-site with more in-depth analysis provided through external contracted services. Similarly, diagnostic imaging would be available on-site through contracted mobile imaging services and possibly at Fairview facilities for more specialized services if needed. However, there may be certain patients that require a higher level of care beyond the capabilities of the mental health hospital. For example, patients requiring certain intravenous fluids, feeding tubes, or transfusions may not be able to be served at this hospital.

While most patients are likely to have co-occurring conditions, the number of patients who would need to be transferred to another facility for care due to an acute event is anticipated to be small.⁸⁹ With most patients at this hospital arriving as a transfer, these would have had their physical and mental health needs addressed before the transfer and admission to an inpatient mental health unit. This means that the hospital will have more control over which patients are admitted, including potentially fewer medically complex patients, such as those with needs noted above.

The staffing plan is unlike that of other inpatient mental health units in Minnesota

It is important to consider how the planned staffing design at the proposed hospital compares to other inpatient mental health units in Minnesota and elsewhere. The proposal calls for 55 nurse and 55 mental health technician full time equivalents (FTE) to act as clinical floor staff for 120 beds. At a customary optimal occupancy rate of 85% (105 beds occupied on average), this would result in a ratio of approximately 3.93 patients per clinical floor staff⁹⁰ on an average shift, while at maximum capacity (120 beds occupied) this would represent approximately 4.58 patients per clinical floor staff.

⁸⁸ [Minnesota Session Laws - 2022, Chapter 99 - HF2725](#)

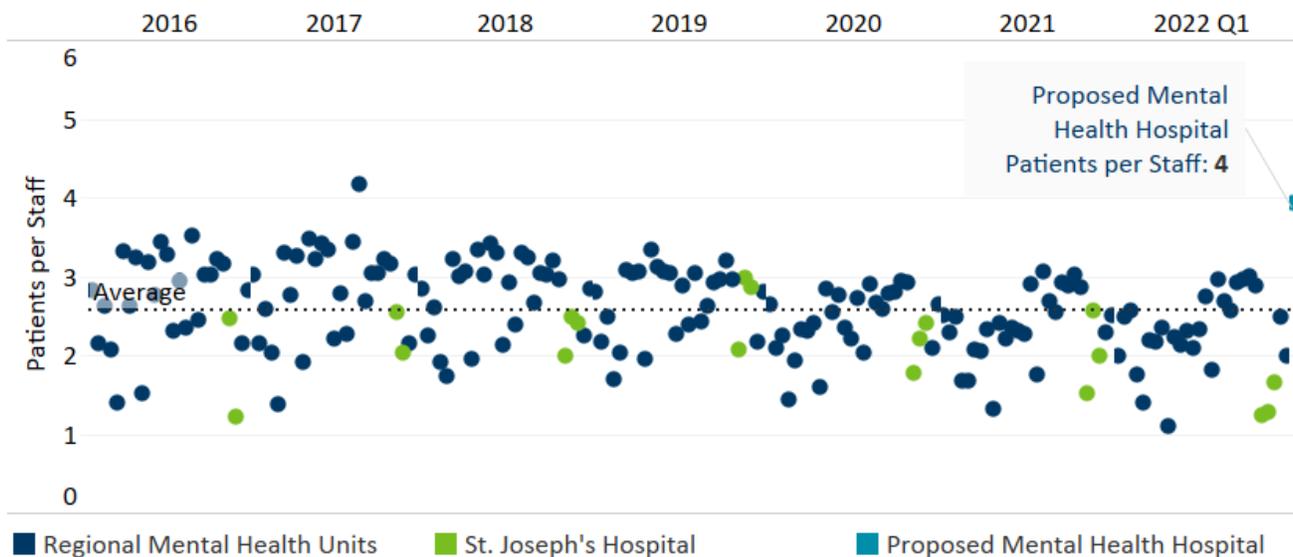
⁸⁹ MDH analysis of Minnesota hospital discharge data from 2016-2020 found that 2.3% of adult psychoses hospitalizations from the proposed service area had records with medical procedures after excluding the following three-digit mental health and substance abuse procedure codes: (GZ1-GZ6; GZB; GZH; HZ2-HZ5, HZ8-HZ9). For more information on procedure codes, please visit: [UMLS Meta-thesaurus - ICD10PCS \(ICD-10 Procedure Coding System\) - Synopsis \(nih.gov\)](#).

⁹⁰ Under the proposed staffing plan, at least one nurse would work in the intake and assessment area, which reduces the clinical floor staff in the inpatient units.

Based on annual staffing data from the Minnesota Hospital Association from 2016 through 2021 and the first quarter of 2022, 29 inpatient mental health units operated in the 15-county service area at 13 different hospitals. These units operated with an average of 2.54 patients per clinical floor staff during this period, with a range of 1.10 to 4.17. Only one of the 28 units exceeded the 3.93 patients per staff ratio estimated for the proposed hospital in one time period five years ago.⁹¹

Using another metric, CMS data on national staffing patterns from 2018, the most recent year available, indicates that freestanding psychiatric hospitals average 340 full-time equivalent (FTE) of total employment for 108 beds, or approximately 0.32 beds per employee FTE. The proposed facility’s staffing plan calls for 200 total employee FTE, or approximately 0.60 beds per FTE, almost double the volume of comparable national facilities.

Figure 14: Annual Number of Patients per Nurse and Assistive Staff for the Proposed Mental Health Hospital and Average Annual Staffing 2016-2021 and First Quarter, 2022



Source: MDH analysis of staffing data from the Minnesota Hospital Association.

The proposed hospital’s staffing plan appears to be designed around significantly lower staffing levels than any existing facility in the service area when averaged across years. Notably, St. Joseph’s Hospital (highlighted in Figure 14 in the lighter green color), reported nearly double the staffing per patient compared to the staffing plan submitted to MDH. The new hospital, as planned, would have nearly two additional patients per clinical floor staff than St. Joseph’s and the two other downtown Saint Paul

⁹¹ It is possible that this staffing plan could be higher or lower than the actual operational experience that is difficult to estimate with 100% precision. For example, the number of patients per staff would be higher if the hospital admitted more than 85% occupancy assumed in the calculations above or if there are fewer staff available due to difficulty filling positions. Conversely, it could be lower if there are fewer patients than the occupancy target while all open positions are filled.

hospitals, and one or more additional patients per clinical floor staff compared with other hospitals serving inpatient mental health patients in the area.

The uniquely low staffing levels planned may pose safety risks and/or a lower level of quality of care. Although there is a lack of clear guidance from the research literature on the dynamics between staffing levels and quality,⁹² there are multiple concerns on quality of care and safety related to low staffing in an inpatient mental health unit that may be associated with a for-profit facility.⁹³ Fewer staff may represent a reduced ability to prevent and appropriately respond to instances of violence against patients or staff, or self-injurious behavior. This is concerning because staff of inpatient mental health hospitals are at higher risk of violence than other health care workers.⁹⁴

Lower staffing levels may also mean a diminished ability to respond to emergency situations requiring a larger response, such as seclusions, restraints, or medical events such as stroke or seizure. Recent research suggests that low staffing levels in inpatient hospitals generally lead to higher risk of mortality.⁹⁵ In terms of quality of care, lower staffing levels may reduce the ability to provide timely services, such as assisting with activities of daily living, administering medications, or simply talking to patients and attending to their needs. Nevertheless, Fairview and Acadia indicated to MDH that the proposed hospital would seek certification from CMS to receive federal reimbursement for services. This would require, among other things, an assessment by MDH survey team that the hospital would be “adequately staffed with qualified mental health professionals and supportive staff to carry out an intensive and comprehensive active treatment program and to protect and promote the physical and mental health of the patients” according to CMS guidelines.

⁹² Moyo, N., Jones, M., Kushemererwa, D., Pantha, S., Gilbert, S., Romero, L., & Gray, R. (2020). The Association between the mental health nurse-to-registered nurse ratio and patient outcomes in psychiatric inpatient wards: A systematic review. *International Journal of Environmental Research and Public Health*, 17(18), 6890.

⁹³ Ibid., Shields, M. C., Stewart, M. T., & Delaney, K. R. (2018).

⁹⁴ Phillips, J. P. (2016). Workplace violence against health care workers in the United States. *New England Journal of Medicine*, 374(17), 1661-1669.

⁹⁵ Needleman, J., Liu, J., Shang, J., Larson, E. L., & Stone, P. W. (2020). Association of registered nurse and nursing support staffing with inpatient hospital mortality. *BMJ Quality & Safety*, 29(1), 10-18. Griffiths, P., Ball, J., Drennan, J., Dall’Ora, C., Jones, J., Maruotti, A., ... & Simon, M. (2016). Nurse staffing and patient outcomes: Strengths and limitations of the evidence to inform policy and practice. A review and discussion paper based on evidence reviewed for the National Institute for Health and Care Excellence Safe Staffing guideline development. *International journal of nursing studies*, 63, 213-225. Kane, R. L., Shamliyan, T. A., Mueller, C., Duval, S., & Wilt, T. J. (2007). The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. *Medical care*, 1195-1204; and, Shekelle, Paul G. "Nurse-patient ratios as a patient safety strategy: a systematic review." *Annals of Internal Medicine* 158, no. 5_Part_2 (2013): 404-409.

As a for-profit entity, the hospital represents a different business model than most Minnesota hospital

This proposal would also change the way care would be provided, in that the facility would be operated by a for-profit entity motivated substantially by an incentive to maximize profits, including by employing fewer staff or staff with lower levels of qualification.⁹⁶ This concern, often held by staff, is illustrated by a number of lawsuits alleging that Acadia Healthcare has a pattern of inadequately staffing facilities to extract higher profits at the expense of patient care and safety⁹⁷ and a three-month strike that was held at an Acadia mental health hospital in Washington State in 2021 over understaffing and lack of security.⁹⁸

The limited available data suggests that many Acadia facilities perform at comparatively high levels of quality. Yet, community stakeholders raised concerns about the extent to which the profit motive in a for-profit facility may affect health care quality. Quality metrics available from the Joint Commission, which conducts performance reviews across many medical institutions, indicate that Acadia's performance relative to national averages has been mostly favorable. Like other hospitals in the 17 states in which Acadia operates and where quality data was available, the majority of Acadia facilities meet or exceed average national scores for process metrics as shown in Figure 15.⁹⁹ For example, 86.1% of Acadia facilities meet or exceed measures for seclusion use, 80.6% meet or exceed measures for physical restraint use, and 72.7% of these facilities met or exceeded measures on completion of assessments of violence risk, substance use disorder, trauma, and patient strengths.

Nevertheless, there was also data suggesting cause for concern. While many Acadia facilities performed well in comparison, Acadia facilities were also disproportionately represented among facilities that performed below the national average, often across all four performance measures. As there are no current similar facilities in Minnesota, comparisons cannot be made to Minnesota facilities.

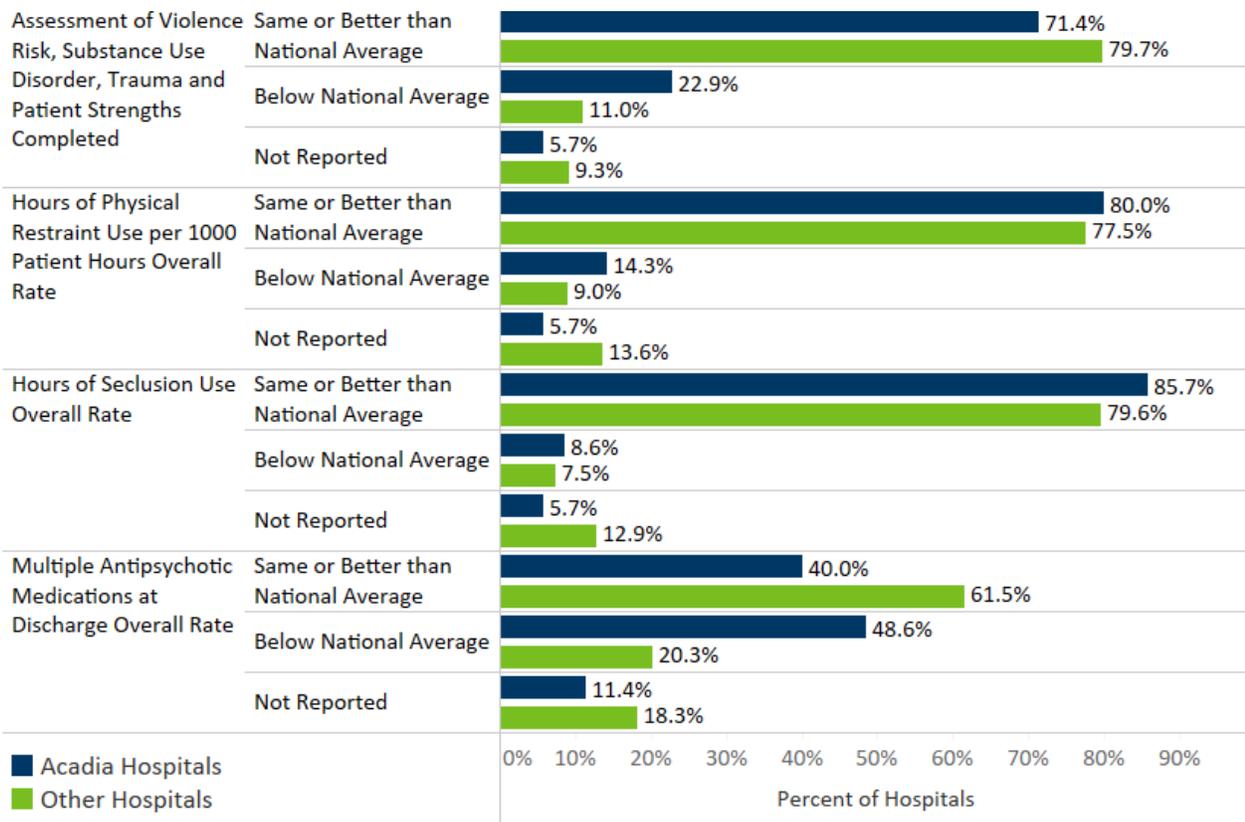
⁹⁶ Shields, M. C., Stewart, M. T., & Delaney, K. R. (2018). Patient safety in inpatient psychiatry: a remaining frontier for health policy. *Health Affairs*, 37(11), 1853-1861.

⁹⁷ [St. Clair County Employees' Retirement System v. Acadia Healthcare Company, Inc. et al, No. 3:2018cv00988 - Document 54 \(M.D. Tenn. 2021\) \(law.justia.com\)](#)

⁹⁸ [Cascade Behavioral Health employees return to work after more than 3 months on strike over safety concerns \(seattletimes.com\)](#)

⁹⁹ MDH staff found hospital-based inpatient psychiatric quality data for April 2020 to March 2021 from the Joint Commission for 37 Acadia inpatient mental health hospitals in 17 states including Arizona, California, Florida, Georgia, Indiana, Louisiana, Massachusetts, Michigan, Missouri, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, and Washington.

Figure 15: Percent of Hospitals Relative to National Average Scores for Hospital-based Inpatient Psychiatric Services Measures



Source: MDH analysis of hospital-based inpatient psychiatric services quality data from the Joint Commission for the April 2020 - March 2021 reporting period. Not reporting data could result from not having enough patients for comparison purposes, not meeting privacy thresholds, results not being statistically valid, or below nine months of measure data.

Gaps in knowledge about barriers to care and inefficiencies

Evaluating this proposal, as alluded to throughout this review, included several areas of uncertainty regarding how the provision of inpatient care might change with the establishment of a freestanding for-profit mental health hospital. While there are many sources of information uniquely available in Minnesota, such as mental health unit staffing data and EMS transports, other relevant data was either unavailable or couldn’t be procured easily or timely from the Minnesota Hospital Association for this review. For example, MDH was unable to obtain data on reasons for potentially avoidable patient days for mental health patients in Minnesota hospitals that would aid in identifying specific gaps in community-based services; however, historical data indicate a substantial number of bed days could be freed up with changes in early detection, effective treatment, and transfer to step-down services.

In addition, MDH was unable to obtain daily data on the availability of mental health beds to assess the extent to which staffing barriers or hospital business decisions affect the availability of mental health

beds in the community. These data are voluntarily submitted by hospitals, they lack the needed granularity, and they are not routinely accessible for analysis by MDH.

Concluding comments

While this report is exclusively focused on the need to access inpatient mental health care, the services received by patients in the proposed hospital are part of a wider continuum of services including outpatient and clinical care, residential treatment, and other services offering differing levels of intensity to support individuals with mental health disorders. National research has found that regardless of the source of insurance, many patients experiencing mental health issues had difficulties accessing mental health care.¹⁰⁰ In Minnesota, recent survey data also suggests that state residents who experienced an elevated number of mentally unhealthy days also ended up forgoing needed mental health care due to cost.¹⁰¹ This level of unhealthy days and foregone care due to cost was similar across different coverage types (public, private/commercial insurance, and uninsured). Furthermore, someone's personal history, the social environment where people live, mental health screening in primary care, as well as the availability and accessibility of services received in other settings can all complicate the ability to access inpatient mental health services.^{102,103,104}

Additional research at the statewide level will be necessary to better understand financial barriers to mental health care, as well larger questions about mental health capacity across the spectrum of care delivery and the effectiveness of the delivery system noted in a recent hospital public interest review.¹⁰⁵ For example, does business opportunity (generating income in excess of expenses) sufficiently overlap with the need for addressing complex problems related to social needs for Minnesotans with mental disorders? How might this new hospital fit into existing day-to-day workforce challenges as well as potential improvements in mental health care staff recruitment and retention? Are the features of the reimbursement system and emergence of for-profit providers limiting

¹⁰⁰ McKenna, R. M., Pintor, J. K., & Ali, M. M. (2019). Insurance-based disparities in access, utilization, and financial strain for adults with psychological distress. *Health Affairs*, 38(5), 826-834.

¹⁰¹ MDH analysis of the 2021 Minnesota Health Access Survey found that Minnesotans that did not get mental health care due to cost had an average of 12 mentally unhealthy days over a 30-day period, while the rest of the population had 4.6 mentally unhealthy days in a 30-day period, a statistically significant difference.

¹⁰² [Behavioral Health Equity Report 2021: Substance Use and Mental Health Indicators Measured from the National Survey on Drug Use and Health \(NSDUH\), 2015–2019 \(samhsa.gov\)](#)

¹⁰³ Alegría, M., NeMoyer, A., Falgàs Bagué, I., Wang, Y., & Alvarez, K. (2018). Social determinants of mental health: where we are and where we need to go. *Current Psychiatry Reports*, 20(11), 1-13.

¹⁰⁴ Penzenstadler, L., Gentil, L., Grenier, G., Khazaal, Y., & Fleury, M. J. (2020). Risk factors of hospitalization for any medical condition among patients with prior emergency department visits for mental health conditions. *BMC Psychiatry*, 20(1), 1-14.

¹⁰⁵ [PrairieCare Brooklyn Park Public Interest Review Final Report, January 28, 2022 \(health.state.mn.us\)](#)

collaboration to meet the needs of all patients in the East Metro? These, and many other questions, will be considered by MDH going forward under its legislative charge to monitor implementation of any exception associated with the establishment of new mental health bed capacity.

Finding

On June 2, 2022, [Minnesota Session Laws, Chapter 99, House File 2725](#) was signed into law, authorizing an exception to the Minnesota hospital construction moratorium for the construction of a 144-bed psychiatric hospital on the site of the former Bethesda hospital in the city of Saint Paul, Ramsey County. The exception is conditional on the commissioner of health finding the project to be in the public interest after completing a public interest review.

