PrairieCare

August 11, 2016

Commissioner Edward Ehlinger, MD, MSPH
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Ehlinger:

Enclosed is an application from PrairieCare requesting a public interest review of a proposal to increase access to inpatient psychiatric services for Minnesota's children and adolescents by adding 21 licensed beds at our existing facility in Brooklyn Park. This proposal seeks to increase the number of licensed beds at the child and adolescent psychiatric hospital from 50 to 71.

We intend to seek an exception to the moratorium law permitting the issuance of a hospital license with increased capacity. Our hospital has the capacity to admit two patients (double-occupancy) to 21 of the hospital's 50 (now entirely single-occupancy) bedrooms; therefore, this proposal would require neither construction of a new facility nor significant modification to the existing facility.

If Minnesota Department of Health staff have any questions or require any additional information regarding this matter, they are welcome to contact PrairieCare's General Counsel John Ryan, JD at:

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763-762-6802

Thank you in advance for your attention to this matter of critical importance Minnesota's youth.

Sincerely,

Joel V. Oberstar, MD
Chief Executive Officer

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Executive Summary

Project and Organization Overview

In order to better meet the need for inpatient psychiatric services for youth, PrairieCare seeks to increase the number of licensed beds from 50 to 71 at its inpatient psychiatric hospital for children and adolescents in Brooklyn Park. PrairieCare would then have the capacity to admit two patients (double-occupy) to each of 21 of the patient rooms and expand its ability to meet the needs of Minnesota children in need of inpatient hospitalization for mental illness. This proposal requires legislative approval due to the hospital moratorium.

PrairieCare is one of the region's largest providers of psychiatric care to youth, with programs designed to address the needs of children in several different settings based on the nature and severity of the patient's illness. Over the last decade, PrairieCare and its sister professional organization PrairieCare Medical Group (PCMG) together have expanded access to all of their psychiatric programs and all levels of care: primary care consultation through the Psychiatric Assistance Line (PAL) made possible by a grant from DHS, routine outpatient clinic services, intensive outpatient programs, partial hospital programs and, finally, inpatient hospitalization.

Objectives

The objective of the project is to provide additional inpatient psychiatric hospital capacity for youth in the Minneapolis/St. Paul metropolitan area and beyond. Our internal analysis has identified a consistent pattern of being unable to accept patients via transfer from emergency departments because our facility lacks an available bed and, very frequently, no other beds are available for youth in the metro or even the state. Expanding capacity is consistent with the mission of PrairieCare: "Providing Every Individual Patient The Psychiatric Care They Truly Need."

Timeline

Because no construction would be required, PrairieCare could make additional capacity available very quickly after legislative approval and expanded licensure, with several additional beds being available in the days or weeks thereafter and the full complement of 21 additional beds being available to receive patients by the fall of 2017.

Summary

This proposal is aimed at meeting the needs of the children of Minnesota who have a mental illness and require inpatient hospitalization due to the severity of symptoms they are exhibiting. As one of only a few facilities within the State providing inpatient psychiatric care to children and adolescents, we decline transfer requests from emergency departments due to lack of available beds with a sufficient frequency to justify from a statistical standpoint doubling our current capacity. We believe that the addition of 21 more beds would be a significant but measured step towards providing adequate psychiatric bed availability for Minnesota's children. While we acknowledge that inpatient care is the most restrictive and highest cost, we also note that it is a critical component to a comprehensive continuum of care. In fact, over the past decade, PrairieCare and PCMG have expanded less restrictive and lower cost services more than any other provider in Minnesota, including partial hospitalization

programs, intensive outpatient programs, outpatient clinic services, services embedded in both primary care clinics and school settings, and primary care consultation services to primary care clinicians. Nevertheless, many youth each day need hospitalization and cannot receive it due to insufficient inpatient bed capacity. This lack of inpatient capacity results in patients boarding in emergency departments for hours, days or longer, while yet other patients are admitted to a general medical/pediatric unit awaiting placement.

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Public Interest Review Application

PrairieCare asks that the Department of Health find its proposal to increase from 50 to 71 the licensed capacity of its child and adolescent psychiatric hospital in Brooklyn Park to be in the public interest, based on the following factors:

The Need for More Beds and Timely Access to Care

PrairieCare currently operates a 50-bed psychiatric hospital for children and adolescents. This facility is less than one year old, having been licensed in September of 2015 and not reaching its full complement of staffing in order to be able to serve 50 patients per day until mid-January of 2016. Since reaching full staffing levels and operating frequently at >90% occupancy, we have closely monitored transfer requests from area emergency departments to ascertain if the overall supply of children's inpatient psychiatric hospital beds can meet the needs of Minnesota's youth, as measured by demand for transfers from hospital emergency departments. We have found that transfer requests greatly exceed available beds and that there are not enough inpatient psychiatric hospital beds available in the state, particularly in the Minneapolis/St. Paul Metropolitan Area ("Metro"; child $\leq$ 12 years of age and adolescent $\geq$ 13 years of age) to meet the demand:

