September 9, 2022

Laura Reed
Chief Nurse Executive and President of Hospitals
Fairview Health Services

Dr. Jeffrey Woods
Operations Group President
Acadia Healthcare

Sent via email

Dear Ms. Reed and Dr. Woods,

As you know, Minnesota Statutes, section 144.552, requires that any hospital seeking to increase its number of licensed beds, or an organization seeking to obtain a hospital license, submit a plan to the Minnesota Department of Health (MDH) for review and assessment as to whether the plan is in the public interest.

On April 12, 2022, MDH received sufficient information to begin conducting a public interest review on the proposal submitted in partnership between Fairview Health Services (Fairview) and Acadia Healthcare (Acadia) to establish a freestanding 144-bed mental health specialty hospital in Saint Paul, Minnesota. In the intervening months, MDH collected additional information to evaluate the proposal, solicited feedback from interested parties and individuals, conducted interviews with experts in care delivery, and obtained clarifications on the proposal from the two entities represented by you.

The purpose of this letter is to provide MDH's findings from the review. The full report will be released after internal department review is complete. The findings are based on quantitative analyses of actual and expected capacity and demand for inpatient mental health services in the hospital service area, the anticipated financial and staffing impact on other hospitals in the region, the effect on staff at closed facilities, the provision of care to low-income patients and patients with an inability to pay for services, the ability for existing hospitals to maintain community benefit, and public comments received on the proposal, as well as other factors.

After completing our 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.

Public input raised a number of significant concerns about the facility as proposed, with which MDH agrees. For the record, these are as follows:

- Though the new facility would be adding badly needed beds for inpatient care of adult psychiatric patients in the East Metro and surrounding service 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 that is at the same level of care as what has been lost in the community, thus leaving a gap in the spectrum of needed 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 some 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 currently 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 to what extent that initiates a downward spiral in the availability of comprehensive inpatient mental health services in Minnesota.

Indeed, a key element in MDH's decision to find this project in the public interest was the recognition that the Legislature expects close, ongoing scrutiny of how the new facility will impact care delivery and the economics of inpatient mental health care services in the community. MDH's new annual oversight responsibilities created in Minnesota Session Laws, 2022 Regular Session, Chapter 99—HF2725, sec. 3 and sec. 4 patient and payer mix, transfers, and patient flow provide the opportunity to inform operational, regulatory, and policy decisions related to mental health care delivery in the service area.

We appreciate the commitments made by Fairview and Acadia throughout the legislative and public interest review process to address these and other issues. This, together with your ongoing engagement with the substantial number of stakeholders who have expressed their concerns with this proposal, will be key to ensuring that the facility and the investment turn out to be in the public interest.

If you have questions or concerns regarding this review, please contact Stefan Gildemeister, Minnesota's State Health Economist, at 651-201-3554 or stefan.gildemeister@state.mn.us

Sincerely,

Jan K. Malcolm
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Enclosure: MDH Public Interest Review, Proposed Mental Health Hospital: Summary of Preliminary Finding.

MDH Public Interest Review, Proposed Mental Health Hospital: Summary of Preliminary Findings

This document is intended to provide detailed empirical context to MDH's September 9, 2022, findings letter from its public interest review of the proposed freestanding mental health hospital in Saint Paul, Minnesota from Fairview Health Services (Fairview) and Acadia Healthcare (Acadia).[1]

The findings and concerns are based on the following considerations:

There is a gap between existing capacity for inpatient mental health care and the need for those services regardless of insurance status. This gap is expected to grow over time due to population growth and will not be completely closed by the proposed hospital.

Occupancy and bed capacity. Based on a May 2022 survey of inpatient mental health beds, MDH estimated occupancy rates for mental health beds at community hospitals in the proposed service area was 95.2%.[2] MDH staff further determined that a minimum of 57 additional beds would be needed for inpatient mental health units to operate at a customary and recommended level of occupancy[3] and a higher number of beds according to national patterns of mental health bed use.[4] In addition, only 84.6% of physically available beds were staffed.

Emergency department waits. The same survey identified an additional 79 individuals in the service area waiting in emergency departments for an inpatient mental health bed on the day of the survey. 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.[5] Long stays in emergency departments negatively affect mental health patients' treatment. They also affect the ability of the trauma system to function effectively and be responsive to mass trauma events. Assuming the proposed facility accepts a significant number of transfers from outside the Fairview system, the additional inpatient mental health beds at the proposed hospital would, therefore, have the potential to alleviate a portion of the patients currently stuck in hospital emergency departments.[6]

Emergency Medical Services transports. 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 MDH. The analysis found that recently, 7.6% or close to 700 mental health patients from the proposed service area required emergency medical services (EMS) transports exceeding an hour—nearly double the proportion in 2019 (3.9%). This analysis also found that out-of-state transfers for mental or behavioral health services

increased substantially (an average of 81 from 2017-2020 to 154 in 2021) and an even higher count in the first half of 2022 compared to 2021. EMS transfers and the emergency department boarding point to a growing number of mental health patients that must be sent outside of normal service areas because of lack of bed availability.

Longer distance EMS services present several issues: 1) the EMS transport is not available to other patients during travel time, potentially causing delays for EMS services; 2) the cost of transporting patients longer distances results in higher spending, potentially impacting out of pocket costs for the person being transported;[7] and 3) to the extent that there are limitations on reimbursement for EMS services, longer-distance transports may result in financial issues for EMS providers.