After completing this review, **MDH finds that the hospital is in the public interest despite the significant concerns raised by our analysis and in the community about the project as proposed.**

The sole reason for finding the hospital in the public interest is the substantial need for hospital beds for mental health patients, which is evident based on lengthy emergency department boardings for many patients and the resulting impact on the trauma system, the transfer of patients over long distances to beds outside of the community, and the high occupancy rate in mental health units. The need for beds was also a consistent and prominent theme in the feedback MDH received in writing and at a public hearing.

- Though the new facility would be adding badly needed inpatient beds for inpatient care of adult psychiatric patients in the East Metro and surrounding services area, it would not fully compensate for decisions by Fairview between 2019 and 2022 to close psychiatric units at two facilities with 123 inpatient beds, a dedicated chemical dependency unit with close to 40 beds, and an emergency department that was a key entry point to accessing mental health care.
- Without the co-location of comprehensive medical services and an emergency department, the new facility would not provide capacity at the same level of care as what has been lost in the community, thus leaving a gap in the needed spectrum of care for adult mental health patients.
- Even though performance data for Acadia are not definitive, the staffing model, which is dramatically leaner than local and national norms, raises significant concerns, supported by the literature, about patient outcomes and staff safety.
- The facility represents a substantially different model of inpatient mental health care than what is otherwise available in Minnesota. While we appreciate the need for innovation in care delivery, this model will need to be carefully evaluated to see what outcomes are actually produced. It will be important to monitor if the introduction of this model begins a trend towards additional similar facilities and if that initiates a downward spiral in the availability of comprehensive inpatient mental health services in Minnesota.

In finding the project in the public interest, a key element was recognizing that the Minnesota Legislature expects close, ongoing scrutiny of how the new facility will impact care delivery and the economics of inpatient mental health services in the community. The legislation authorizing the exception to the hospital construction moratorium for this proposal mandated that the new hospital comply with several requirements.

One of those requirements is that the hospital annually submit information to MDH on the hospital's case mix, payer mix, patient transfers, and patient diversions, as well as information necessary to investigate inpatient mental health access and quality.¹⁰⁶ The collection of this and other information from various partners across Minnesota will be important to fully understand the impact this new hospital will have on Minnesotans in need of inpatient mental health care. It will also be a tool to inform any needed operational, regulatory, or policy refinements – at this site and across Minnesota's inpatient mental health system – including about how the delivery of services with lower profitability can be equitably shared among service providers and reliably exist as essential care to those who need it.

To expedite gaining access to additional mental health beds in Minnesota, approximately consistent with capacity in 2019, MDH publicly issued a findings letter on September 12, 2022 that summarizes the commissioner's decision, her reasoning and analyses, and the remaining concerns.¹⁰⁷

¹⁰⁶ [Minnesota Session Laws 2022, Chapter 99 - HF 2725 \(revisor.mn.gov\).](#)

¹⁰⁷ <https://www.health.state.mn.us/data/economics/moratorium/index.html>

Appendix A: Data sources used in review

The Minnesota Department of Health used data from the following sources in completing this public interest review:

- **Hospital Annual Report:** All hospitals in Minnesota file annual reports with the Minnesota Department of Health. Data used in this report includes the following items:
 - *Available beds:* for the number and type of available beds (acute care beds that are immediately available for use or could be brought online within a short period of time) in the most recent fiscal year. Available beds are also separated into dedicated specialty units (i.e., mental health and chemical dependency) as reported by the hospital.¹⁰⁸
 - *Charity care, bad debt, and other hospital financial information:* Acute care hospitals in Minnesota file annual financial reports to MDH on overall revenue and expenses, uncollectible bills, and other adjustments. Data used in this report includes the following sources:
 - Section 1: Revenue and Expense Summary
 - Section 2: Non-Operating Revenue and Expense
 - Section 3: Patient Revenue
 - Section 4: Other Operating Revenue
 - Section 13: Primary Payer Charges Summary
 - Section 14: Primary Payer Adjustments & Un-collectibles
 - Section 21: Community Benefit Summary
- **Hospital Discharge Data:** The Minnesota Hospital Association collects administrative billing data from hospitals in Minnesota and for Minnesota residents who were patients in Iowa, North Dakota, and South Dakota hospitals (Wisconsin hospitals do not provide data). The unit of analysis is the hospital stay, or emergency department discharges, at short-term, non-Federal, non-State, and non-specialty, general acute care hospitals. Inpatient hospital stays and emergency department visits were identified and analyzed using the following sources:
 - 3M All-Payer Refined Diagnosis Related Groups (APR-DRG)
 - Hospital billing codes developed by the National Uniform Billing Committee

¹⁰⁸ These categorizations are based on self-reported hospital data; because hospitals can designate beds to be used for specific purposes within the hospital (such as obstetrics, intensive care unit, cardiac care, etc.) there are only two specific designations on both a state and federal level (the state uses federal designations in licensing.): “excluded psychiatric units” and “rehabilitation units.” Hospitals designate beds as mental health/psychiatric beds on the Hospital Annual Report that are not licensed as such under federal and state law.

- Clinical Classifications Software Refined (CCSR) defined by the U.S. Agency for Healthcare Research and Quality
- Medicare Severity Diagnosis Related Groups (MS-DRGs) developed by the Centers for Medicare and Medicaid Services
- **Population Projections:** Population estimates and projections were used from the Minnesota State Demographic Center for the 15-county service area: ‘Long-term Population Projections for Minnesota’ (February 2021 release).
- **Ambulance run data:** Information on emergency medical services (EMS) response incidents originating within the 15-county service area for mental health patients from calendar year 2017 through July of 2022 from the Emergency Medical Services Regulatory Board.
- **Point-in-time survey of non-governmental hospitals:**¹⁰⁹ MDH collects information on the availability of inpatient mental health beds annually; however, the most recent data was two years old at the time of this report and the beginning of a global pandemic. For these reasons, and a need to gather additional information, a survey was administered statewide for administrators at 29 hospitals with known inpatient mental health units. The questions used to administer the survey are found in Appendix B.

The survey was answered by hospitals with adult inpatient mental health units in Minnesota during May 2022 (with follow up for non-responses in June and July) to gather information on the number of beds, bed specialty population (i.e., geriatric, medical-surgical, etc.), occupancy, number of patients on a waitlist for a bed, and the number of patients awaiting discharge for non-clinical reasons such as awaiting community placement, administrative difficulties, or any other reason.

¹⁰⁹ Capacity information for Minnesota Department of Human Services hospitals were obtained online from the DHS Legislative Report, Quarterly Clinical Report, Second Fiscal Year 2022. [DCT Quarterly Clinic Report \(mn.gov\)](https://dhs.mn.gov/quarterly-clinic-report) within the 15-county boundary including Anoka Metro Regional Treatment Center and Annandale Community Behavioral Health Hospital. The hospitals in the service area included Abbott Northwestern Hospital, Cambridge Medical Center, CentraCare Health – Monticello, Hennepin Healthcare (HCMC), Fairview University of Minnesota Medical Center, Mercy Hospital, Mille Lacs Health System, North Memorial Health Hospital, Regina Hospital, Regions Hospital, United Hospital, and St. Cloud Hospital (which was outside of the 15-county area, but primarily serves Benton, Sherburne, and Wright counties).

Appendix B: Hospital survey data collection

Mental Health Bed Capacity Questionnaire

This brief survey asks 10 questions about inpatient mental health bed capacity at your hospital to help the Minnesota Department of Health assess the provision of these services across the state. The information submitted is classified as nonpublic data according to Minnesota Statutes, section 62J.321 subdivision 5. This means it is not available to the public unless in aggregate form. Please enter separate entries for each hospital.

Enter Hospital Name, Location, and Primary Contact Email: _____

We are collecting an inventory of adult inpatient mental health beds.

1. How many physical inpatient mental health beds (dedicated primarily for psychiatric disorders) does the hospital have?
2. On May 18, 2022, how many staffed adult inpatient mental health beds (dedicated primarily for psychiatric disorders) did the hospital have?
3. Within the past six months, what is the number of increased or decreased staffed inpatient mental health beds (dedicated primarily for psychiatric disorders) at the hospital? (Please use negative "-" sign for decrease and enter "0" for no change).
4. Does this hospital have special units for staffed inpatient mental health beds?
5. How many staffed inpatient mental health beds are in specialized units? (Please provide number and type of specialty (i.e., Co-occurring chronic health condition med/psych bed, Co-occurring substance use disorder, Crisis Stabilization, Extended Stay, Geriatric, Forensic or Law Enforcement, and any other type).

We would also like to assess how many adult inpatient mental health beds were occupied on May 18, 2022.

6. To the best of your ability, please estimate how many adult mental health beds were occupied at midnight census?
7. How many patients in adult inpatient mental health beds were medically unstable on May 18, 2022 (i.e., require oxygen, intravenous therapies, transfusions, or other chronic health condition)?
8. How many patients right now are unable to be discharged from adult inpatient mental health beds for non-clinical reasons e.g., administrative or insurance difficulties; lack of appropriate step-down transfer destination such as community-based services, residential treatment, or nursing home; lack of availability for state operated services mental health bed; or other reason? Please enter date of observation.

Finally, we would like to ask about patients waiting in your hospital emergency department.

9. What is the average wait time in the emergency department for an adult inpatient mental health bed, in days (please estimate)?
10. How many people are on the waitlist on May 18, 2022 in the emergency department for an adult inpatient mental health bed (please estimate)?

Appendix C: Public comments

March 8, 2022

Senator Paul Utke
95 University Avenue W.
Minnesota Senate Bldg., Room 3403
St. Paul, MN 55155

Re: SF3248

Dear Chair Utke and members of the Committee,

Thank you for the opportunity to provide comments on SF 3248 (Rosen) that would allow Fairview Health Services/Acadia Healthcare to build an adult mental health hospital in Saint Paul through an exemption to Minnesota's hospital bed moratorium law.

We remain supportive of the legislative and public interest review process as a way to provide policymakers with additional perspectives as they evaluate the Fairview proposal within the context of their existing capacity as well as the community's needs. While we understand that this process can be resource intensive, it creates an important dialogue among stakeholders and policy makers about the impacts of adding resources into the health care system.

Access to adolescent, adult and geriatric inpatient mental health services remains a critical need across the state. We reviewed the publicly posted proposal and are pleased to see the range of services for adults the new mental health hospital will provide. However, we have some concerns with the closed access model of care. Most notably, the new mental health hospital will not have an emergency department (ED), which eliminates an access point to receive care for people in crisis in the east metro, regardless of their insurance status. United Hospital is already an extremely busy ED and with the closure of St Joe's ED in 2020, United Hospital ED saw a 12% increase in overall volume and a disproportionate increase of 21% in mental health volume in 2021. Additionally, the proposed model will not address all patient care needs on site. With no medical/surgical services, patients in need of serious medical attention will need to be transported to an ED for care.

The pandemic and workforce challenges have frequently pushed our hospitals to capacity and these challenges are expected to continue for the foreseeable future. Fairview is planning to close the remaining 40 mental health beds at St. Joe's in June 2022, leaving a net loss in available beds until the new facility opens in 2023 or 2024. Even a temporary loss of inpatient mental health beds in the east metro increases the possibility of mental health patients boarding in our EDs, a situation we are already desperately trying to address as it is not in the best interest of the patient in crisis and prevents other patients' access to care.

To truly meet the needs of the community, as well as maintain the spirit of collaboration the health care systems have built in the east metro, we recommend that any approved proposal should ensure there is a robust plan to care for patients in crisis, as well as patients from outside the Fairview referral system, regardless of their insurance status. This includes a clear admitting protocol, including an interfacility agreement, with other healthcare systems to ensure access. Fairview should also maintain their existing bed capacity at St. Joe's until the new hospital opens, eliminating the gap in access to beds. It is critically

important there are mitigation efforts in place during the transition to this new facility and model of care to minimize pressures on the remaining hospitals in the east metro.

We are confident that a solution can be found that prioritizes the needs of the community and balances the interests of all stakeholders.

Sincerely,

A handwritten signature in black ink, appearing to read "Sara Criger".

Sara Criger
Senior Vice President of Operations
President, United and Mercy Hospitals
Allina Health

A handwritten signature in blue ink, appearing to read "Joe Clubb MSW LISCSW".

Joe Clubb, MSW, LISCSW
Vice President, Operations, Mental Health and Addiction
Allina Health

A handwritten signature in brown ink, appearing to read "Brian Palmer MD".

Brian Palmer, MD
Vice President, Operations, Mental Health and Addiction
Allina Health

June 13, 2022

Stefan Gildemeister
Director, Health Economics
MN Department of Health
Submitted via email

Dear Mr. Gildemeister

Thank you for the opportunity to provide comments as part of the public interest review process of the Fairview Health Services/Acadia Healthcare proposal for 144 bed licenses to build an adult mental health hospital in Saint Paul through an exemption to Minnesota's hospital bed moratorium law.

We remain supportive of the public interest review process as a way to provide additional perspectives on the Fairview proposal within the context of their existing capacity as well as the community's needs. While we understand that this process can be resource intensive for both the applicant and the Department, it creates an important dialogue among stakeholders and policy makers about the impacts of adding resources into the health care system.

Allina Health is one of the largest mental health and addiction service providers in the state, with 250 staffed inpatient beds across 7 hospitals serving over 7500 patients annually, a network of 12 emergency departments with 24/7 mental health staffing and over 20,000 annual visits, extensive partial hospitalization and day treatment services caring for over 400 people every day, and robust outpatient services providing over 350,000 visits per year. Even with our strong commitment to mental health and addiction services, we know that access to adolescent, adult, and geriatric inpatient mental health services remains a critical need across the state.

The original publicly posted proposal raised concerns that we shared in our March 8, 2022 letter to legislators, including the new mental health hospital care model will not have an emergency department (ED), which eliminates an access point to receive care for people in crisis in the east metro, regardless of their insurance status. However, we are pleased to see some monitoring and reporting requirements in place as part of HF 2725, signed into law on June 2. Article 1, Subd 1, sec 31 states that upon completion of the construction project, the commissioner of health shall monitor the hospital, including by assessing the hospital's case mix and payer mix, patient transfers, and patient diversions. The hospital must have an intake and assessment area. The hospital must accommodate patients with acute mental health needs, whether they walk up to the facility, are delivered by ambulances or law enforcement, or are transferred from other facilities. The hospital must annually submit de-identified data to the department in the format and manner defined by the commissioner. We are hopeful these monitoring and reporting mechanisms will support and enable continued discussion to ensure equitable access for patients.

The legislative requirements address our primary concerns with a new care model and we hope to see that this new model enhances our community's access to mental health services in the East metro for all who need care. Please contact Kristen McHenry at Kristen.McHenry@allina.com if you have any additional questions or would like further information. Thank you.

Sincerely,

Jill Ostrem
President, United and Mercy Hospitals
Allina Health

Joe Clubb, MSW, LISCSW
Vice President, Operations, Mental Health and Addiction
Allina Health

Brian Palmer, MD
Vice President, Mental Health and Addiction
Allina Health

Minnesota Department of Health

From: Engdahl, Ryan <EngdahIR@centracare.com>
Sent: Wednesday, June 15, 2022 7:10 AM
To: MN_Health_PIR@state.mn.us
Subject: Mental Health Hospital Responses

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Feedback on Proposal to Establish a New Mental Health Hospital

MDH welcomes comments that address the factors identified below and any others that you may consider relevant to the review:

- Whether the new beds are needed to provide timely access to care;
- The financial impact of the new hospital beds on existing acute care hospitals;
- How new hospital beds would affect the ability of existing hospitals to maintain staff;
- The extent to which the hospital beds will provide services to nonpaying or low-income patients;
- The ability of the new hospital to maintain the level of community benefit currently provided by the hospital system; and
- The impact of layoffs at the current facility and transitioning workers to the new facility.

Feedback from 2 hospital based Psychiatrists:

1. *My initial thought is of course – that is great. I would add that at times I don't think we have a lack of beds, it is more a lack of placements. The bottleneck seems just as bad for leaving the hospital as it does for entering. I estimate at any one time about ¼ to 1/3 of the adult unit does not need to be hospitalized, but is just waiting placement (I just checked the current list and it is 36%). I am assuming other facilities are having the same difficulty. If we could increase the bed availability by 20 -30% by having better access to placement that also would solve a lot of the problems.*
2. *The priorities I see are the following:*
 1. *Increased options for community placement, including patients who have chronic high acuity but for whom inpatient care is not required.*
 2. *Increased beds through SOS.*
 3. *Increased child/adolescent beds and crisis services/placement options.*
 4. *Increased geropsych placement options, both inpatient and community (#1.) Tied to this is having all current geropsych units being staffed/designed appropriately so they can be full (including our own.)*

I wonder what their acceptance is going to be for high acuity (including high violence risk) adult as well as high acuity geropsych and child/adolescent. These are the needs that I am seeing across our region, including St. Cloud. If not accepting these patients, I don't see us needing to use them much and wouldn't see then impacting us financially. I don't feel the addition of this facility would likely reduce our workforce. It seems to me there is plenty of opportunity that exists for anyone who might want to transfer to the Cities to work in mental health.

I suspect this unit will fill a strong need in the Cities but think its impact to our communities will be small, positively or negatively.

Ryan Engdahl, PhD, LP | Senior Director, Behavioral Health

P: 320-251-2700, ext. 72351

M: 320-492-7383

CentraCare.com

Assistant: Sheila Herges | 320-229-5199, ext. 71667 | Sheila.Herges@CentraCare.com



March 9, 2022

Chair Utke and Committee members:

My name is Chelsea Schafter and I am currently a certified psychiatric-mental health nurse at Fairview Riverside. I've been at Riverside for over two years now. I'm writing with my perspective about SF 3248 being heard in committee today.

I have been told that Fairview wants to add the 20 beds from St. Joes hospital to Riverside until the new behavioral hospital they have proposed opens. My question to Fairview would be - where do we intend to put these beds in our current hospital? Who is going to work to cover these beds (physicians, nurses, psych associates, CTCs, Occupational therapists to name a few)? What does this mean to the nurses currently working at Riverside? While additional beds at our hospital would be great due to influx of mental health patients we are experiencing - we all know that just because we have a bed, does not mean we have all the resources in place to appropriately and safely care for the patient in that bed.

I do not remember a time where we have been fully staffed. Since I've worked here, staffing has always been dependent on people picking up extra shifts or working doubles. Even currently with the bonuses being offered we are still working short at times, even when people are working extra.

The burnout we are experiencing is real. Mental Health is not always a physically demanding job, but it is always a mentally challenging one. We are helping people during some of their darkest, most difficult days. Sometimes that includes patients being extremely psychotic and violent. These kind of situations, along with unsafe staffing, lead to nursing staff experiencing workplace violence and further perpetuating the burnout we already experience from just the day to day grind. I also want to clarify, when most think 'workplace violence' they think physical violence - but this very much includes the verbal assault many of us experience on a daily basis. The patients we encounter do not just need us there to give them medications and task oriented skills. The patients are there because they need the emotional support. That emotional support comes from nurses taking the time to sit and help patients process what is happening to them not only physically, but most importantly, mentally.