Days with Zero Beds Available

	Child Metro	Child Statewide	Adolescent Metro	Adolescent Statewide
2015 Nov	18	10	16	0
2015 Dec	10	7	15	1
2016 Jan	12	18	18	1
2016 Feb	12	9	22	2
2016 Mar	16	12	13	0
2016 Apr	21	20	18	0
2016 May	17	14	25	2

Of the approximately 200 Child & Adolescent inpatient psychiatric hospital beds in the state, approximately 160 are located in the Twin Cities Metro. Even still, the lack of inpatient psychiatric hospital capacity is striking; with an alarming frequency these seven months, zero beds were available to children and adolescents needing inpatient care. There is no other context in medical service need analysis where one would imagine concluding that it would be sufficient to have appropriate emergency care available to children less than 50% of the time.

Description of Proposal

Having previously operated an inpatient psychiatric hospital in which both single- and double-occupancy rooms were utilized at its former location (Maple Grove), PrairieCare proposes to expand capacity in its existing 50-bedroom facility through double-occupancy in 21 bedrooms. Patients would be screened for double-occupancy placement considering a variety of factors including past history, presenting symptoms/behaviors and presence of a communicable disease. Since construction to accommodate this expansion is not required, PrairieCare would only need to add the additional staff and bedroom furniture in order to expand and provide the ability to serve up to 840 additional patients each year (based on the typical length of stay).

Description of Patients Served

The patients served will be substantially similar to those patients currently served at our Brooklyn Park hospital. The vast majority of patients hospitalized in our facility are admitted via transfer from Minnesota emergency departments by ambulance. The patients in our facility reflect the demographics of Minnesota youth. All patients hospitalized must meet our admission criteria; exclusionary criteria are considered as well:

Inpatient General Unit Inclusion Criteria:

Those patients appropriate for admission or transfer to a general unit have medical needs including but not limited to situations such as:

- High risk for engaging in behavior in the immediate future that could result in significant harm to self or others resulting in whole or in part from a DSM-5 established mental illness for which intensive staffing and treatment is medically indicated.
- Intermittent and/or mildly-moderately dysregulated/aggressive behavior resulting in whole or in part from a DSM-5 established mental illness for which intensive staffing and treatment is medically indicated.
- Psychosis or mania requiring intensive staffing and treatment.
- Medical monitoring of treatment by trained staff 24 hours per day is required for safety (e.g., medication washout in a patient with strong history of dysregulated/aggressive behavior when not treated with medication, etc.).
- Less intensive intervention is unlikely to be sufficient for symptom management/reduction.

Inpatient General Unit Exclusionary Criteria:

Certain patients are not appropriate for admission to the inpatient general unit including but not limited to:

- Patients who are developmentally inappropriate for milieu (e.g., patient out of high school, in college, married, employed full time, etc.).
- Patients with disorders caused by chronic organic brain dysfunction without treatable psychiatric symptoms.
- Patients with behavioral, cognitive and/or physical impairments which would render them unable to function at a minimally acceptable level within the treatment program (e.g., a medically unstable patient whose safety requires treatment in a medical-surgical hospital, etc.).
- Patients in whom substance use disorder (SUD) concerns predominate
    - Patients can have co-occurring DSM-5 established SUD concerns if they are in remission or sufficiently stabilized such that they do not significantly interfere with treatment of the primary non-SUD DSM-5 condition(s).
- Patients who are physically assaultive to staff and/or destructive of property not primarily as product of an insufficiently treated DSM-5 mental illness but of a sufficiently volitional nature for which involvement of and intervention by the legal/justice system is more appropriate.
- Those patients who meet criteria for less restrictive treatment.

Impact on Other Facilities – Financial and Staffing

Expanding by 21 beds would require adding approximately 2.0 Full Time Equivalent (FTE) Child and Adolescent Psychiatrists, 10 FTE Registered Nurses, 2.0 FTE Masters-level psychotherapists (LICSW, LMFT, etc.) and 2.0 FTE Bachelors-level social workers.

PrairieCare does not believe that any other facility would by negatively impacted by the addition of 21 additional beds to its existing facility. In the five years since it began offering inpatient psychiatric hospital services in 2011, PrairieCare has expanded its child and adolescent psychiatric staff almost exclusively without recruiting from competing services. It has accomplished this in part through its involvement in the training of new child and adolescent psychiatrists through its formal affiliation with the University of Minnesota Medical School; many of those trainees have joined PrairieCare Medical Group in addition to some who have been recruited from outside Minnesota to join the organization's efforts to meet the needs of Minnesota's youth. In other words, by being a single specialty center of excellence, PrairieCare has had a net positive impact on child psychiatric workforce in the state, attracting out of state doctors, increasing the percentage of graduating doctors willing to practice in acute care settings and curbing the degree of out migration of Minnesota graduates. In addition to child and adolescent psychiatry fellows, PrairieCare serves as a training site for family medicine residents, medical students, post-doctoral psychology interns, social workers and nurses. In this way PrairieCare plays a role in developing the State's overall mental health workforce.