When we do not have the appropriate staffing, patients do not receive the emotional support needed. We frequently also work short when it comes to psychiatrists. Many times, units are capped due to this provider shortage. While some units have multiple double occupancy rooms, a lot of times these rooms have to be blocked due to the patient being not roommate appropriate because of their current mental or physical state. Sometimes this improves and they are able to have a roommate, but many times this is not the case. Currently with the beds we do have, many times patients are left waiting in the emergency department for days, and on some occasions weeks before bed placement can be found. At the same time, because of staffing issues, we have a unit, 3C, that sits empty and has since the beginning of the pandemic.

While additional beds would be great - the logistics of it are not clear and could lead to us having another unit like 3C that sits empty. We all know the need for mental health beds is dire, but this needs to be done safely for both patients and staff.

Thank you,
Chelsea Schafter BSN, RN, PMH-BC, Fairview Riverside

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Bloomington, MN 55425

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Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309



December 27, 2021

VIA ELECTRONIC MAIL

Office of Commissioner Jan Malcolm
Minnesota Department of Health
625 North Robert Street
St Paul, MN 55155

Dear Commissioner Malcolm:

Thank you for the opportunity to submit comments to the Minnesota Department of Health related to the letter of intent from Fairview Health Services to seek a license to operate a 120 bed inpatient mental health hospital for adults in the East Metro area of the Twin Cities. Our understanding is that a new facility would be built on the former Bethesda Hospital site, in partnership with publicly traded Acadia Healthcare.

Regions Hospital is a major provider of mental health inpatient care in the east metro, serving patients regardless of ability to pay for these services. We recently opened an additional 20 beds, bringing our total mental health inpatient bed capacity to 120. We are proud of the longstanding commitment to caring for persons with mental illness in our community, in partnership with many organizations. HealthPartners and Regions Hospital have convened and participated in the East Metro Mental Health Roundtable since 2003, and appreciate the interconnectedness of preventive, crisis and acute care services that are in short supply in our region. The construction of a new facility or transfer of mental health beds or services within Fairview would have an impact on hospitals providing inpatient care. With additional information we will be better able to tailor input on any associated care delivery and access impacts. These are some introductory questions that will help shape our future response:

Will the current inpatient beds at St. Joseph's Hospital remain open at full capacity until the new facility opens in the future? Any reduction will have a major impact on patient access to a range of services.

Will the new facility be open to all patients, including those without insurance, those on fee for service Medicaid, and those enrolled in prepaid Medical Assistance?

Due to the shortage of bed capacity in the east metro, and the closure of the St. Joseph's emergency room in 2021, the hospitals work very closely together on capacity issues, noted even more during the pandemic. Will there be an emergency room to access services, and if not, how will patients access care if they are not already in the system?

Will the new facility and care model be able to serve persons with co-existing medical and psychiatric conditions? If the facility does not provide medical care, patients could end up needing to be transferred to other east metro hospitals for that care, thus disintegrating their medical and psychiatric care plans.

Will the new facility be able to accept patients from law enforcement personnel at all times and other emergent transfers?

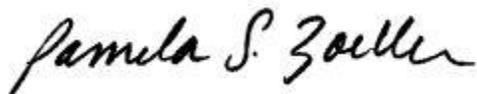
What other resources and services for persons with mental illness will the new facility provide besides inpatient care?

Will the new facility share the east metro patients awaiting transfers to MN State Operated Services?

How will Fairview Health Systems meet the workforce demands to staff the facility?

There are opportunities to improve access in the east metro through collaboration between hospitals, nonprofit providers, counties and the State of Minnesota, and much groundwork has been laid with programs such as the East Metro Mental Health Crisis Alliance. It would be our hope that this new facility will partner with these organizations and help address the gaps we've collectively identified. We look forward to working with our partners in mental health care and with Fairview Health Services as we learn more about how this new hospital will serve patients in our east metro area. We will appreciate the opportunity to comment further as the public interest review process proceeds forward.

Sincerely,

A handwritten signature in black ink that reads "Pamela S. Zoeller". The signature is written in a cursive, flowing style.

Pam Zoeller
Vice President, Specialty Care
HealthPartners

HealthPartners
8170 33rd Avenue South
Bloomington, MN 55425



healthpartners.com

Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309

June 27, 2022

VIA ELECTRONIC MAIL

Office of Commissioner Jan Malcolm
Minnesota Department of Health
625 North Robert Street St Paul, MN 55155

Dear Commissioner Malcolm:

Thank you for the opportunity to comment on the proposed new inpatient mental health facility at the former Bethesda Hospital site in Saint Paul. Inpatient mental health services are in short supply in Minnesota, and we are supportive of efforts to increase capacity. In addition, we believe broader mental health reforms are needed to address community health and ensure a robust continuum of care and services for people with mental illness. With respect to inpatient mental health care, we strongly believe that direct community access to any new facility is equally important to bringing new capacity online. If new inpatient bed capacity is not directly accessible to people in mental health crisis, it will not address the biggest and most challenging bottlenecks we see in the provision of acute mental health services. ***We are supportive of this proposal so long as direct and enforceable community access is guaranteed 24 hours a day, 7 days a week. We appreciate the bipartisan legislation that was passed last session to ensure that community access.***

Regions Hospital is a major provider of mental health inpatient care in the east metro, serving patients regardless of ability to pay for these services. We recently opened an additional 20 beds, bringing our total mental health inpatient bed capacity to 120 beds. We are proud of the longstanding commitment to caring for people with mental illness in our community, in partnership with many organizations. HealthPartners and Regions Hospital have convened and participated in the East Metro Mental Health Roundtable since 2003, and appreciate the interconnectedness of preventive, crisis and acute care services that are in short supply in our region. We welcome the addition of new inpatient mental health bed capacity, but if that new capacity is not at least as accessible to the community as the facility it is replacing, it will be a step backward rather than progress toward the mental health service infrastructure necessary to meet the growing needs of our state.

The closure of St. Joseph's emergency department in 2020, which saw over 24,000 patients visits the prior year, has already put additional pressure on Saint Paul's remaining hospitals to manage higher volumes of patients in mental health crisis as well as all other patients seeking emergency care. Even more concerning is the planned closure of St. Joseph's remaining inpatient mental the health beds over a year before this proposed facility could replace or add any new capacity. This will result in even more patients in need of inpatient mental health care boarding in the emergency department of other metro hospitals while waiting

for limited capacity to open. This is obviously not optimal care for patients waiting for a bed, and it leads to longer wait times and other cascading negative impacts for people in need of all other types of emergency care.

This proposal is a standalone mental health facility without an emergency department. While we appreciate that M Health Fairview provides emergency medical services across the state, the fact remains that the closure of St. Joseph's emergency department and inpatient mental health beds is a major loss that creates a gap in access in Saint Paul in the short term. Even after a new facility is completed in Saint Paul, it will not help address the acute inpatient mental health bottlenecks and boarding in emergency departments in Saint Paul and the greater east metro if patients in crisis can only access the new beds after being transferred from emergency departments in other cities. That is why direct community access to the new capacity in this proposal is our paramount concern and why we will support it if that access is guaranteed.

By direct community access we mean 24/7 access to walk-in patients regardless of insurance coverage, patients transported by emergency medical services or law enforcement, and transfers of patients boarding in hospital emergency rooms outside of the M Health Fairview system. We also think it is important that if patients need to be transferred from the facility due to other acute medical needs that it is not equipped to handle, the facility should reserve space for that patient to return if they have ongoing acute mental health needs after their other medical conditions have stabilized.

We appreciate that the Minnesota legislature passed a bill during the last legislative session that was signed into law by the Governor addressing these primary community access concerns, stating:

The hospital must have an intake and assessment area. The hospital must accommodate patients with acute mental health needs, whether they walk up to the facility, are delivered by ambulances or law enforcement, or are transferred from other facilities. The hospital must comply with subdivision 1a, paragraph (b).

Minnesota Session Laws - 2022, Regular Session- CHAPTER 99- HF 2725, Sec 3, Subd. 1, (31)

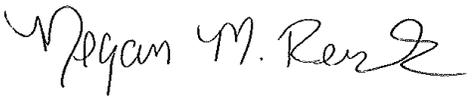
We hope the department will elaborate on how it intends to monitor and enforce these provisions in its final report if it finds this project to be in the public interest.

Finally, we do have some concern about Medicaid reimbursement at a standalone mental health facility and the interaction with the Medicaid Institutions for Mental Diseases (IMD) exclusion rule that limits the use of federal Medicaid financing for care provided in certain mental health facilities larger than 16 beds. We hope the department's review will include some analysis of how this may impact admissions and discharges at the facility and any potential unintended consequences for the state budget. While perhaps outside the direct scope of this review, we would be remiss if we did not mention one of the major underlying barriers to the increase in inpatient mental health bed capacity is the low reimbursement rates for Medicaid inpatient mental health services. We look forward to working with the department and all interested

stakeholders on that any other barriers to improving access to this critical part of our state's continuum of care for mental health services.

Thank you again for your consideration and this opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Megan M. Remark". The signature is written in a cursive style with a large initial "M" and a stylized "R".

Megan M. Remark, MHA, MBA
President, Regions Hospital
Senior Vice President, HealthPartners

From: [Condon, Emily](#)
To: MN_Health_PIR@state.mn.us
Subject: Feedback on Adult Mental Health Care in MN
Date: Monday, June 27, 2022 7:28:26 PM

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To whom it may concern –

We appreciate the opportunity to comment on the proposal to build a new mental health hospital in St. Paul. We recognize the need for significant investment in our mental health continuum in Minnesota, in particular for those Minnesotans who do not need a hospital level of care, but who could successfully receive treatment in the community. We would like any expansion of inpatient beds to ensure Minnesotans on Medicaid receive access to these services, and there are not negative repercussions for surrounding providers that would further exacerbate existing mental health workforce shortages. We look forward to partnering with our colleagues across the health systems to address the mental health care needs of Minnesotans.

We offer the following recommendations of the new facility in question:

- Required access for acute cases regardless of payor
- Required 24/7 admissions, regardless of onsite Emergency Department/services
- Require reporting on:
 - Number of Medicaid Patients and Length of Stay
 - Patient level reporting of those denied admission and reasons for denial
 - Tracked by insurer
 - Specific tracking of patients deemed “too sick” for a particular level of care in order to assess if facilities are selecting less acute patients
 - Reporting of baseline percentage of Medicaid and Uncompensated Care patients across the whole organization/system to ensure a proportionate increase in MA/Uncompensated Care in relation to the increase in available mental health beds. This would help to ensure MA/Uncompensated Care patients are not being shift to other health systems.
 - CMS Inpatient Psychiatric Facilities Quality Reporting Program (IPFQR) quality measures
- Allow for priority admittance for patients from certain health systems when experiencing issues such as low staffing.

Sincerely –

Hennepin Healthcare

[Survey: Tell us how we're doing](#)

Thank you

Emily Condon, RN, CPHQ

Quality and Performance Improvement Data (QPID) Analyst

QPID Team, PM&I | Hennepin Healthcare

MS Teams | 612-873-7174 | G2.342



OFFICE OF THE RAMSEY COUNTY ATTORNEY

John J. Choi

May 4, 2022

The Honorable Senator Rich Draheim
95 University Avenue W.
Minnesota Senate Bldg., Room 3227
St. Paul, MN 55155

Re: Exception for Increased Mental Health Bed Capacity, Senate File 3249

Dear Senator Draheim,

I am writing to express my support for the proposed exception to Minnesota's hospital bed moratorium, contained in Senate File 3249, that would specifically allow our health systems to establish more inpatient mental health opportunities.

Our office encounters those with mental illness daily in our community. Our civil commitment attorneys, working with law enforcement and correctional officers, struggle to meet the safety and legal needs of those in crisis. Having a local and stable mental health care facility partnership is critical to our success in managing these challenging and dynamic needs.

There is an urgent, unmet need for additional inpatient mental health beds that requires immediate action. Today, there are simply not enough mental health beds to meet the needs of our community.

We fully understand that there are barriers to the establishment and operation of mental health beds. We are asking the legislature, governor, and the Minnesota Department of Health to remove one of those barriers, even for a limited amount of time. Granting this exception to the moratorium would allow a health system – or others – to propose and invest in creative solutions to the deficit of needed inpatient mental health care options.

Please help our communities to address the growing crisis in mental health care. Please support the limited exception to the hospital bed moratorium for inpatient mental health beds. I would welcome an opportunity to discuss this issue further.

Sincerely,

John Choi
Ramsey County Attorney

345 Wabasha Street North, Suite 120 • Saint Paul, Minnesota 55102-1432
651-266-3079 • RamseyCountyAttorney.org



Minnesota Department of Health (MDH)

From: Jodi Ritacca [REDACTED]
Sent: Monday, June 13, 2022 4:04 PM
To: MN_Health_PIR@state.mn.us
Subject: Comments on need for more inpatient mental health beds

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MDH,

I participated in the MDH virtual public hearing last Thursday evening. After hearing Fairview and Arcadia presentations and the proposed new stand alone hospital for more mental health beds, especially in the Twin Cities Metro East side in St Paul, here are my comments:

My family and I have lived in Minnesota for more than 29 years and specifically in the East Metro.

As a video and documentary producer and former news reporter, I have covered health and medical news in Minnesota since 1993.

So, I am acutely aware of the ongoing and emerging health and medical issues in Minnesota including the need for more inpatient mental health beds.

The need for more inpatient mental health beds is an issue that hit close to home when my family personally experienced the need for an inpatient mental health bed during a family crisis.

Late last year, my 15-year-old nephew, Max, had a mental health crisis. He spent several DAYS in one of the local ERs waiting for an inpatient mental health bed, and waiting for the specialized addiction care services that he desperately needed before he harmed himself or someone else.

Thank goodness an inpatient bed was finally found, and he received the specialized mental health care services he needed to survive his mental health crisis.

I know my nephew is not alone. More inpatient mental health beds means people like my nephew can get access to inpatient mental health care services faster, where the patient can be stabilized.

I believe a stand alone mental health hospital on the Twin Cities East Metro will positively impact the availability and quality of inpatient mental health and addiction services in Minnesota, and build a stronger, more sustainable system for mental health care.

Until 2015, I was employed with HealthEast Care System, which is now part of M Health Fairview. So, I'm well aware that Fairview is a trusted leader and valued partner in meeting the mental health and addiction care needs in our community.

For these reasons and because of my nephew's recent experience, that is why I support the proposed stand alone new state-of-the-art mental health hospital be in St Paul. Thank you!

Jodi Carlini



Mental Health Minnesota is the voice of lived mental health experience.

We carry that declaration forward as we work to advance mental health and well-being for all, increase access to mental health treatment and services, and provide education, resources and support across Minnesota.

February 21, 2022

Dear Members of the House Health Finance and Policy Committee:

I write today to convey Mental Health Minnesota's opposition to HF3281, which would provide a bed moratorium exception to allow for construction of a new hospital in Ramsey County, with 144 licensed psychiatric beds.

While we agree that there is a significant unmet need for inpatient mental health care in Minnesota, we do not agree with this approach to resolving the crisis.

First, we do not believe that it makes sense to build a stand-alone hospital for those seeking inpatient mental health care that does not include an emergency department. Emergency rooms remain a primary gateway for people experiencing serious mental health symptoms to get into inpatient care.

Second, creating a stand-alone facility that does not provide other medical services will not serve people well who are experiencing mental health crisis or are seeking inpatient mental health care. It is our position that we need health care to care for the whole person, and separating physical and mental health care into separate facilities is simply not reflective of individual reality or the need for a more integrated and collaborative approach to health care.

Finally, federal law prohibits states from using Medicaid to pay for mental health care in psychiatric facilities with more than 16 beds. To open this proposed facility and utilize Medicaid, Minnesota would need to request an IMD Exclusion waiver. Many people in Minnesota who are living with mental health concerns rely on Medicaid to pay for their care, and building a facility without having a direct funding mechanism tied to Medicaid is a significant concern.

Again, we agree that there is a crisis when it comes to access to inpatient mental health beds. However, we believe that this need must be addressed in a way that best serves the people of Minnesota, and that includes an approach that includes an emergency department, reflects both physical and mental health needs, and has the ability to accept Medicaid for patient care.

Thank you. We appreciate the opportunity to convey our opposition to this proposal.

Sincerely,

Shannah C. Mulvihill, MA, CFRE
Executive Director



June 27, 2022

Professional Distinction

Personal Dignity

Patient Advocacy

Office of Commissioner Jan Malcolm
Minnesota Department of Health
625 North Robert Street
St Paul, MN 55155

Dear Commissioner Malcolm:

Our names are Chelsea Schafter and Ami Tillemans and we are Chairs at the Minnesota Nurses Association (MNA), representing 22,000 nurses, 80 percent of all bedside hospital nurses in Minnesota.

Every day, nurses confront the ongoing staff shortages in our hospitals and experience firsthand the mental health crisis in our state. Nurses understand the need for additional mental healthcare beds. However, as frontline healthcare professionals, we recognize that there is a right way to go about it, and a wrong way.

Nurses believe that healthcare in Minnesota should put patients before profits. We believe that safe patient care should be the top priority in Minnesota hospitals, not the profits of hospital executives or corporate bottom lines and results for shareholders. This is why we are deeply concerned with M Health Fairview's decision to partner with a profit-driven corporation, Acadia Healthcare, which will have 85 percent ownership of this new venture.

Acadia's recent track record speaks volumes about the company's priorities:

- In 2019, a youth treatment center in New Mexico owned by Acadia [shut down](#) after abuse allegations, multiple lawsuits, and loss of certification from state regulators. Seven lawsuits were filed against the Desert Hills of New Mexico facility in Albuquerque and its parent company in the month prior to its closing, alleging the company failed to protect its clients from physical and sexual abuse from its workers and other patients.
- That same year, the United States Attorney's Office announced a \$17 million fraud [settlement](#) with Acadia Healthcare in West Virginia, the largest healthcare fraud settlement in the state's history. Under the settlement agreement, Acadia, which operated the treatment centers since [February 2015](#), agreed to pay \$17 million to resolve allegations of a billing scheme that defrauded Medicaid of \$8.5 million between January 1, 2012 and July 31, 2018.
- In 2021, three current and former executives brought a [class action lawsuit](#) against Acadia Healthcare stating that the company misled investors. The action, which dates back to 2018, alleges the defendants misled investors after stock prices dropped as a result of understaffing and other issues. The

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AFL-CIO

- suit, launched by St. Clair County Employees' Retirement System, accuses Acadia of falsely claiming to have a commitment to excellent patient care, while calling out reports of understaffing and allegations of violence at Acadia facilities.

Despite racking up millions in [fines and regulatory violations](#), Acadia continues to expand, describing the investment environment for behavioral facilities in the U.S. as a “large market with attractive trends.” This is the wrong focus when we’re talking about services for patients with mental health needs. We are concerned that the proposed partnership will put shareholders' expectations above the interests of the community, especially the most vulnerable who are in desperate need of mental health services.

Nurses do our research before we take a job. We want to work in a place that treats patients and coworkers with respect and dignity. A review of data from the nonprofit group, The Joint Commission,¹ reveals that many Acadia-run facilities fall behind national quality standards and may jeopardize patient care.

At San Jose Behavioral Health in California, for example, Acadia fell below the national average in screening patients for violence risk, substance use disorder, trauma, and other factors with the potential to put both patients and healthcare workers at risk. At the same hospital, Acadia used physical restraint and seclusion at rates above the national average, notably keeping adolescents ages 13 – 17 in seclusion at more than six times the national rate and using physical restraint on seniors at almost five times the national rate. These conditions are disturbing for patients, and also point to inadequate staffing levels where patients do not receive the full care and attention they need. These attitudes and behaviors from Acadia will drive experienced healthcare workers away and further degrade the quality of care.

For-profit healthcare is not the way we do things in Minnesota. This corporate model puts executive compensation, shareholder returns, and the bottom line before the care of Minnesotans, including our most vulnerable. M Health Fairview’s plan to outsource care to the profit-driven Acadia corporation raises several serious questions about the proposed Mental Health Hospital and its impacts for patients and workers. If the answers to these questions reveal that the priorities of Acadia Healthcare are not in alignment with our values as Minnesotans, the project should not be found to be in the public interest by the Minnesota Department of Health.

Community Need

There is no doubt that there is a continued mental health crisis in Minnesota, which shows no sign of slowing down. While M Health Fairview and Acadia state that they intend to increase the number of mental health beds, the parties’ application reflects that M Health Fairview’s practice has been to do the opposite. In fact, M Health Fairview reduced the number of mental health beds at St. Joseph’s by [more than 50%](#) since 2018 and decreased mental health beds system-wide by [nearly 15%](#) between 2016 and 2020. When Regions Hospital came before MDH in 2017 to [propose an increase in beds](#), including 20 mental health beds, M Health Fairview [opposed it](#) while acknowledging unmet mental health needs in downtown St. Paul.

MNA has significant concerns that M Health Fairview intends to [close the remaining](#) 40 beds at St. Joseph’s Hospital before the new Mental Health Hospital is built. This decision would undoubtedly put strain on existing emergency departments which are already operating at or above capacity.

Moreover, we ask why M Health Fairview is seeking additional beds when [data from MDH](#) shows that the system has a total of 3,455 licensed beds but has only been using 2,013 of them.

¹ Compiled from Quality Reports, available at <https://www.qualitycheck.org/>.

Staffing

MNA's own research shows that chronic short staffing is a [principal reason](#) nurses leave the bedside, and MDH research shows that more registered nurses are now working [outside the profession](#). As MDH reviews "[h]ow the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff," we have questions about staffing plans at the proposed Mental Health Hospital:

- 1) M Health Fairview employed [106 Registered Nurses](#) (RNs) in relation to the operation of inpatient mental health units at St. Joseph's Hospital as of December 2021. While M Health Fairview and Acadia state that they intend to increase the number of mental health beds, the project partners estimate that they will only have [55 FTE RNs](#). How will a 48% reduction in nurse staffing improve the mental health crisis in Minnesota?
- 2) M Health Fairview has represented that the continued decline in available beds at St. Joseph's Hospital were the result of "[staffing challenges experienced by hospitals nationally and locally related to COVID-19.](#)" Given the continued relevance of COVID-19, what are the project partners' plans to attract and retain qualified behavioral health psychiatrists, psychiatric nurses, and other behavioral health professionals at this new hospital and increase the capacity of available beds?
- 3) The average length of stay for inpatient mental health (psychiatric) admissions at St. Joseph's hospital between 2017 and 2020 was 11.31 days, 50% higher than the average for private facilities in the 7-county metro.² How does M Health Fairview account for this difference? What will be the intended average length of stay in the Mental Health Hospital? If the average length of stay continues to be high, but the project partners intend on hiring fewer staff, what is the plan to accommodate patients?
- 4) The project partners' original submission reflects that 1) when the Mental Health Hospital opens, it will have [120 inpatient beds](#); and 2) the Mental Health Hospital will employ approximately [200 full-time equivalent employees](#) by the end of year two. What is the breakdown of FTEs when the hospital opens?
- 5) With the staff reduction to just 55 Registered Nurses employed, what is the expected ratio of nursing hours per patient day at the new facility? How will this differ before the Mental Health Hospital reaches the estimated staffing of 200 FTE?
- 6) What is the ratio of staffing for Physicians to Physician Assistants to Nurse Practitioners?
- 7) What is the expected nurse to patient ratio in this center vs. a co-located center?
- 8) MNA is concerned whether the minimum of [one licensed psychologist](#) on staff is adequate for a 144-bed facility. How does this compare to industry benchmarks, as well as other M Health Fairview and Acadia facilities?
- 9) What are the project partners' plans for staffing the new facility to ensure the hospital meets or exceeds national and state quality measures?

Patient Suicides and Violence

2020 data from the Centers for Disease Control and Prevention show that suicide is the [8th leading cause of death](#) in Minnesota. It is the 2nd and 3rd highest cause of death for ages 10-34 and 35-44, respectively. Our analysis of Acadia facilities in major metropolitan areas finds that Acadia lags behind the national average on important metrics (see figures 1-3), which are often related to a lack of adequate staffing.

² Statistics gathered from Minnesota Department of Health's data set, "Mental Health and Chemical Dependency," available at <https://www.health.state.mn.us/data/economics/hccis/data/stndrdrpts.html>.

Assessment of violence risk, substance use disorder, trauma

Figure 1: Selected Acadia facilities that scored below the national average on the measure: Assessment of violence risk, substance use disorder, trauma and patient strengths completed - Overall Rate

Facility	City	State
San Jose Behavioral Health Hospital	San Jose	CA
Stonecrest Behavioral Health Hospital	Detroit	MI
Belmont Behavioral Health System	Philadelphia	PA

Medications at Discharge

Figure 2: Selected Acadia facilities that scored below the national average on the measure: Multiple Antipsychotic Medications at Discharge with Appropriate Justification - Overall Rate

Facility	City	State
Sonora Behavioral Health Hospital	Tucson	AZ
San Jose Behavioral Health Hospital	San Jose	CA
Belmont Behavioral Health System	Philadelphia	PA
Crestwyn Behavioral Health Hospital	Memphis	TN
Delta Specialty Hospital	Memphis	TN
Cross Creek Hospital	Austin	TX
Rio Vista Behavioral Health Hospital	El Paso	TX

Physical Restraint Use

Figure 3: Selected Acadia facilities that scored above the national average on the measure: Hours of Physical Restraint Use per 1000 Patient Hours - Overall Rate

Facility	City	State
San Jose Behavioral Health Hospital	San Jose	CA
Pacific Grove Hospital	Riverside	CA
Delta Specialty Hospital	Memphis	TN

- 10) What is the current rate of admitted patient suicides at M Health Fairview and Acadia hospitals?
- 11) What is the current rate of homicides at M Health Fairview’s acute care hospitals and Acadia hospitals?
- 12) How do these rates compare to industry standard benchmarks?

Workplace Violence and Security

Workplace violence is a persistent problem in the healthcare industry. Certain occupations and environments within the industry may be more prone to such violence. [The Minnesota Nurses’ Study](#) found that the annual rate of verbal and physical assaults for RNs and LPNs was 39% and 13%, respectively. Additionally, researchers have found an elevated risk of workplace violence at inpatient psychiatric facilities, including rates that are [69 times](#) the national rate of violence in the workplace for psychiatric aides.

We have concerns about how M Health Fairview and Acadia plan to combat this problem, given that several of Acadia’s inpatient facilities scored below the national average on assessing patients for violence risk. Recently, healthcare workers at [Cascade Behavioral Health](#) in Tukwila, WA highlighted Acadia’s failure to provide safe working conditions after an incident left 11 staff members injured, four of whom were sent to the emergency

room with severe injuries. Workers' demands were simple: hire dedicated security staff and implement safety procedures so they can best serve patients.

- 13) What is the current rate of incidents of workplace violence at M Health Fairview's behavioral health hospitals?
- 14) What is the current rate of incidents of workplace violence at M Health Fairview's other acute care hospitals?
- 15) What is the current rate of incidents of workplace violence at Acadia's hospitals?
- 16) How do these rates compare to industry standard benchmarks?
- 17) MNA has concerns with M Health Fairview and Acadia's belief that [one on-site security officer](#) is adequate for this facility. How does this compare to industry benchmarks, and other M Health Fairview and Acadia facilities?
- 18) Will the Mental Health Hospital have locked facilities?

Operations

As a profit-driven corporation, Acadia Healthcare operates its facilities with an eye on shareholder returns, executive compensation and bonuses, and the bottom line. MNA nurses have concerns and questions as to how these priorities will affect day-to-day operations for patients and staff at the proposed Mental Health Hospital.

- 19) The parties told MDH that ["In extreme medical crisis situations, patients would be transported and admitted to an appropriate acute care setting."](#) Is the new Mental Health Hospital intended to be an acute inpatient behavioral health hospital?
- 20) Will the Mental Health Hospital involuntarily detain individuals with a mental challenge who are an imminent danger to themselves or others for a 72-hour psychiatric hospitalization under Section 5150 of the Welfare and Institutions Code?
- 21) What is the current number of 5150 holds initiated by law enforcement? What are the anticipated number of holds in the future?
- 22) The project partners point to ["desired scale"](#) and ["level of specialized care"](#) as part of the rationale to establish a freestanding facility. What is the "desired scale" of the Mental Health Hospital? What is the intended scope of specialization (e.g., adult, child, adolescent, geriatric, drug rehabilitation, alcohol rehabilitation, etc.)?
- 23) The project partners indicate that the Mental Health Hospital will provide ["operational efficiencies."](#) What do these efficiencies entail, and how will they impact patient care?
- 24) The parties indicate that all care will be covered under [Diagnosis Related Group \(DRG\) 885](#) and assert that DRG 885 is an all exhaustive DRG for all mental health and substance use disorders. However, DRG 885 is limited to Psychosis, and there are several other DRGs in the Major Diagnostic Category (MDC) for Mental Diseases & Disorders that are highly relevant in our community, including: Acute Adjustment Reaction & Psychosocial Dysfunction, Depressive Neurosis, Disorders of Personality and Impulse Control, and Alcohol/Drug Abuse or Dependency without Rehabilitation Therapy. What are the other DRGs that the parties are willing to provide care for our community?
- 25) What surgical interventions do the parties intend to perform at this new facility? Will electroconvulsive therapy services (ECT) be offered at this facility?
- 26) There are multiple service lines within behavioral health. What lines do the parties expect to provide to the community?

- 27) In the event the Capitol Area Architectural and Planning Board does not approve M Health Fairview and Acadia's [preferred location](#), how will the alternative site serve the same current community behavioral health needs?
- 28) Will this joint venture be branded under the banner "M Health Fairview"?

Patient Transfers

MNA nurses know patients are best served when they have access to the full range of care services they may need, as a well-staffed hospital can provide. Given the for-profit model of Acadia Healthcare, nurses have concerns and questions as to how patient needs will be assessed and met for care and treatments not offered at the new Mental Health Hospital.

- 29) The parties indicate that ["If the best medical option for a patient is hospitalization, they will be transferred to an inpatient mental health and addiction unit at UMMC or the new mental health hospital."](#) What does this statement mean for patient care at the new Mental Health Hospital, or at another facility? How will such decisions and transfers be made in practice?
- 30) What diagnoses will not be able to be treated at this hospital?
- 31) What types of patients would be transferred?
- 32) What are the limitations of this new behavioral health hospital?
- 33) What is the ratio of Emergency/Urgent/Elective admissions currently? What is the planned ratio at the new facility?

Conclusion

The profit-driven model of healthcare pursued by Acadia raises serious questions as to whether the needs and best interests of the Minnesota public will be served by the proposed partnership between M Health Fairview and the private corporation. If answers to these questions show that concerns with executive compensation, shareholder returns, and the bottom line would come before the care of Minnesotans, including our most vulnerable, nurses urge that the Department find the proposal to not be in the public interest. More mental health beds are needed in Minnesota – not more profits at the expense of patient care in our health system.

Sincerely,

Chelsea Schafter, RN
Ami Tillemans, RN
MNA Chairs

HealthEast Closures

While Fairview has sought to downplay the disruption caused to healthcare workers and the community with the closure of Bethesda and St. Joseph's, nurses can speak to the truth.

In his testimony, RN Daniel Clute told the Minnesota Legislature:

At the end of 2019 M Health Fairview announced the partial closure of Bethesda hospital while warning that St. Joe's was also at risk of closing. Just a few months later, we entered into a global pandemic and Bethesda was converted to a standalone COVID hospital. I worked at Bethesda until the COVID unit transitioned to St. Joe's after just 6 months. This was a pivotal moment of transition for St. Joe's, with existing med surg and ICU units, the converted COVID units along with the closing of the emergency room, leaving only the mental health units. These closures left St. Paul's population of 300K with just 2 adult emergency rooms.

When the COVID units closed, there were 4 Mental Health units and a separate unit of 15 beds from the previous Bethesda left. Local hospitals had been getting overwhelmed even with the downturn in COVID numbers and the staffing crises was starting to worsen. As COVID picked up again in the fall of 2021, things began to get dire once more.

Critically ill patients are still being kept in the ER for many hours and even days due to lack of hospital beds; mental health patients are also waiting days for a bed to open. There are not enough mental health beds for those who need them. Yet M Health Fairview is moving forward with the closure of those 4 mental health units.

Nurses not only had to reckon with the closure of Bethesda, but they did it during a global pandemic when resources and staffing were stretched dangerously thin.

Daniel's experience working at Bethesda, and subsequently St. Joseph's, is not unique. Due to rights enshrined in our collective bargaining agreement, MNA was able to negotiate with Fairview over planned closures and help create a layoff process which would see nurses retain good-paying union jobs, where possible. Our records indicate that over half of nurses who worked at Bethesda in 2020 and obtained subsequent employment at an MNA-represented facility went on to work at St. Joseph's. While back then, the future of St. Joseph's was up in the air, now, these nurses stand to lose once again because of Fairview executives' decisions.

Despite our best efforts, we were unable to mitigate all adverse impacts. Under the agreement, for a nurse to retain a job, they may have had to accept positions with a different full-time equivalent (FTE), shift, or work on a unit other than what they preferred. Our available data reflects that more than half of nurses who moved from Bethesda to another MNA-represented facility are working a different FTE. Additionally, members who work at a facility not covered under our collective bargaining agreement with HealthEast are working agreements with different pay scales, benefits, and work rules.

Looking at the past and future closures at St. Joseph's, nurses stand to see big day-to-day differences. Our records indicate that over half of nurses who obtained subsequent employment at an MNA-represented facility work under a different FTE than the one they worked at St. Joseph's. Additionally, 32 percent of nurses who obtained subsequent employment at an MNA-represented facility will work

under a collective bargaining agreement other than the one with HealthEast. Our contracts differ tremendously from hospital to hospital. Nurses who went to work at facilities without a defined benefit retirement plan may stand to lose in retirement since defined contribution plans (e.g., 401k) typically shift the [burden of saving](#) on to the employee.

Fairview's Plans for the University of Minnesota Medical Center

Fairview executives' decision to close Bethesda and St. Joseph's have been critiqued widely and publicly. MDH's data¹ shows that St. Joseph's has been over capacity with regard to mental health beds since 2018 (104% as of 2020²) in a poor payer mix area.

If these beds vanish into a hospital without an emergency department, as proposed, patients will likely be sent to the following hospitals with emergency departments: the University of Minnesota Medical Center (UMMC), Hennepin County Medical Center, Abbott Northwestern, North Memorial, Regions, and United, among others. Several of these same hospitals, [wrote to Fairview](#) asking executives not to close beds at St. Joseph's before they open the new facility.

What has not yet been discussed is an additional plan by Fairview that has the potential to affect mental healthcare in Minnesota. At a University of Minnesota Regents meeting in [May 2022](#), Dr. Jakub Tolar, Dean of the University of Minnesota Medical School, [proposed](#) building a new hospital. At this meeting, he emphasized four elements: 1) locating a single hospital on one bank; 2) the hospital would be a destination for not just the Twin Cities, but the whole state; 3) the hospital would have more than a thousand beds; and 4) the hospital would focus on specialty care.

As of 2020, the University of Minnesota Medical Center is the second largest hospital by number of licensed and available beds in the state, next to Mayo Clinic – Rochester. Of significance, it is also the hospital with the highest number of inpatient mental health (psychiatric) available beds and has the highest number of inpatient mental health (psychiatric) admissions in the state. Fairview acknowledges this role, stating that [“the largest provider of mental health and addiction care in the Upper Midwest.”](#)

The University of Minnesota receives \$226M in funding from the National Institutes of Health (NIH).³ 10 percent of the NIH money is for the psychiatry department. While Fairview claims that the new mental health hospital will have a [“complimentary impact”](#) on existing inpatient mental health units, we are concerned that significant changes to UMMC could reduce the number of beds, staff, and potentially funding for the U of M Medical School. Given the hospitals' role providing mental healthcare in Minnesota, we believe it is more crucial than ever that Fairview explain what services it intends to provide and how this plan intersects with the proposed Mental Health Hospital.

¹ Statistics gathered from Minnesota Department of Health's data set, “Mental Health and Chemical Dependency,” available at <https://www.health.state.mn.us/data/economics/hccis/data/stndrdrpts.html>.

² Calculated as Inpatient Mental Health (Psychiatric) Patient Days / (Inpatient Mental Health (Psychiatric) Available Beds * 365 days).

³ Funding gathered from Blue Ridge Institute for Medical Research, available at http://www.brimr.org/NIH_Awards/2021/default.htm.

Impact on the Community

Training Tomorrow's Physician Leaders

With the closure of St. Joseph's⁴ and Bethesda, where are intern and resident programs going to go and how does this affect the funding the University of Minnesota's psychiatry department?

Location

We are concerned that Fairview and Acadia may ultimately abandon the site of the former Bethesda hospital and move to a location in the suburbs, given the requirements of the Capitol Area Architectural and Planning Board.

If the facility were to be located outside of a 30-mile radius, it would create an underserved community that was previously cared for at St. Joseph's and could reflect a preference to cater to wealthier, less diverse, and privately insured patients.

Given that more than one of every eight St. Paul residents do not have a car, and more than 50 percent have one car or less,⁵ it is crucial to look not just at the distance by car, but also by public transportation as well (see Appendix).

Examining the "Union Premium"

Countless studies have supported the notion that there is a [wage premium](#) for unionized workers over their non-union counterparts. In addition, there is evidence of a [spillover](#) effect where a unionized workforce actually raises non-union wages. This may especially be the case in the Minnesota, where many large hospitals have unionized RNs.

However, the "Union Premium" is not limited to wages. A recent study found that unionized workers are [more likely](#) than their non-union counterparts to speak up about health and safety problems in the workplace. As a result, unionized workplaces are 30% more likely to face an inspection for a health or safety violation. Given that inpatient psychiatric facilities have [elevated rates](#) of workplace violence and nurses report [leaving the bedside](#) because of short staffing and unresponsive management, we believe that is crucial for workers to have a voice on the job.

Continuity of Care

In our meeting, we discussed the importance of continuity of care when treating mental health patients. Our understanding is in California health plans are required under certain circumstances to continue to cover care by a provider whose contract with the health plan is terminated.⁶ For most types of care there is a 90-day window where insurers must continue to cover care until an orderly transfer to another provider in-network. However, for "serious chronic condition[s]" including mental health,

⁴ As of 2019, St. Joseph's had 11+ FTE interns and residents

⁵ Census ACS 5-Year Estimates, available at <https://www.census.gov/acs/www/about/why-we-ask-each-question/vehicles/>.

⁶ Under the Federal [No Surprises Act](#), "[t]erminated is defined as, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud."

continuity of care can be extended to a full 12 months. We have provided examples of written continuity of care policies required in California as well as the citations to California regulations.

While Minnesota law does not extend this benefit to 12 months, it does [recognize](#) enrollees engaged in a current course of treatment for a life-threatening mental illness, a mental disability that has lasted or can be expected to last for at least one year, and chronic conditions that are in an acute phase are entitled to continuity of care for up to 120 days by their health plan.