Services to Nonpaying or low-income patients

PrairieCare accepts all inpatients transferred from emergency rooms without regard to payment source or ability to pay. PrairieCare also has charity care policies that provide discounts for uninsured or underinsured patients. These discounts begin at 400% of the federal poverty level and consist of a graded approach such that care to uninsured patients falling below 160% of the federal poverty level is provided free.

Anticipated Reservations

Based upon previous requests for Public Interest Reviews, we can anticipate at least two reservations being expressed. First, historically there have been stakeholders who simply oppose generally the addition of more inpatient beds in favor of non-hospital alternatives, a sentiment captured in this quote from a 2009 Mental Health Work Group: "adding new beds to the system will not address the underlying problem. Using the MHCP data, if the number of bed days for those 210 children and adolescents could be reduced by even 25%, an additional 521 children and adolescents (based on an average length of stay of 8 days) would be able to access inpatient care. Thus capacity – in terms of the number of children and adolescents served – could be increased by over 12%." - Mental Health Acute Care Needs Report, March, 2009.

Increasing capacity by over 12% would seem promising, but based on convergent statistical predictors, PrairieCare estimates that at least 25 additional beds are needed in addition to fully funding the non-hospital alternatives (which has not happened), to adequately address the needs of Twin Cities Metro youth. Those statistical predictors include an analysis of how many beds are needed in the Metro based upon how many patients are turned away due to lack of an available bed. During the seven month time

period referenced above, we analyzed how many patients were turned away when no beds were available. The number of patients turned away from PrairieCare alone, coupled with an average length of stay of 8 to 10 days, would predict that between 25 and 50 additional inpatient psychiatric hospital beds are needed in the Twin Cities Metro. When children outside the Metro and failing to fully fund non-hospital alternatives are taken into account, at least another 25 beds could be needed. Thus the 12% of beds potentially freed (by programs not yet created) on the existing 90 or so at the time of the 2009 study cited above, or 11 beds, falls well short in any case of the 50 to 75 needed.

Furthermore, the logic applied to psychiatric hospital bed need for child and adolescent psychiatry services should be more consistent with that for medical/pediatric hospital beds generally. In other words, the threshold for adding enough capacity in a system to account adequately for fluctuating needs should not be when occupancy reaches >90%, but rather in the 65-70% range. This becomes a matter of parity in the application of service availability standards.

Another potential objection could arise in the context of the Psychiatric Residential Treatment Facility (PRTF) beds scheduled to come online in 2017. But we remind MDH that (a) this is likely not to add more residential beds to the system, but instead to simply reposition existing "residential" beds as "PRTF" beds, therefore causing no reduction in excess inpatient days for cases awaiting placement and that (b) in any case, by definition these beds as they are proposed are not equivalent services to acute inpatient psychiatric hospitalization beds.

Conclusion

By our utilization data and statistical modeling, we believe that 21 beds, while less than the number necessary to fully ameliorate the number of patients boarding in Minneapolis/St. Paul metropolitan area emergency departments or being hospitalized on general medical/pediatric units awaiting an available psychiatric bed, would represent a significant positive expansion of needed acute care services.

PrairieCare and PrairieCare Medical Group have innovated and expanded many cost-effective, community based, early interventions and alternatives to hospitalization. This includes innovations at all points on the cost and acuity continua, to meet patients where they are with the care they truly need. We have developed mental health "micro-clinics" within primary care clinics to aid in early identification and intervention for youth with a mental illness, after school intensive outpatient programs located on school grounds to reduce barriers to attendance, and have added over 150 "slots" to various programs located in several convenient outpatient locations throughout the Twin Cities and Rochester designed to prevent the need for more restrictive, higher cost inpatient hospitalization. We have also partnered with DHS to provide child and adolescent psychiatrist consultations to primary care clinicians free of charge as a way of helping them manage more mental illnesses in the primary care setting.

If we believed that simply expanding these other innovations would obviate the need for greater inpatient capacity, we would just do more of what we have already done. However we believe this is a false choice, in the same way that no one advocates preventing the addition of cardiac stent or stroke thrombolytic services *when need clearly exists* simply because diet and exercise initiatives are known to impact the epidemiology of those conditions. Advocating increased prevention for the future does not justify withholding treatment in the present.

We ask the Department of Health to find this proposal to add 21 inpatient psychiatric hospital beds to the child/adolescent psychiatric care continuum to be in the public interest. Thank you for your time and consideration; we stand ready to answer any questions you may have before beginning and during your review.