Optimizing Profitability

During our recent meeting, MDH requested any insight that MNA may have into the economics of the facility.

Our experience is that there are three primary strategies to optimize profitability in a psychiatric facility, all of which potentially come at the expense of patients: 1) controlling the front door; 2) design as a freestanding facility; 3) reduce staffing. Fairview and Acadia's proposal seeks to achieve all of these efficiencies in a way that would put profitability above patient care.

To control the patient population, Fairview and Acadia have proposed a 24/7 intake office instead of an emergency department. The lack of an emergency department raises concerns about the degree to which the facility would be subject to EMTALA or not. This may give Fairview-Acadia greater latitude in selecting their patients for intake based on their preferred payor mix over considerations for patient health needs. Greater flexibility for Fairview-Acadia in this regard would likely exacerbate existing disparities in access to mental health care.

Further, this may push those in need of mental health care and other medical interventions into St. Paul's other emergency departments, putting further strain on their resources. Should patients be moved to other emergency departments, we would anticipate disruptions to those hospitals' med-surge units as they may have to take in overflow patients. Hospitals in the Twin Cities, Fairview notably among them, are already [struggling to care for patients](#) in need of mental health care, often boarding patients for extended periods of time in emergency departments. Nurses and other healthcare workers in these departments who may not specialize in caring for mental health patients are then put in potentially dangerous environments without adequate training and resource support from their employers.

Our understanding is that mental healthcare in freestanding facilities such as that proposed by Fairview-Acadia would be reimbursable under TEFRA which is based on cost and not on a fee-for-service basis. This has the potential to incentivize providing very minimal ancillary services to patients and eliminating the cost of operating ancillary departments such as labs, radiology, emergency department, cardiology, etc.

Of significant concern to nurses are the currently proposed staffing plans for the Fairview-Acadia facility. The plan proposes a reduction in registered nursing staff of nearly 50%. The plan also proposes fewer ancillary staff, which will place further burden on an already reduced nursing staff. Further, the plan proposes a shift from physicians to nurse practitioners, presumably in the interest of minimizing costs and maximizing profitability. The [Bureau of Labor Statistics](#) data for Minnesota in the year 2021 shows the average annual income for psychiatrists to be \$290,570 whereas the average annual for nurse practitioners is less than half of that at \$127,010.

Quality Standards

Fairview

At Fairview's own hospitals, hospice and home care facilities, and through its subsidiaries operating long-term senior care facilities and senior housing, Fairview has allowed bad practices to go on. Between 2015 and 2022, we counted a total of 55 substantiated provider complaints from MDH's database,⁷ the majority of which took place during the height of the pandemic. In complaint descriptions, we counted:

- Six mentions of "physical abuse"
- Five mentions of "exploitation" and "staff"
- Eight mentions of "neglect"
- Six mentions of "infection"
- Eight mentions of "quality of care" or "QOC"

Many of these same facilities, and other nursing homes associated with Fairview, were inspected by CMS, resulting in:⁸

- At least 174 total deficiencies, including 20 related to infection
- At least \$69,000 in penalties, including one payment suspension at a Cerenity Care facility in St. Paul

Many of these provider complaints involve the most vulnerable among our population. In [2019](#) a patient admitted to the St. Joseph's inpatient psychiatric unit obtained a pair of scissors and stabbed herself in the abdomen, shortly after being taken off 1:1 supervision. After she was stabilized, the patient was transported by ambulance to another hospital to undergo emergency ambulatory surgery to remove the scissors. Countless advocates have raised concerns about the lack of an emergency department in Fairview and Acadia's proposal. If this situation were to take place at the new mental health hospital, would the facility be prepared to respond and provide the immediate care needed?

Acadia

While Fairview's record clearly deserves scrutiny, we believe it is far worse for hospital executives to offload responsibility to a for-profit corporation, Acadia Healthcare, which will have 85 percent ownership of this new venture. Acadia's record is even worse when it comes to caring for the most vulnerable.

Despite telling MDH that it has never lost a state license or been forced to close, reporting shows that [Acadia closed the doors](#) of its Desert Hills of New Mexico facility in Albuquerque after at least 7 lawsuits were filed and the New Mexico Children, Youth and Families Department decided not to extend the facility's license. Furthermore, Acadia has come under fire in other states, including [West Virginia](#), where the company was ordered to pay \$17M to resolve allegations of Medicaid billing fraud. Do regulatory agencies in Minnesota want to invite a company with this track record into the state, which could expend valuable resources?

Whereas the data cited in our public comment reflected Acadia's performance in major metropolitan areas, these trends extend across the country. Looking more broadly at acute inpatient hospitals with

⁷ Available at <https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>.

⁸ Compiled from ProPublica Nursing Home Inspect, available at <https://projects.propublica.org/nursing-homes/>.

quality standards data,⁹ we found 25 Acadia facilities that the Joint Commission identified as having at least one measure where the hospital met the National Quality Improvement Goal less often than the national average. Between these 25 hospitals, they had 90 instances of falling behind national quality goals, meaning that each hospital, on average, fell behind on 3 measures.

Number of Acadia facilities that scored below the national average on the following measures

Measure	Count
Assessment of violence risk, substance use disorder, trauma and patient strengths completed	7
Assessment of violence risk, substance use disorder, trauma and patient strengths completed - Adolescent (13-17 years)	2
Assessment of violence risk, substance use disorder, trauma and patient strengths completed - Children (1-12 years)	1
Assessment of violence risk, substance use disorder, trauma and patient strengths completed - Older Adult (>= 65 years)	4
Assessment of violence risk, substance use disorder, trauma and patient strengths completed - Adult (18-64 years)	6
Multiple Antipsychotic Medications at Discharge Overall Rate	20
Multiple Antipsychotic Medications at Discharge with Appropriate Justification Adults Age 18 - 64	18
Multiple Antipsychotic Medications at Discharge with Appropriate Justification Older Adults Age 65 and Older	5

Number of Acadia facilities that scored below the national average on the following measures

Measure	Count
Hours of Physical Restraint Use Adolescents Age 13 - 17	2
Hours of Physical Restraint Use Adults Age 18 - 64	5
Hours of Physical Restraint Use Older Adults Age 65 and Older	2
Hours of Physical Restraint Use per 1000 Patient Hours Overall Rate	5
Hours of Seclusion Use Adolescents Age 13 - 17	3
Hours of Seclusion Use Adults Age 18 - 64	3
Hours of Seclusion Use Children Age 1 - 12	1
Hours of Seclusion Use Older Adults Age 65 and Older	3
Hours of Seclusion Use Overall Rate	3

Taken in context with reporting and firsthand accounts, this data demonstrates that these are not isolated events, but rather part of Acadia’s business model. As NAMI Executive Director, Sue

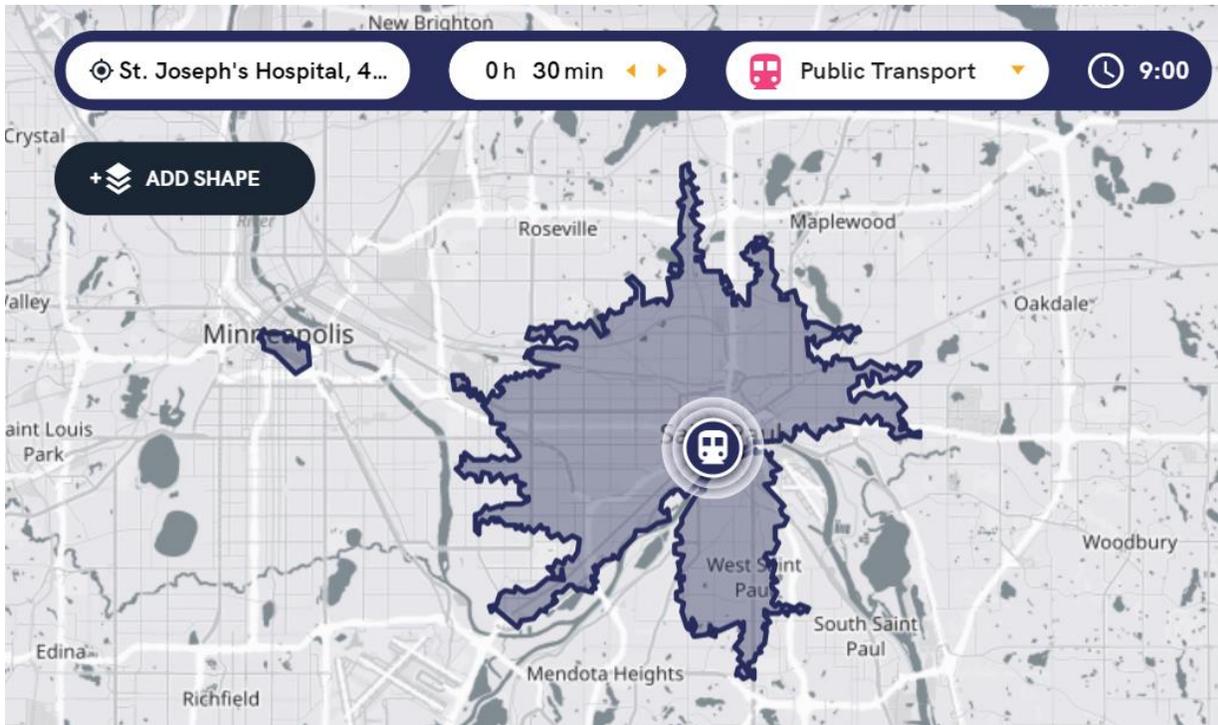
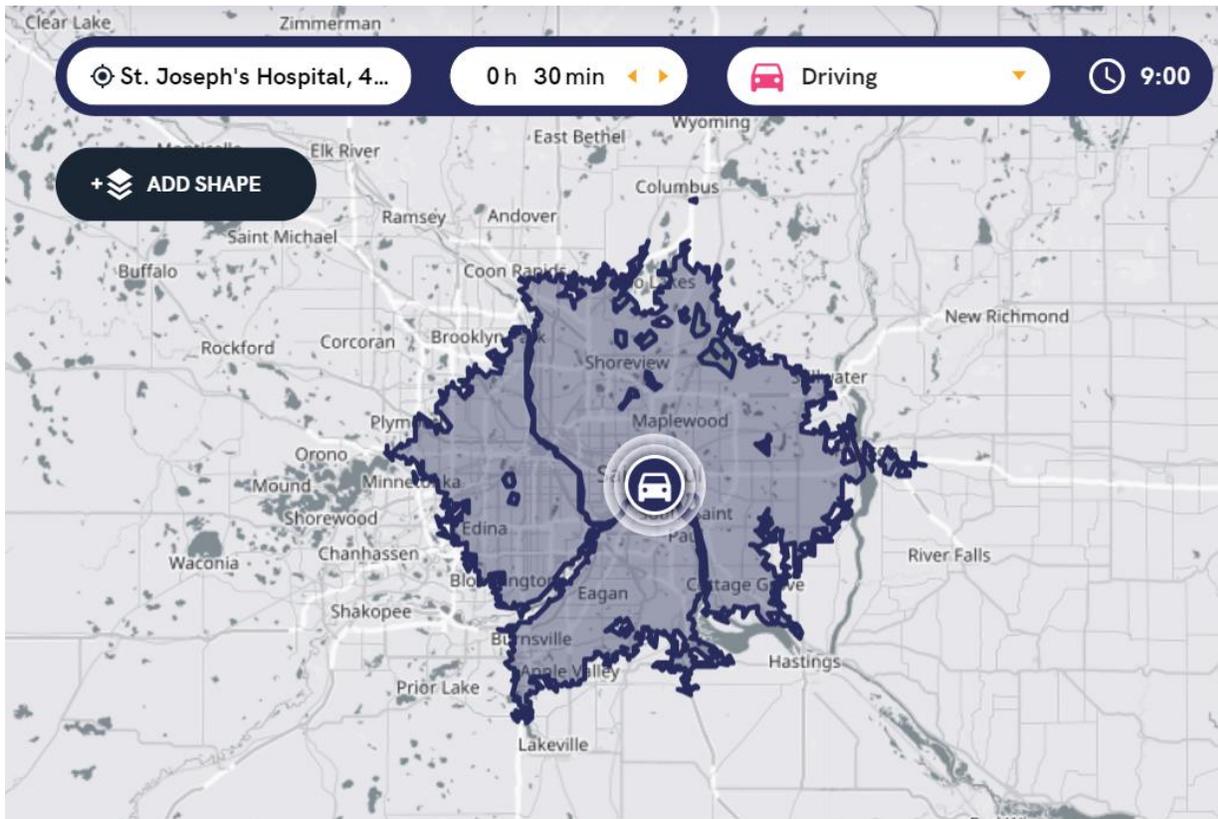
⁹ Compiled from Quality Reports, available at <https://www.qualitycheck.org/>.

Abderholden wrote, “[it] is curious as to how nearly every other hospital providing inpatient psychiatric care loses money, but Acadia finds it profitable.” If practices like these are the answer, then Acadia has no place in Minnesota.

Additional Information

A current healthcare worker in the M Health Fairview system has expressed concerns about the proposed Fairview-Acadia facility based on what they have seen firsthand in their facility. Among these concerns is the timeliness of Community Access for Disability Inclusion (CADI) assessments. Patients within the system have been facing wait times of weeks or months for these assessments. Patients can become “stuck” in the system and not be moved through, as there are not currently adequate places for them to be discharged through. This issue is further exacerbated by recruitment and retainment issues for providers withing the M Health system.

Appendix



June 9, 2022

Re: Comments on Fairview/Acadia Psychiatric Hospital

Dear MDH Division of Health Policy Colleagues,

Thank you for soliciting public input on the establishment of a new 144-licensed bed freestanding mental health hospital in Saint Paul, Ramsey County by a partnership between M Health Fairview and Acadia Healthcare. The Office of Ombudsman for Mental Health and Developmental Disabilities submits this letter to express our concerns about this project.

Like many in the mental health community, we realize that there is a critical need to expand the availability of inpatient mental health care in Minnesota. However, this particular proposal is problematic for a handful of reasons. Building a stand-alone hospital for providing inpatient mental health care that does not also include an emergency department greatly limits the functionality and accessibility of the facility. Emergency rooms are a frequent entry point for people experiencing serious mental health symptoms to obtain inpatient care.

People requiring inpatient mental health care also often have coexisting or other conditions also requiring care. A facility that does not provide other medical care and services will be unable to serve people with other care needs. It is unrealistic and inefficient to try to compartmentalize and separate physical from mental health care needs. If Minnesota is going to approve an exception to the existing moratorium, we should do so for a facility that can provide quality inpatient mental health care while also accommodating the medical /physical care needs of a diverse client population.

Finally, as others have noted, without an IMD Exclusion waiver, Medicaid cannot pay for mental health care in a stand-alone psychiatric facility with more than 16 beds. If Medicaid is not a viable funding source for the services provided in this facility, then many of the people who most need the care that this facility could provide will be unable to get it.

We appreciate the focus on the serious gaps in our mental health services system. However, we urge a cautious and comprehensive approach. Building a facility that is overly restricted in the care needs it can address would be a missed opportunity. We hope that this process will

take as broadly inclusive a view of client populations and needs as possible to do the most good.

Sincerely,

Barnett (Bud) Rosenfield
Ombudsman

Minnesota Office of Ombudsman for Mental Health and Developmental Disabilities
121 7th Place E, Ste 420 Metro Square Building
Saint Paul, Minnesota 55101-2117

O: 651-757-1806

C: 651-529-0014

F: 651-797-1957



Minnesota Psychiatric Society

Improving Minnesota's mental health care through education, advocacy, and sound psychiatric practice, and achieving health equity.

August 22, 2022

Stefan Gildemeister
State Health Economist & Director, MDH Health Economics Program
P.O. Box 64975
St. Paul, MN 55164-0975

Regarding: Proposed M Health/Acadia Hospital

Dear Mr. Gildemeister:

This is to inform you that Minnesota Psychiatric Society (MPS) opposes building this hospital. There are significant mental health and substance abuse treatment needs in Minnesota, for a range of treatment services, including adult inpatient beds. However, we do not think the proposed hospital will best meet those needs. Further, we are concerned the proposed hospital will disadvantage existing hospitals and services. In short, it is our opinion that the proposed hospital is not the best use of our scarce community resources.

Access to hospital beds in Minnesota is a problem, especially for some segments of the mentally ill population. We also have a shortage of places to send patients when they might be able to leave acute hospital care, a problem which contributes to the unavailability of hospital beds when they are needed by other patients. MPS is very concerned that some of the patients most in need of an acute bed are those who are most ill, a large segment of whom have public insurance. The proposed hospital will be restricted in its ability to bill Medical Assistance under federal law because the proposed hospital will meet federal criteria for "institute for mental disease."

Another concern is that the proposed hospital will not have an emergency room. The consequence of that design is that the hospital will depend upon referrals from other ED's. As practicing psychiatrists, we have seen in our community how that lack of ability to provide emergency assessment allows the hospital to cherry pick which patients they will accept, since they do not have the immediate responsibility for the patient. That leads to denying acceptance to some patients who have insurance that does not pay well and denying to accept some patients with more challenging and often more expensive care needs. That would include patients with more severe and complex other medical illness, and behaviors that will require a higher level of staffing for safety. In the end, it is the other hospitals that must pick up a disproportionate amount of the more expensive and less well reimbursed care. This occurs in an environment where the new hospital at the same time hires away nursing and psychiatric staff from the existing hospitals. Ultimately all that can compromise those other hospitals' abilities to maintain their own psychiatric hospital beds. We are very concerned that for profit Acadia will have 85% financial stake in the proposed facility.

Thank you for your attention to this.

Sincerely,

Handwritten signature of Matt Kruse in black ink.

Matt Kruse, MD, FAPA
MPS President

Handwritten signature of Michael Trangle in black ink.

Michael Trangle, MD, DLFAPA
MPS Legislative Committee Chair



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Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Mr. Gildemeister:

Thank you for the opportunity to provide comments in your review of plans submitted by Fairview Health Services and Acadia Healthcare to establish a 144-bed adult and geriatric mental health hospital in St. Paul. We strongly believe a new mental health hospital is in the public interest, as it would contribute to a long-term solution to Minnesota's persistent shortage of inpatient mental health care beds.

Our community is in the midst of a mental health crisis, pushing an already strained mental health system to the brink. M Health Fairview University of Minnesota Medical Center operates more inpatient mental health beds than any tertiary or quaternary care hospital in the state. The M Health Fairview Mental Health and Addiction teams are in constant communication with hospitals and providers inside the Fairview system and across our state to help people with the most acute psychiatric conditions, often in crisis, access the care they need.

Sadly however, patients who arrive at the UMMC emergency department, or at an emergency department elsewhere in our system, consistently must wait for care while staff search for a bed, boarding in our emergency department for hours or even days. For someone experiencing an acute illness, any delay care can be damaging. This is equally true for someone experiencing an acute psychiatric emergency, where time spent awaiting care, in the high-stress environment of an emergency department, can also be traumatic. All too frequently, after this time spent waiting, the only option for patients are hospitals located hours away from their family and support network.

Building a new 144-bed inpatient mental health hospital would reduce strain on hospitals like ours, who manage scarce capacity for inpatient mental health care. Simply put: more inpatient mental health and addiction beds in St. Paul would mean patients get care sooner and can move faster toward further treatment and recover.

In operating one of the state's largest hospitals, we also believe the opening of the new mental health hospital will have a net positive impact to our overall operations. The positive impact on patient flow at UMMC alone will create a positive downstream impact on our staff and patients' experience, as well as the hospital's long-term financial health.

Certainly, our hospital, like all of healthcare, is navigating a historically difficult period as it relates to our workforce and staffing. The new mental health hospital would not create any new challenges to what is





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universally known to be a very challenging environment. In fact, we believe welcoming a well-established leader like Acadia Healthcare – that can deploy national recruitment strategies and robust talent development efforts – could enrich the overall market for mental health professionals in our state.

Finally, we are optimistic about the model of care planned for the new mental health hospital. Building a new, specialized mental health hospital would mean a step toward treating the needs of patients experiencing mental illness with the same urgency and intention as those patients experience acute physical health issues. The new hospital's integration with the Fairview system means patients will benefit from the full capabilities of M Health Fairview, in an environment designed for their needs, no matter their income, insurance status, or where they seek care.

Thank you again for the opportunity to provide comments for consideration by the department.

Sincerely,

A handwritten signature in black ink that reads 'Mary Johnson'.

Mary Johnson
Chief Operating Officer
M Health Fairview University of Minnesota Medical Center





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University of Minnesota Physicians and Fairview Health Services

SURVEY RESPONSES

Enter hospital name, location, and primary contact email

M Health Fairview University of Minnesota Medical Center
2450 Riverside Ave, Minneapolis, MN 55454
Mary Johnson, Mary.Johnson1@fairview.org

We are collecting an inventory of ADULT inpatient mental health beds. How many PHYSICAL inpatient mental health beds (dedicated primarily for psychiatric disorders) does the hospital have?

150

*On **June 1, 2022**, how many STAFFED inpatient mental health beds (dedicated primarily for psychiatric disorders) did the hospital have?*

100 beds

Within the past six months, what is the number of increased or decreased STAFFED inpatient mental health beds (dedicated primarily for psychiatric disorders) at the hospital? (Please use negative "-" sign for decrease and enter "0" for no change).

+20 beds

Does this hospital have special units for STAFFED inpatient mental health beds?

Yes

How many STAFFED inpatient mental health beds are in specialized units? (Please provide number and type of specialty (i.e., Co-occurring chronic health condition med/psych bed, Co-occurring substance use disorder, Crisis Stabilization, Extended Stay, Geriatric, Forensic or Law Enforcement, and any other type).

20 Adult Detox; 16 Young Adult; 16 Senior; 14 ITC

*Next, we would like to discuss how many ADULT inpatient mental health beds were occupied **on June 1, 2022**. To the best of your ability, please estimate how many ADULT inpatient mental health beds were occupied at midnight census?*

100 census

*How many patients **on June 1, 2022** in ADULT inpatient mental health beds were medically unstable (i.e., require oxygen, intravenous therapies, transfusions, or other chronic health condition)?*

0 patients

How many patients right now are unable to be discharged from ADULT inpatient mental health beds for non-clinical reasons e.g., administrative or insurance difficulties; lack of appropriate step-down transfer





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destination such as community-based services, residential treatment, or nursing home; lack of availability for state operated services mental health bed; or, other reason?

On average, 25% of adult patients remain hospitalized for placement issues only

Finally, we would like to ask about patients waiting in your hospital emergency department. What is the average wait time in the emergency department for an adult inpatient mental health bed, in days (please estimate)?

Across the Fairview system, average wait time for adults in the emergency department prior to admission to an inpatient bed is approximately .75 days. However, at times patients may wait as long as 7.8 days.

How many people are on the waitlist right now in the emergency department for an ADULT inpatient mental health bed (please estimate)?

24 patients





June 9, 2022

To: Minnesota Department of Health

NAMI Minnesota believes that there are not enough inpatient psychiatric beds in Minnesota to meet the needs of children or adults struggling with their mental health. People wait days, sometime weeks, and are either sent home without being connected to appropriate care or sent hundreds of miles away from home making it difficult to stay connected to their community of supports.

The downsizing and soon closure of the 110 beds at St Joseph's hospital and the closure of the 18 inpatient beds at Southdale have had a devastating impact on the mental health system in Minnesota. At St. Joe's alone, there were over 1,800 inpatient psych admissions every year. The beds at these two hospitals represent about 16% of the inpatient psychiatric beds in the metro area.

There is broad agreement that early intervention and community services are important; however, inpatient hospital services will always be needed. In previous communications NAMI Minnesota has stated clearly that inpatient capacity should not be reduced until the early intervention and community services are in place. But those beds were closed anyway by Fairview.

Over and over again we have heard from hospitals that the low payment rates for inpatient psychiatric care, especially under Medicaid, are the reason that more hospitals do not add beds and why hospitals close beds. Hospitals across the country note that providing inpatient psychiatric care causes them to lose money – millions of dollars.

While inpatient psychiatric hospital beds are needed, NAMI Minnesota has concerns with M Health Fairview's proposal to build a free-standing psychiatric hospital. Our concerns are as follows:

1. Your head is connected to the rest of your body. President Eisenhower, in his seminal mental health report, believed that every community hospital should have a psychiatric unit to ensure that people had access to comprehensive care close to home. Conversely, we believe that psych only hospitals that provide acute - and not long-term care - are not providing comprehensive care close to home.

When you are having an acute psychiatric episode or a mental health crisis of some kind, you deserve to be cared for in a regular hospital with access to any other health care you might need. People end up needing psychiatric care after a suicide attempt, self-harm, intoxication, or an overdose. People with serious mental illnesses are more likely to have other health care conditions such as diabetes, COPD, heart disease, liver, or kidney issues. People experiencing homelessness who also have a mental illness may end up



1919 University Ave. W., Suite 400, St. Paul, MN 55104
651-645-2948 | 1-888-NAMI-HELPS | www.namimn.org



needing hospitalization for their mental illness but also health care conditions associated with being unhoused such as frostbite or fungal infections.

It is hard to treat the whole person when you are only focusing care for their mental health. A study by Hendrie et al found that older adults with mental illnesses had “higher rates of emergency care, longer hospitalizations, and increased frequency of falls, substance abuse, and alcoholism.” They went on to recommend that this population be provided an integrated model of care.

We also believe it is less than ideal for someone who finally gets a psychiatric bed to be transferred to another facility when they need other types of health care. It is unsettling to be tied down to a gurney and be transported.

This passage is from an article in the San Diego Business Journal: “Despite a hit to one area of the bottom line, hospitals have more incentive to invest in psychiatric care, said Lindsay Scollin. Payment models increasingly emphasize patient outcomes. ‘Organizations are starting to think about care of the patient more holistically’ said Scollin, a senior manager with consulting firm Deloitte. ‘They see mental health as an area they really need to invest in or they’re going to have longer-term implications.’ They aren’t only pouring money into facilities. Scollin said hospitals have turned to telepsychiatry and other technology, despite reimbursement being slow to catch up. Dr. Michael Plopper agreed that **it makes business sense to treat the whole patient**, and he said it’s the right thing to do. He’s the chief medical officer of Sharp HealthCare, which among San Diego hospitals carries the greatest load in behavioral health with 200 inpatient beds.”

2. This hospital will not have an emergency room. That means that they decide which patients will be admitted. Will there be an incentive to not admit people with the most serious mental illnesses or people who have other health care conditions? Will then not admit people who have more complex needs?
3. Medicaid limits payments to what is called an IMD – Institute for Mental Disease. IMD hospitals cannot bill Medicaid if people are on fee-for-service Medicaid. They can bill for limited days for people on managed care Medicaid but if they exceed the limit on the number of days, the state pays 100% of the capitation rate. When all the other hospitals in Minnesota and across the country are reluctant to add beds due to the low reimbursement rates, particularly under Medicaid, we are worried that the only way this hospital is profitable is if they limit the number of admissions of people who are on Medicaid. People with more serious mental illnesses tend to be insured by Medicaid and have longer stays than is allowed under the IMD exclusion for managed care.
4. In a letter to many of the advocates in January of 2020, M Health Fairview, in defense of it closing St Joe’s, wrote that “the hospital is operating at a significant loss of roughly

\$45 million a year due to reimbursement changes and because of its age it now requires more than \$35 million in infrastructure upgrades.” Which is interesting since the capitol costs for this new proposal is between \$57-65M. We are struggling to understand the financing of this new hospital.

5. We are also concerned that if M Health Fairview admits far fewer Medicaid patients, it could upend the payor mix at other hospitals in the metro area. If other hospitals serve a higher percentage of Medicaid patients, they may face greater losses.

Typically, hospitals providing psychiatric services rely on providing other services to cross subsidize mental health care. In a research paper by Sachs, studying psych bed closures in CA she found that “Neighboring hospitals experience negative financial spillovers as a result of closures. Care at nearby hospitals shifts towards the most severe and least profitable patients, individuals with schizophrenia and Medicaid beneficiaries. As a result, loss margins double at nearby psychiatric units.”

A story in the [San Diego business journal](#) noted the following: “Earthquake regulations with a 2030 deadline led Scripps Health to reimagine its Hillcrest campus. They also forced a reckoning in behavioral health. Scripps is planning a 15-story tower to replace Scripps Mercy Hospital, including a locked psychiatric ward with 36 beds. It was estimated a replacement behavioral health facility attached to Scripps Mercy would cost \$3 million to \$4 million per bed, according to Scripps, a costly proposition. And operations lose money. Scripps lost \$4.7 million on psychiatric services in 2017, similar to the two prior years. Making behavioral health pencil out has become a greater challenge for San Diego hospitals like Scripps, Sharp HealthCare, Palomar Health, and UC San Diego Health. Partly for fiscal reasons, Tri-City Medical Center last year suspended inpatient beds...Rather than the \$3 million to \$4 million per bed plan, Scripps Health decided partnering would be the best route. Under a deal announced in February, the health system, and Acadia Healthcare plan to develop a 120-bed psychiatric inpatient unit by 2023...Scripps would have a 20-percent ownership stake in the new hospital, which would be in Chula Vista due to land constraints in Hillcrest. Van Gorder said not only would the deal free up funds for other construction projects, but also aims to eliminate Scripps’ annual losses in behavioral health. Acadia would have the scale, expertise and patient mix to make the venture profitable, he added. He noted that Acadia will honor Scripps’ charity care policy, namely taking low-income patients with Medi-Cal. Tennessee-based Acadia, a for-profit provider, is a powerhouse with 586 behavioral health facilities. In 2016, the company embarked on a strategy of partnering on facilities with not-for-profit hospitals like Scripps, attracting them with the promise of allaying patient backups in emergency rooms. But Acadia has come under scrutiny in several communities, including lawsuits in Oklahoma over patient injuries, highlighted by The Oklahoman newspaper. ‘ As it happened, the city council rejected the proposal due to concerns about the distance from a hospital and thus limited access to EMS, neighbors’ concerns, and concerns with Acadia. Read the article [here](#).

NAMI Minnesota is curious as to how nearly every other hospital providing inpatient psychiatric care loses money, but Acadia finds it profitable. They are also a for profit company which would be unusual for this state. We are concerned that a national company will have control over patient care, and that it will be difficult to obtain responses to concerns and problems. In looking at their current board of directors they have people from a private equity company, Financial Advisory North America, Maxum Petroleum, Deloitte, Guidon Partners, Arcadia Strategies, LLC, Jo-Ann Stores, and one psychiatrist. There is nothing on their website as to where to share any concerns or complaints. In other hospitals in Minnesota there are patient advocates whose job it is to listen to complaints and concerns. Many hospitals also provide a comment form, such as on Regions Hospital's website, where people can email comments and concerns.

NAMI Minnesota has struggled with the need for more inpatient psychiatric beds and this proposal. If M Health Fairview were proposing additional beds on the campus of any of their hospitals - St John's, Woodwinds, West Bank, Southdale – we would be wholeheartedly supporting it. But we have valid and serious concerns about their proposal for a free-standing psychiatric hospital that does not have an emergency room.

Sincerely,

A handwritten signature in black ink, appearing to read 'Sue Abderholden', with a stylized flourish at the end.

Sue Abderholden, MPH
Executive Director

Stefan Gildemeister
Director, Health Economics Program
State Health Economist
Minnesota Department of Health
Delivered electronically to: health.pir@state.mn.us

June 23, 2022

Re: Fairview Health Services/Acadia Healthcare Mental Health Hospital Proposal

Dear Mr. Gildemeister,

Thank you for the opportunity to provide comments through the public interest review process on the proposal submitted by Fairview Health Services and Acadia Healthcare to establish a 144-bed adult mental health hospital in St. Paul.

As you know, access to mental health services remains a critical need, including capacity across the continuum of care, at state facilities, inpatient and outpatient services and an adequate workforce of trained mental health professionals to meet the demand of the state and our communities. While we continue to serve our patients within the existing mental health infrastructure, we have ongoing challenges finding appropriate beds to safely discharge patients out of our hospitals, both when a patient needs a higher level of care or an outpatient treatment facility or program. Additionally, we continue to see mental health patients boarded in our emergency departments awaiting inpatient beds.

While we support the addition of inpatient mental health and substance abuse disorder treatment bed capacity, we have concerns with patient and provider access to the beds and the potential impact on an already strained mental health workforce. It is critical to maintain care delivery regardless of a patient's ability to pay, including in this new facility. Without an emergency department, this facility is not subject to the same regulations as an acute care hospital and while we appreciate the legislature's thoughtful addition to the language around the hospital accepting patients by ambulance, transfers, and walk-up patients, we hope the department will remain diligent in ensuring compliance to these criteria is maintained.

Similarly, we experience as the other health systems in the State do significant challenges in recruiting and retaining providers for the existing services, including inpatient psychiatric beds and the necessary ancillary services. Without a plan and commitment to increase the overall workforce availability along with the new inpatient beds, the resource and talent challenges we all face today will only be worse.

As we welcome the needed services in our state, we expect this project with a majority ownership stake held by a publicly traded company to uphold our current providers' commitment to delivering care to all Minnesotans. In addition, we expect a commitment to investing back into the community, including but not limited to investments in community benefits, charity care

and financial assistance programs. We hope Fairview and Acadia will be thoughtful in minimizing the transition time to the new facility and closing St. Joe's inpatient mental health beds that could result in additional strain during the transition and even more patients boarded in emergency departments across metro hospitals.

Again, thank you for the opportunity to comment on this project. We welcome additional capacity to these services and look forward to continuing to partner with the state and other providers to ensure we minimize the impact of the transition to the new hospital and ensure access to care for all Minnesotans.

Please feel free to reach out with any additional questions.

Sincerely,



Andrew S. Cochrane
Chief Hospital Officer, North Memorial Health

North Memorial Health (NMH) is a health system with 2 hospitals, North Memorial Health Hospital and Maple Grove Hospital, and over 25 associated clinics including primary, specialty, and urgent care and an expansive statewide medical transportation division. We employ over 6,000 team members, serving over 55,000 customers per month.

Minnesota Department of Health

From: Brandon Griffin <bgriffin@thesannehfoundation.org>
Sent: Thursday, June 9, 2022 6:10 PM
To: MN_Health_PIR@state.mn.us
Subject: Sanneh Foundation Public Comment

This message may be from an external email source.

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See official comment below:

"My name is Brandon Griffin, Senior Vice President for The Sanneh Foundation, an organization which addresses the Social Determinants of Health to remove barriers to health & wellness including mental health support for families and individuals in the Twin Cities community. More specifically, In our work in fighting hunger insecurity, a large population of our food shelf and distribution participants are experiencing significant challenges related to mental health and homelessness.

In our work with Fairview at The Hub in Saint Paul, our organization's Nutritional Services team has partnered with the hospital and other innovative organizations to address systemic poverty in our community. Our organization currently utilizes a portion of the former emergency clinic and ambulance bay to receive, sort, and distribute food to thousands of families in the Twin Cities Metro every week. Without this space, this work would not be possible and we commend Fairview on their commitment to collaboration and creating authentic community partnerships. We are proud to be a partner in this work.

We know we are in the midst of a mental health crisis and need more access to more services across the continuum of care. Among other innovations across the continuum of care, our state needs more access to inpatient mental health care. We understand the need for more inpatient mental health beds means people get access to inpatient care faster, where they are stabilized and connected with the next best step in their care. As an organization that partners with direct service providers throughout the Twin Cities to address barriers to self-sufficiency, Fairview is a trusted leader and valued partner in meeting the mental health and addiction care needs in our community.

Together with Acadia Healthcare, a national leader in mental health and addiction care, a new mental health hospital will positively impact the availability and quality of inpatient mental health and addiction services in Minnesota. With a standalone, dedicated hospital, Fairview and Acadia will be able to serve all patients in a highly specialized environment and state-of-the-art facility. Thank you."

--



SANNEH



Brandon Griffin
Senior VP of Operations
(he/him/his)

Cell: 501.672.3280
Office: 651.690.4855 ext. 3
Email: bgriffin@thesannehfoundation.org

www.thesannehfoundation.org
2090 Conway Street, St. Paul, MN 55119

August 15th, 2022



Office of Commissioner Jan Malcolm
Minnesota Department of Health (MDH)
625 North Robert Street
St. Paul, MN 55155

Jamie Gulley
President

Dear Commissioner Malcolm:

SEIU Healthcare Minnesota & Iowa represents almost 50,000 healthcare workers, including over 10,000 Minnesota hospital workers. We appreciate the opportunity to provide input for your review of the proposed mHealth/Acadia hospital project.

To begin, we fully share and want to echo the concerns and questions raised by the Minnesota Nurses Association in their letter of June 27, 2022. Like them, we are troubled by a for-profit company in general and, more specifically, by Acadia's record. It is obvious and universally acknowledged that Minnesota needs more mental health bed capacity. Yet we lack these beds because our healthcare financing system undervalues mental health and other basic healthcare services that don't produce large returns. If we allow a for-profit company to carve out a profitable section of the market, we just reinforce a failed model. At a minimum, MDH should require a strict and enforceable guarantee that mHealth will not reduce its remaining mental health bed capacity at other facilities, such as the mHealth Riverside campus.

In addition, we would like to share some of our own concerns with mHealth that lead us to doubt their ability to ensure that this project serves the public interest. While mHealth may say they have not laid-off employees at Bethesda or St. Joseph's, they have taken steps to eliminate jobs. For example:

- Around October 2020, they gave a reduction notice for approximately 4.5 FTEs to the pharmacy unit at St. Joseph's.
- Around the same time, they gave notice that all 5 LPN positions at St. Joseph's would be eliminated.
- Around April 2021, they gave another reduction notice for 3 FTEs to the pharmacy unit at St. Joseph's.
- Finally, when mHealth shut down the Bethesda facility, we know that not all workers were rehired by mHealth. In addition, even those that were rehired lost important scheduling and other seniority benefits.

Judged simply by their actions, mHealth has sought to replace an important community asset staffed by quality caregivers with good jobs, with a for-profit facility staffed by employees without the guarantee of similar quality careers. If your analysis substantiates this record of prioritizing their own economic benefits over the health of our community, we encourage the Department to find that the proposal is not in the public interest.

Sincerely yours,

A handwritten signature in black ink, appearing to read "J. Gulley", written in a cursive style.

Jamie Gulley

Jigme Ugen
Executive Vice President

Phillip Cryan
Executive Vice President

Brenda Hilbrich
Executive Vice President

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Story of Fairview Behavioral Intake and EMTALA

In 2015, the year before I started at Fairview Range Behavioral Health as a Psychiatric Registered Nurse, I learned that the Charge RN's on this unit were responsible for updating the State Mental Health Bed Tracker. This tool was developed by the State of Minnesota, The MN Hospital Association, and NAMI MN to help Emergency Departments see bed availability and place patients across the state. Charge RN's were trained to follow EMTALA Laws, evaluate the unit milieu, contact the on-call Psychiatrist or Psychiatric Nurse Practitioner, and evaluate the individual patient for placement based on these variables. This important screening is within a Registered Nurse's scope of practice, however, it takes time. Charge RN's have a patient assignment in addition to this screening and other Charge duties. To do a good job in all these areas, they asked for a decreased patient load. Always mindful of profit margins, Fairview Range Leadership denied this request and in response, the director of Fairview Behavioral Health, Paula Pennington, and Dr. Simon from Fairview Riverside decided to create Behavioral Intake to delegate this responsibility onto (cheaper) non-licensed staff. Behavioral Intake Staff, who never actually worked with patients or in these units, were supposed to be trained to take on this screening role, to update the State of MN Mental Health Bed tracker, and supposed to be trained to follow the law. What has happened with Fairview Behavioral Intake is very different from this plan. RN staff in Fairview Behavioral Health systemwide were advised by policy to not share our open bed status with other hospitals directly. Instead, we are to direct all ER inquiries to Fairview

Behavioral Intake (This was to prevent possible EMTALA violations).

In 2016, I had just started at Fairview Range after working 10 years at St. Luke's Behavioral Health Unit in Duluth, MN. As a Clinical Educator there, I had helped develop the patient screening tool still used by Charge RN's at St. Luke's. I brought this background with me as I started at Fairview Range Behavioral Health. There is a nationwide crisis due to the lack of Behavioral Health beds available. Fairview Range had just added a 15 additional mental health beds to their 19 bed unit. During this time, I was stunned when nurses were being mandated to stay home and the North Unit was closed due to the lack of patients. This is not even remotely possible due to lack of need, so I started checking the State Mental Health Bed Tracker every day I was working. I found that we were listed as having ZERO bed availability when we actually had the capacity to take up to 15 or 18 patients! After speaking to Management and learning that other Iron Range Hospitals had also complained to Fairview Leadership, in response Management directed Charge RNs to update the State Mental Health Bed Tracker to reflect accurate bed availability and we immediately started getting patients from the entire state of MN. ^{{}L}_{{}SEP} About two years ago, Charge RNs were told we could no longer update the State Mental Health Bed Tracker and this would be again be the responsibility of Behavioral Intake. We started getting fewer and fewer patients from Duluth and other ER's in Northern MN. I brought up my concerns with Fairview Range Management at monthly Labor/Management meetings. Ironically, I was told that Fairview Range wanted to get rid of Behavioral Intake but that it was not possible due to some contract obligations. We started getting more and more patients from the Twin

Cities Fairview system, we learned that Iron Range patients were being sent to far off destinations in North Dakota or even as far away as Eau Claire, Wisconsin. We started hearing distressing stories from our patients; when needing Mental Health services, they had resorted to getting rides from family or friends, even driving themselves, taking Ubers or taxis get to the Fairview Range ER, so they would not be sent to some far away mental health unit when they are in crisis. I also started hearing from nurses at other hospital ER's that they were always told by Behavioral Intake that Fairview Range had no beds. As a result, many MNA nurses from ER's in Duluth and Northern MN told me that their hospitals pretty much gave up trying to send patients to Fairview Range Behavioral Health.

Due to these reports, the Social Work Supervisor at Fairview Range Behavioral Health, Deb Overby, started making calls to Iron Range hospital ER's asking them to contact her, the Unit Supervisor Derek DeSold, or the Nursing Shift Supervisor to bypass and work around Fairview Behavioral Intake.

This helped for a while, but then St. Joseph's and Fairview Southdale closed their behavioral health units. Behavioral Intake ignored the pleas from our supervisors to admit local patients and did not send the local referrals through to our providers. I overheard one of these calls regarding a patient in the Cook, MN ER. Shift Supervisor Kate told Behavioral Intake to send the Cook ER referral to the Behavioral Health on-call provider. Two hours later, I asked the on-call provider, Nicole Gandberg, if she received a call from Behavioral Intake about the patient in the Cook ER. She told me, "No." I asked our new Medical Director, Dr. Rebman, "Why aren't getting a patient from the Cook ER

that is 30 miles away?" He told me that Fairview ER's in the Twin Cities Metro had 36 Mental Health patients boarding in their ER's and these patients were taking priority. I explained forcefully that this is illegal and that I was going to call the Cook ER and inform them to file an EMTALA complaint. Dr Rebman made a call to leadership at Fairview Riverside and Behavior Intake telling them to accept the patient from the Cook ER. Dr Rebman told me that we were going start doing our own screening as soon as it could be set up. That was four months ago. In these four months, we have had up to two thirds of our patients being from Fairview ER's in the Twin Cities Metro. I often see the Mental Health Bed Tracker set at zero when we have 4-6 beds open. Our shift supervisors routinely hold beds for the Fairview Range ER, which is illegal. Monday, July 25th, I had a nurse from Fairview Grand Itasca ER in Grand Rapids (which is 23 miles away) call me to see if we had beds at noon. I told her that we had 4 beds over the weekend and admitted two patients from the Twin Cities area. We had discharged two patients Monday morning. She told me they had three mental health patients boarding in their ER all weekend. One of the patients was boarded in the ER for 4 days, was very psychotic, and was extremely difficult to manage. I immediately called the on-call provider who spoke to Grand Itasca staff and admitted the three patients bypassing Behavioral Intake. Sunday, July 31st we received a call from the Red Lake Reservation ER with a patient to be admitted. They had called Behavior Intake many times and were told that Fairview Range had zero beds. We had three discharges the day before and could take up to four patients that Sunday. The shift Supervisor Peggy told me that they are not taking any admits other than the Fairview Range ER until after 1500. She said

Behavioral Intake would call them to refer this patient to the on-call provider. This never happened. Instead, a patient from a Twin Cities Fairview ER was admitted and one from Grand Itasca. We still had two beds, plenty of staff, and the capacity to take the patient from Red Lake.

Mental Health patient's who are sent far away from home are harmed by:

- 1) Being far away from their support systems and most likely not going to get visitors.
- 2) Transportation, often difficult and expensive, must be arranged to get the patients back to their home after hospitalization.
- 3) Social workers are not familiar with the available resources in these far away communities making referrals to outpatient care more difficult.
- 4) If the patient needs civil commitment, it is more difficult for social workers and providers to navigate processes from the counties that all have different processes for civil commitment.
- 5) When mental health patients are admitted to a familiar hospital they experience less fear and crisis during their transition to inpatient care. I personally know most of the chronically mentally ill people from northern Minnesota after 18 years working in the acute behavioral hospitals. Familiar faces and settings deescalate patients, leading to better outcomes.

In conclusion, Mental/Behavioral Health patients are vulnerable and deserve to be cared for as close to their home communities as possible. Emergency Departments throughout MN are overwhelmed by having to care for mental health patients whom they

are not equipped to handle for long periods of time and may have to board for days. Rural emergency rooms are even less equipped to handle mental health crisis and the mental health beds available in rural MN are far less than those in the Twin Cities metro. If there is no current need within the CMS defined service area, then accepting patients from across the state is fine. Fairview Leadership has maintained a strong hand in orchestrating bed availability and patient placement. Fairview Leadership actively made the shortage of mental health beds even worse by closing St. Joseph's Hospital and Fairview Southdale Behavioral Health Units in order to demonstrate scarcity and obtain state funding to open a new, stand alone, FOR PROFIT Mental Health Hospital. Run by the notorious Acadia Behavioral Health, this new hospital is designed to be EMTALA-proof as it will have no Emergency Department. For 18 years, I have given my heart, soul and voice to people living with mental health challenges. To witness corporate healthcare use these people as pawns with no regard for their well-being, but to maximize corporate profit wounds me to my core. These are my people and I implore Law Enforcement and both State and Federal Regulators to intervene on their behalf, to put a stop to the exploitation, neglect, and abuse of vulnerable mentally ill people.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 7:30:56 PM

Name:

Allison Holt

Where do you live:

Minneapolis, MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I'm a psychiatrist and I think we need more mental health beds and I'm in support of the proposed mental health hospital.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/16/2022 4:46:21 PM

Name:

Audrey Neylon

Where do you live:

Anoka

Do you represent an organization?

Yes

What organization do you represent?

M Health Fairview

What is your comment on the proposed mental health hospital?

It will be great additional to our community.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 8:02:49 PM

Name:

Carrie

Where do you live:

Hennepin county MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

Adding inpatient beds that we cannot staff adequately is not going to solve the mental health crisis we are facing in our community. We already have open beds that we are unable to staff adequately. Many people are "stuck" on the units now that are waiting for transitional care in a nursing home, group home or residential care. They are at capacity, many of them understaffed and also leaving beds open due to a lack of available staff. The turnover is extremely high because they are not paid livable wages to care for our sickest residents. What is desperately needed is an investment in the level of outpatient services and supports so we can give people the needed skills to maintain health in their community- where they live. Inpatient is just a place where treatment can be provided, Treatment can and should be able to be accessed in the community, but many people can not get appointments, or into a crisis residence and are so decompensated by the time they show up to the ED that they need a higher level of care. With other illnesses we focus on preventative measures and care but yet the answer for mental health is more beds to admit to? Add 144 more residential care beds, or group home beds that can be staffed. That is more of a need in the community than a freestanding inpatient MH unit where patients will be "cherry-picked" for admission while the rest of the hospitals will be left to treat the sickest and poorest an unsustainable proposition which will have a profound negative impact on their ability to provide care.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/2/2022 12:34:22 PM

Name:

Carrie Davis

Where do you live:

Marshall, MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I would consider a larger expansion (to 200), and at either level, a set # of beds for juveniles. There is a huge shortage of these beds, and our struggling kids need a place to go without looking out of state. As a Foster parent, I have spent 4-5 hours, and have had 3-4 foster children that waited over 24 hours for a bed for children's mental health. This is a key component to consider in ANY mental health hospitalization expansion. Please consider 20-30 dedicated beds for juveniles. They need us to step up.

~Foster Parent, Mental Health Practitioner and concerned citizen.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/27/2022 10:20:46 AM

Name:

Lorna Schmidt

Where do you live:

St. Paul, MN

Do you represent an organization?

Yes

What organization do you represent?

Catholic Charities of St. Paul & Minneapolis

What is your comment on the proposed mental health hospital?

Catholic Charities of St. Paul & Minneapolis is a leading provider of social service programs throughout the Twin Cities, serving more than 23,000 men, women, children and families annually, with a focus on housing justice. Many of the guests and residents of our emergency shelter services and supportive housing programs are greatly impacted by the lack of access to mental health treatment in the St. Paul region. Many of these individuals are either uninsured or covered by Medicaid, and many also have complex physical health conditions, are of the geriatric psych population, or have dual diagnoses. These individuals require – and are worthy of – comprehensive and dignified mental health supports such as those that could be offered at the proposed hospital by Fairview and Acadia Healthcare.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/3/2022 10:27:40 AM

Name:

Chelsea Schafter

Where do you live:

Minnetonka, MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

The potential opening of the Acadia hospital in St. Paul would have negative effects on the patient population seeking treatment for mental health care in our state. While we know that mental health beds are needed tremendously in the State of Minnesota, utilizing a for-profit, private company which has a negative history in the treatment of its patients is not the way to go about fixing this issue. There have been numerous safety concerns brought forward as well in regards to the operations of Acadia facilities. Is that the kind of care we want to allow in the State of Minnesota? M Health Fairview has hundreds of banked beds within its system. Why are these beds not being utilized? They are putting PROFITS over patients by trying to push out having to provide inpatient mental health care to the people of Minnesota. They have said themselves, "mental health care is not reimbursed adequately." M Health Fairview operates under the guise of being a non-profit hospital but with the move they are attempting to make with opening Acadia to transition mental health services to, can be seen as an attempt to maximize their own profits. In terms of the effects this will have on the current staff who work in mental health services at other M Health Fairview sites, this can be seen as a union busting tactic with RNs and newly unionized psych associates who provide care to the mental health patients currently in their system as Acadia is not going to be a union facility. Also, according to their staffing plan, they will not be employing psych associates, but rather mental health technicians. This facility will also not have an emergency room attached to it. That is not going to change another real issue we are facing in our emergency rooms currently – the boarding of mental health patients. With Acadia, I do not doubt there will be extreme reviewing of potential patients to ensure they can obtain maximum profitability from

their acceptance with the least amount of liability – meaning very low acuity patients that they can get the most dollars from. A similar hospital was proposed in Woodbury in 2008 – with the same exact number of beds, 144. This hospital was not found to be in the public's best interest. What is the difference now? Mental health patients are not always just suffering from a mental health crisis – many also having preexisting medical conditions that need to be addressed as well. A lot of mental health patients come from indigent backgrounds and have not been compliant with medical treatments as well due to lack of accessibility. They need concurrent access to complete medical and mental health treatment without any delays. I currently work in a geriatric inpatient mental health unit, and we are continuously working with and needing our medical team to help care for our patients. Many times, these patients require transfers to higher levels of medical care while on our unit. Delays in treatment can occur when a “free-standing” mental health facility does not have all the appropriate resources to deal with a patient in a medical crisis and require transfer to a medical facility – which in turn, can lead to increased costs.

M Health Fairview needs to operate as they say they do – as a NON-PROFIT hospital – and stop trying to outsource services in the name of maximizing their profits. Keep mental health services in the hospitals – as they should be and currently are.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/4/2022 8:08:43 PM

Name:

Cynthia K McInroy

Where do you live:

Bloomington

Do you represent an organization?

No

What organization do you represent?

n/a

What is your comment on the proposed mental health hospital?

As a family member of an adult with a chronic mental health history and many hospitalizations in a 10 year span (United St Paul, Regions St Paul, Worthington, and New Ulm) I understand the importance of fast access to and quality care from in patient mental health facilities. There have been times my sibling sat in an emergency room for 2 days waiting for a bed to open. The waits at these times feeling inhumane as no one could stay with them and they had a security guard stationed at their door/curtain. Their stays in Worthington and New Ulm were because those were the nearest facility with an open bed. My sibling would be taken there by ambulance from a metro area ER, which sometimes was paid for by insurance. But a family member had to go and pick them up at discharge. My sibling had private health insurance, so we didn't have the additional burden of waiting for a site that took uninsured or Medical Assistance only patients.

The proposed new facility at St. Joe's will provide 144 much needed beds for emotional health care. That it is a focused facility for only this population and not in a general large medical hospital makes it more welcoming to family members. The effectiveness of facilities with a focused mission and treatment course makes long term stability in mental health much more possible, and less likely for the repetitive cycle of hospitalization when someone is not able to stay long enough because they are no longer in "critical care" need.

I would hope that the State will approve this new facility since Fairview is an established "good faith" provider and approaching with partnership of a provider specialized in mental health. It is a small answer to much needed services.

I would also hope that consideration of additional similar stand alone facilities would be given in the future to a site for pre-teens and adolescents, and young pediatric mental health patients (2 separate facilities) - since it saddens me when these populations are mixed in at large institutional sites with people older than themselves. The atmosphere being too adult for adolescents who are exposed to the chronic chemical abuse and other life experiences from adults there, and too "hospital" and frightening for young children. That all facilities could be constructed with well health environs that still provide low risk for self-harm, rather than being adapted hospital rooms and units, should be a goal of a state that leads in health care. The emotional health of our state being as important as the physical one for all our residents.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 7:34:13 PM

Name:

Danielle

Where do you live:

Stillwater

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

What level of consideration is MDH taking to the recommendations/concerns of other hospitals and first responders in St. Paul?

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/8/2022 9:27:06 AM

Name:

Denise Rekedal RN

Where do you live:

Willmar, MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

There is a dire need for expanded mental health treatment/care for inpatient care in MN, as well as the chemical dependency treatment. We are in a rural area and our ER is clogged with mentally ill patients awaiting placement day after day and especially a great number of minors in addition to the adult crisis we see.

If you could solve the nursing/staffing crisis with better pay/staffing at existing facilities first(unless they are unsafe buildings for pt to staff violence) makes more sense.

Please engage MDH and cooperatively incentivize working in mental health such as covering most of tuition costs, etc for those that commit to five years in the field of mental health treatment. This would be a worthwhile endeavor for use of my taxpayer dollars that would greatly benefit all MN communities.

We need updated, safe facilities but we also need to pay the front line staff working with these individuals.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/11/2022 11:49:42 PM

Name:

Diana Williams

Where do you live:

Westbrook MN

Do you represent an organization?

No

What organization do you represent?

I work for Sanford - this is a personal opinion

What is your comment on the proposed mental health hospital?

Additional mental health beds are needed! We keep patients for extended periods of time, waiting for beds to open. I can't comment on the proposed location - we currently send patients long distances (Thief River - Fargo...)

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/2/2022 11:33:58 PM

Name:

Emma F.

Where do you live:

NE Minneapolis

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I am very concerned about the quality of care provided at existing Acadia facilities and the impact of this business' moral turpitude on care for those suffering from mental illness in the Twin Cities as well as the impact on community members who will be working at this facility.

Acadia has a lengthy documented history of fraud and unsafe care conditions.

-For example, health inspectors from the Centers for Medicare and Medicaid Services documented over 50 pages of violations at Acadia's Rolling Hills Hospital in Oklahoma including instances of restraint and seclusion violations where minors were left unmonitored in seclusion rooms.

-During a one-week period in 2017, two suicides occurred at Acadia's Belmont Hospital in Philadelphia. The State cited the facility for lack of staff and lack of facilities that would prevent suicides, among other things. When state inspectors visited in November of 2017, they declared a state of imminent danger.

-At Acadia's Park Royal Hospital in FL, federal inspectors reported that the facility is "... too short-staffed to properly supervise patients"

A member of the direct care team at Acadia's Sierra Tucson (located in Oro Valley, AZ), mentioned the following in a Glassdoor employment review entitled "Short staffed to the point that patients are put in danger,"

Cons: Too few staff members to treat patients appropriately. As a result, Sierra Tucson has been charged with several wrongful deaths. Working here will land you with people's deaths on your conscience.
Advice to Management: SHUT THIS PLACE DOWN BEFORE ANYONE ELSE IS KILLED.

The deleterious impact the proposed joint venture between Acadia Health and MHealth Fairview would have on our community needs to be stopped. This for-profit venture will shatter the established high quality of care provided to mental health patients in the metro. The unionized workforce of M Health Fairview hospitals offering psychiatric care will be dissolved (therapists, psychiatric associates, and RNs all have independent union representation at MHealth Fairview West Bank Campus hospital). The dismemberment of the workers' unions is an apparent long term goal for Fairview Leadership and opens the door for the new facility to slash wages and benefits. In contrast, the Director of Acadia, Reece Waud, has personally profited from stock-dumping investments in Acadia and is so wealthy he owns a home referred to as "Maine's largest mansion".

Fairview already has mental health beds located in hospitals with Emergency Rooms in the metropolitan area and will likely close their existing psych units to transfer those beds to this Acadia facility to boost profits. Unless this new facility also has an ER, Fairview's inpatient mental health services will no longer be bound by the Emergency Medical Treatment and Labor Act (EMTALA). This is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. Many many people suffering from mental illness are poor and uninsured - they could be turned away from care based on the capacity, or lack thereof, their insurance to compensate for their care. This is a detriment to the community - not a benefit as Acadia and Fairview advertise. Moving psych beds from one facility to another and demolishing workers' unions for the profit of a publicly traded company with a lengthy history of poor patient care is truly heinous and does not belong in Minnesota.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/3/2022 3:25:58 PM

Name:

Julie Bluhm

Where do you live:

St. Paul

Do you represent an organization?

Yes

What organization do you represent?

Guild

What is your comment on the proposed mental health hospital?

This is a very difficult, nuanced comment to be making, but it's the result of deep thinking about this proposal. As a mental health professional and a leader of an agency in St. Paul working with folks who are experiencing mental health challenges and homelessness, I fully acknowledge that we need more beds- people are languishing and not accessing the services they need. However, like every eco-system, the treatment interventions we have are interdependent and it's important to understand how an investment, or significant change, in one service area has an impact on the whole. The impact this plan will have: 1) without an ED, the hospital can choose who to admit from other places. Our health system is a capitalist system and there is little incentive to treat the highest barrier clients- those on Medicaid, experiencing homelessness- which impacts their ability to be discharged timely so the hospital can still get payment- have poorer prognoses, less complex or disruptive or in need of care that makes health care workers jobs easier. Which all works out well for Fairview. But these clients don't go away, they will now be managed elsewhere, creating additional stress, including financial, in other hospitals. 2) We did away with institutions of mental disease- stand alone psych hospitals- for a reason. People don't get the holistic care they need when there are not integrated specialists- neuro, med surge, cardiology- available. It's difficult to rule out comorbidities or other factors that may be impacting, even creating, the symptoms that we are diagnosing based on presentation as mental illness. 3) investing in inpatient beds, at the expense of not investing in other, less intensive interventions, will inevitably lead to more inpatient demand. Our system truly is an eco system and early interventions and support absolutely

(proven over and over) prevent inpatient hospitalization, which is very costly, often traumatic and not helpful post discharge. Without comprehensive, fully funded and supported, community supports, we get what we pay for, people moving in and out of the hospital, never really thriving. This proposal- I fear- is a model for how hospitals can stand-up mental health beds and make money, serving the haves (private, commercial insurance) at the expense of those on Medicaid, the most vulnerable, costly members.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/6/2022 11:12:06 PM

Name:

Jairo Molina RN

Where do you live:

Minneapolis

Do you represent an organization?

Yes

What organization do you represent?

HCMC

What is your comment on the proposed mental health hospital?

I work for HCMC as a case manager. We are constantly struggling to find placement for our patients who need a bed in our in-patient psych unit. With the pandemic worsening people's mental problems (among other factors), we need a dedicated psych hospital now more than ever.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/10/2022 10:33:31 AM

Name:

Jayne

Where do you live:

Farmington

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

Concern with how to safely staff this hospital and using Acadia who has documented, horrible outcomes and staffing and patient ratios.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/13/2022 4:03:02 PM

Name:

Jodi Carlini

Where do you live:

Woodbury

Do you represent an organization?

No

What organization do you represent?

Minnesota resident for more than 29 years

What is your comment on the proposed mental health hospital?

I participated in the MDH virtual public hearing last Thursday evening. After hearing Fairview and Arcadia presentations and the proposed new stand alone hospital for more mental health beds, especially in the Twin Cities Metro East side in St Paul, here are my comments:

My family and I have lived in Minnesota for more than 29 years and specifically in the East Metro.

As a video and documentary producer and former news reporter, I have covered health and medical news in Minnesota since 1993.

So, I am acutely aware of the ongoing and emerging health and medical issues in Minnesota including the need for more inpatient mental health beds.

The need for more inpatient mental health beds is an issue that hit close to home when my family personally experienced the need for an inpatient mental health bed during a family crisis.

Late last year, my 15-year-old nephew, Max, had a mental health crisis. He spent several DAYS in one of the local ERs waiting for an inpatient mental health bed, and waiting for the specialized addiction care services that he desperately needed before he harmed himself or someone else.

Thank goodness an inpatient bed was finally found, and he received the specialized mental health care services he needed to survive his mental health crisis.

I know my nephew is not alone. More inpatient mental health beds means people like my nephew can get access to inpatient mental health care services faster, where the patient can be stabilized.

I believe a stand alone mental health hospital on the Twin Cities East Metro will positively impact the availability and quality of inpatient mental health and addiction services in Minnesota, and build a stronger, more sustainable system for mental health care.

Until 2015, I was employed with HealthEast Care System, which is now part of M Health Fairview. So, I'm well aware that Fairview is a trusted leader and valued partner in meeting the mental health and addiction care needs in our community.

For these reasons and because of my nephew's recent experience, that is why I support the proposed stand alone new state-of-the-art mental health hospital be in St Paul. Thank you!

Jodi Carlini

Jritacca2268@gmail.com

651-249-8625

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 4:06:09 PM

Name:

Kathleen Murphy

Where do you live:

Minnesota

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I am employed at M Health Fairview. I would like to point out this very important issue. Fairview closed two hospitals that served the general public . Including our underserved community. These were both Non-profit facilities. Now they want to help the community by opening a For Profit facility?? How does this help our underserved population that they abandoned when they closed St. Joseph's? Not to mention that this new facility is Non union. The two facilities they closed were union hospitals. This is union busting at its finest. This is NOT what is best for our community.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 11:19:19 AM

Name:

Katie Freeman, MD

Where do you live:

St Paul, MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

As a local St Paul resident and primary care physician, my biggest concern is who will be served by the new hospital located on the Bethesda Hospital site. Certainly, increase mental health beds are needed, both locally in St Paul and Ramsey County, as well as across the state of MN. These resources are in high demand and there will be competition for spots. It is an important service.

The MHealth Fairview proposal indicates a service area of the "greater 15 county region." What percentage of patients from St Paul and Ramsey County will be served from this site? What percentage of state insurance (Medicare and Medicaid) patients will be served by this site? How will patient intake and selection be made? Given that MHealth Fairview has no acute care hospitals/ERs within 6 miles of the Bethesda site, and no urgent care within 4 miles, how will local residents and community members who might benefit from these programs be able to access this site and these important services? How can local outpatient mental health and primary care providers help patients to access services at the hospital? What supports will be in place for chemical dependency and addiction medicine needs for those admitted? The St Joseph's inpatient chemical dependency unit provided high need essential care--will this also be available at the new site? What process will be in place for transferring to an acute care hospital if needed? Where will patient with medical needs be transferred?

Unfortunately, when I look at this proposal, what I see is a large major health system discontinuing healthcare services in an urban, diverse setting, and opening up a new mental health hospital where they can ship in patients from their higher paying, white, suburban hospitals and clinics, while limiting

access to those diverse patients in the neighborhood who need these programs. This hospital should have benefits for St Paul and the local community, especially for patients, and not just for the system as a whole. This is a health equity issue.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 3:26:43 AM

Name:

Keri Nelson

Where do you live:

Dresser WI

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I work in WI at a critical access hospital owned by Allina. I think this is intentional union busting on the part of MHealth FV. Closing St Joe's and opening another hospital with new staff instead of simply maintaining the current labor pool is a detriment to the staff and also the patients.

Competent trained staff are available at St Joe's but the employer will simply re-open and start over, potentially hiring travelers instead of simply transferring the staff who want to work at the new facility and maintain their union status, seniority, pension, pay etc.

I have been a nurse for 34 years, most of it in the ER and trained mental health staff are a magnificent find.....MHealth FV needs to consider that in this transition and do what is best for the patients and the staff.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 7:50:02 PM

Name:

Kirsten Peterson

Where do you live:

Saint Paul

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I want to echo the concerns of the health care professionals and public servants on the call, thank you all for having the courage to speak up. As a resident of Saint Paul who has been employed on the inside of for-profit healthcare organizations, I am gravely concerned about the level of care, treatment of employees, and overall effect on job market Acadia's presence would have in Minnesota. Closing union facilities to replace with non-union facilities drives down wages and work life balance for all workers in the sector.

Fairview has admitted on the public record at least once that they have "lost sight of their non-profit mission." Have they lost sight of that again?

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/24/2022 9:57:02 AM

Name:

Lanae Horner

Where do you live:

Tracy MN

Do you represent an organization?

Yes

What organization do you represent?

Sanford Medical Center Westbrook MN

What is your comment on the proposed mental health hospital?

As a small rural hospital, we are definitely in need of more acute Mental Health inpatient hospitals. We have had people in our ER's who wait for days to find placement. We have also reached out to other states for assistance. Some of our patients travel 6 hours to get to a Mental health facility. Please let this happen for Fairview/Acadia.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/3/2022 9:27:51 AM

Name:

Lara Villavaso

Where do you live:

Lino Lakes Minnesota

Do you represent an organization?

No

What organization do you represent?

Self interested party. Current RN at Fairview

What is your comment on the proposed mental health hospital?

I have worked as a RN on Fairview's Riverside 6a; a dual adolescent inpatient mental health unit for 12 years. In total Riverside has about 50 child and adolescent inpatient beds spread across four units- 3c, 6a, 7a and ITC. A few years back management closed one of those units, 3c. Those 15 bed remain empty. Of course management has been stating this is only temporary.

A few months, during a Joint Commission visit, management decided to combine two adolescent units together (6a and 7a). Each unit HAD 18 beds. We now have a combined total of 12 patients on one unit. With combining the two units, 7a was left empty unit. On 7a the second beds were removed subsequently lowering patient capacity to 10. Management decided to then move the the ITC patients (intense treatment- high acuity) to 7a. ITC is now closed to inpatient admissions.

With in the span of about 5 years, Fairview went from having about 50 child and adolescent beds to about 20 beds. Most of the reduction has occurred within the past few months.

Another significant concern is psychiatric providers. Fairview is unable to attract or retain psychiatrist. Specially child psychiatrists

My first comment was submitted before I was finished. And please note it was also submitted prior to making corrections.

In summary Fairview has a very difficult time attracting and retaining child psychiatrists. We have had approximately a dozen child psychiatrists over the last 10 years. Not one of those psychiatrists still work for Fairview. Why is that? Fairview has beds but they lack providers to attend to those beds. Perhaps before opening up a new facility they should get their current facility up to par. Arcadia is not a healthcare system that we should welcome with open arms. I also encourage everyone to talk with Prairie Care employees about working for a for profit free standing mental hospital facility. Rather than calling for additional mental health support, free standing facilities call the police in a crisis. Thank you for you time

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 8:17:45 PM

Name:

Lori

Where do you live:

Minnesota

Do you represent an organization?

No

What organization do you represent?

N/A

What is your comment on the proposed mental health hospital?

I'm very concerned about the proposal of a stand alone 144 bed Psych/Geriatric/Addictions hospital being proposed by Fairview in St. Paul. My adult son (age 26) has a serious persistent mental illness & is on Medicaid. Will he be turned away when in need due to his poor insurance coverage? Or the possibility that it may/usually takes 6+ weeks to stabilize & find a antipsychotic that works well for him to function? Will any beds be available for psych patients when addiction recovery patients' insurance pays the hospital better? Could you tell us what kind of "geriatric" patients will be accepted at the proposed hospital? Will they stay there as in a long term care facility? Can you please describe Dr. Woods statement "fully-integrated" & "will have access" regarding patients physical medical problems as well as the psych issues that bring them to the hospital? Sending patients by ambulance for scans at another hospital doesn't seem very efficient~ I'm concerned that as a for profit hospital, you will be able to pick & choose which patients will be admitted driven by their insurance policy. In my support groups, about half of our families have loved ones living with a serious persistent mental illness as well as a chemical dependency; dual diagnosis. In my opinion, we are in desperate need of inpatient psych beds (adult & child) as well as facilities like IRTS & group homes. I'm very skeptical of this hospital proposal. Thank you for taking the time to ask us & read our comments.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/2/2022 12:23:54 PM

Name:

Mark Willenbring

Where do you live:

Downtown St. Paul

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

This is badly needed. There is a shortage of acute care beds in Minnesota. I strongly support the remodel into a MH facility.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/2/2022 2:23:58 PM

Name:

Chris Kujava

Where do you live:

Warren, MN

Do you represent an organization?

Yes

What organization do you represent?

Marshall County Social Services

What is your comment on the proposed mental health hospital?

A mental health hospital is greatly needed in MN. Even though we are a long distance off from St. Paul the whole system is jammed up and hospitals for MH issues are almost impossible to find. We have to use ND facilities almost exclusively unless the person is committed. This will give much needed help to folks before a commitment is needed. I cannot say strong enough in writing how much I think this is needed if it increases beds for MH in MN. It says in the request for commit it will be a 144 bed facility but replacing what is at Fairview and St Joseph's right now which I have no idea the beds they serve now. Any bed increase even a few is much needed.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/6/2022 11:59:30 AM

Name:

Chris Chell

Where do you live:

Metropolitan area - Anoka County

Do you represent an organization?

Yes

What organization do you represent?

Metro Health & Medical Preparedness Coalition

What is your comment on the proposed mental health hospital?

The metro region, all regions in the state, are in desperate need of mental health beds. I think it is wonderful that MHealth is stepping up to meet the GAP that is in so prevalent in the state. Each day, across the state, children and adults are waiting in Emergency Department rooms for a BH/MH bed. Or some are taking up a medical bed. None of these individuals are getting their BH/MH needs met. There is a great need in our state for more beds, staff, appointments. This is a medical issue that needs to be addressed. YES please support the Mental Health hospital and I hope other systems follow their example.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/23/2022 1:11:58 PM

Name:

Roland Hayes

Where do you live:

Shoreview

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

June 23, 2022

Jan Malcolm, Commissioner

Minnesota Department of Health

P.O. Box 64975

St. Paul, MN 55164-0975

Dear Commissioner Malcolm,

I am a retired ELCA Lutheran pastor who served for thirty-eight years at St. Michael's Lutheran in Roseville. During my time in the parish, I was asked to provide counsel and support for a number of members struggling with mental health issues and addiction. Many responded well to the outpatient services that were available to them. Some were fortunate to receive the inpatient care they needed. But there were others, too many others, that were not able to access appropriate inpatient care in the community. Several ended up at facilities hundreds of miles away which added to their distress as well as that of their families. And there was one occasion where the lack of timely access to needed inpatient care ended with the person tragically taking his own life.

I also served on the board of Health East Care system for sixteen years. There were countless times when we were confronted with need to address the growing challenge of providing appropriate care for people dealing with mental health issues and addiction...especially those who needed inpatient treatment. We heard of people spending days in the Emergency Room because it was unsafe to release them but there were no available beds to be found. We authorized building out "holding" rooms that would free-up the Emergency Room space while people waited for an inpatient bed to open. At every turn we sought to find appropriate, cost-effective ways to expand existing services and facilities to address the health and well-being of a growing number of people. But to do so required more.

Based on these experiences, and continued conversations with folks who currently provide care to

people with mental illness and addiction, I fully support Fairview's proposal to build a dedicated mental health hospital. I am convinced that it will be a significant and vital step in effectively meeting the critical needs of community members for whom inpatient care is necessary yet too often unavailable.

I would, therefore, ask that you provide the necessary approval for this new facility. In doing so you will be expanding hope, healing and creating the opportunity for a new-life for countless people today and for years to come.

Sincerely,

Roland L. Hayes, Pastor

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/27/2022 8:06:55 AM

Name:

Sarah Thompson

Where do you live:

Windom, MN

Do you represent an organization?

Yes

What organization do you represent?

Sanford Medical Center, Westbrook MN

What is your comment on the proposed mental health hospital?

As a small rural hospital, we are definitely in need of more acute Mental Health inpatient hospitals. We have had people in our ER's who wait for days to find placement. We have also reached out to other states for assistance. Some of our patients travel 6 hours to get to a Mental health facility. Please let this happen for Fairview/Acadia.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/9/2022 5:22:09 PM

Name:

Sonja

Where do you live:

Saint Paul

Do you represent an organization?

No

What organization do you represent?

N/A

What is your comment on the proposed mental health hospital?

My comment is to request that if the new hospital goes forward, that there is not a gap in time between closing the existing mental health in-patient unit and opening the new one, so that people in crisis still have access to these critical health care services and mental health beds. Thank you very much for your time and careful consideration of how to best provide mental health care.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/23/2022 1:16:51 PM

Name:

Thomas Fee

Where do you live:

Inver Grove Heights

Do you represent an organization?

No

What organization do you represent?

personal

What is your comment on the proposed mental health hospital?

6.23.2022

Jan Malcolm, Commissioner

Minnesota Department of Health

P.O. Box 64975

St. Paul, MN 55164 - 0975

Commissioner Malcom:

My name is Tom Fee, and I, like most, encounter people with mental illness almost every day. Some have needs that can be met in community settings, but some truly need the services that can only be provided in an inpatient setting. The simple truth today there are not enough inpatient mental health beds available. There is an urgent, unmet need for additional inpatient mental health beds that requires immediate action. Fairview's proposed mental health hospital is an important example of such action and will expand the state's capacity to meet the need for inpatient mental health and addiction beds.

For over 4 decades we have tried to "mainstream" folks suffering from persistent mental illness, asking them to manage their medications and take on the challenges of everyday life. This effort, while well intended has been a national failure and a societal shame. We need to re-build a model from the ground up and the small effort by Fairview represents a step forward in offering our brothers and sisters who struggle daily. Our State has been a leader in healthcare innovation and to do anything but wholeheartedly support this project would run contrary to our heritage as leaders in building future models of success.

I have served as board chair of both HealthEast Foundation and following the merger, Fairview Foundation. During my time we reinvented the mission of the foundation from replacing chapel chairs

to immersing ourselves in the communities we serve and empowering those communities, in partnership with the foundation, to address the needs of the communities from the inside out. I know what it takes to create change, and doing things 3% different does not cut it. To get 20% change you must do things 40% different. Fairview's commitment to the Bethesda conversion is an example of this- do not hesitate, stand for those who struggle without delay.

Fairview is a trusted leader and valued partner in meeting the mental health and addiction care needs in our region, and we are hopeful that Fairview will receive approval to build the new facility which will better position our healthcare community to address the current shortage of inpatient beds and bolster Minnesota's capacity to serve those in need.

Sincerely,

Thomas Fee

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/23/2022 5:43:36 PM

Name:

Tiffany Blank

Where do you live:

St. Paul

Do you represent an organization?

Yes

What organization do you represent?

Fairview Health Services

What is your comment on the proposed mental health hospital?

Although I work for Fairview, my support for this hospital is related to being a citizen of St. Paul. My family and I are supportive of this much-needed resource in our community.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/17/2022 4:12:39 PM

Name:

Wendy Slade

Where do you live:

St Paul

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

I do not support this because Fairview had operable hospitals at St Joseph's and Bethesda and decided to close them during a pandemic, questioning their business ethics. These hospitals were not for profit and this new one would be for profit, changing the landscape of Minnesota's healthcare system. The hospitals were also union employed, and this one would be non union, creating suspicion that was part of Fairview's long term leadership plan.

Comment on Proposed Fairview Health Services - Acadia Healthcare Mental Health Hospital

Date, Time:

6/2/2022 1:38:02 PM

Name:

Wendy Trout

Where do you live:

Northfield, MN

Do you represent an organization?

No

What organization do you represent?

What is your comment on the proposed mental health hospital?

A few years ago, my 20 year old son was brought to Hennepin Medical center for mental health evaluation. I was shocked when he was released the next day, with no attention given to family concerns about our son. He was sent via police intervention. Thank God he is doing better now, due to his family's perseverance. Yes, a mental health hospital IS VERY MUCH NEEDED!!!!!! THANK YOU FOR CREATING THIS OPPORTUNITY for people to receive mental health services that can truly help them.