There is significant uncertainty about the proposed hospital's impact on the finances of other facilities because its business and care model will vary so significantly from other hospitals in Minnesota with psychiatric care units.

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 type of patients admitted to the facility might very much affected by 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. Other factors contributing to uncertainty include staffing progression at the facility and dynamics in the overall labor market and the behavioral response to the new facility by the Emergency Medical Service operators and existing hospitals. Though we have simulated a number of potential scenarios, MDH does not feel confident in predicting actual patient and payer mix, as well as patient flows from the service area subsequent to the establishment of the proposed facility.

That said, in and of itself, we do not believe that the new facility would significantly negatively affect 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 beds may help alleviate some of the potentially unprofitable emergency department boarding of mental health patients at other hospitals.[8]

Both nearby Regions Hospital and United Hospital sent information to MDH demonstrating an increase in mental health patients at their emergency departments subsequent to the closure of St. Joseph's Hospital emergency department. In addition, Regions provided information showing an increase in patients 'boarding' as mentioned earlier. The lack of replacement emergency department capacity for mental health patients is concerning because Regions is also one of five level 1 trauma centers in Minnesota, providing regional trauma services that are necessary but can also be unprofitable.[9]

Presumably, having more availability of beds may relieve some of the pressure on emergency department boarding, as mentioned earlier. However, the new hospital is likely to draw the majority of its patients from Fairview hospitals, so the impact of the new beds on non-Fairview hospitals may be limited. In terms of financial impact, if, as was raised in concerns, the new

hospital takes fewer patients with public coverage or without health insurance from within the Fairview system, any adverse impact will primarily fall on Fairview hospitals. At the same time, it is possible that without an emergency department as an entry point, the facility is likely to attract more private patients, something that has been demonstrated in other similar facilities. It is also highly likely that there will be an adverse mix of patient complexity for other hospitals if the new hospital will only accept low to moderate severity mental health patients.

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 from, 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.

It is unclear how the new hospital will impact other hospitals' ability to maintain staff because the proposed facility is characterized by an unusually lean staffing plan, and we were unable to determine how many former staff at closed Fairview mental health units would be employed at the new hospital.

We note later in this document that the proposed staffing plan of 200 full-time equivalent employees (FTE) for 120 hospital beds constitutes a much higher ratio of patients to staff in comparison to Minnesota or national norms or practices.

While Fairview has closed 123 inpatient mental health beds across their system since 2019,[10] it is unlikely that all of these staff will become available for employment at the new facility for a number of reasons: 1) much time has passed and staff likely have already made alternative employment decisions; and 2) these workers would face loss of seniority and access to their Fairview union contracts, something that may discourage existing Fairview staff to transition to the new facility.

Nonetheless, we anticipate that since the advanced practitioners will be staffed 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. 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.

That said, given the existing labor market challenges related to supply and the cost associated with attracting and retaining qualified staff,[11] there is the potential that the facility will be staffing up more slowly than anticipated and require different approaches, some of which might affect retention in the market. For example, recent employment data indicated that there were 94 vacancies for psychiatrists, 402 openings for psychiatric technicians, and 5,587 vacancies for registered nurses across the state.[12]

Fairview was found to make a good faith effort to avoid layoffs when submitting plans for the new hospital to MDH, yet there was anecdotal evidence presented to MDH that a portion of the workforce was negatively impacted from these changes.

Fairview reported that they are working closely with former St. Joseph's Hospital employees to assist in placing them in comparable roles across their health system. They noted that dozens of workers have already applied for and been accepted to new roles, while a smaller number voluntarily resigned, decided to retire, or elected a voluntary layoff. Fairview states that no involuntary layoffs occurred, and that even those workers who elected a voluntary layoff will receive priority in access to newly opening positions. Fairview further states 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.

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. Staff from the Minnesota Nurses Association (MNA) and Service Employees International Union Healthcare Minnesota & Iowa (SEIU), representing nurses and psychiatric associates working in the Fairview system, asserted that there were negative impacts on workers in closed units. MNA stated that over half of nurses who obtained subsequent employment at an MNA-represented facility work under a different full-time equivalent (FTE) than the one they worked at St. Joseph's. SEIU indicated that workers were not rehired from recently closed Bethesda Hospital (where the new mental hospital would be located).

Authorizing legislation mandates that low-income patients covered by Medicaid or without coverage will be accepted; the state of Minnesota will face a loss of federal financial support for some Medicaid patients at the new hospital.

Low-income and uninsured patients: The legislation authorizing the new hospital mandated the acceptance of patients enrolled in public programs funded by Medicaid, who would also likely be low-income; further it requires that the new hospital abide by the agreement between Minnesota hospitals and the Minnesota Attorney General on billing practices and guaranteeing best-payer discounts to the uninsured.[13] As proposed, the new hospital would also extend the same charity care policies and discounts to uninsured or underinsured patients as does Fairview. Moreover, the legislation authorizing the new hospital requires that MDH monitor payer mix, patient transfers, and patient diversions at the new hospital.[14]

Federal match for Medicaid patients: Federal statute has largely prohibited the use of federal matching funds under the Medicaid program from being paid to hospitals (and other facilities) that are primarily engaged in providing diagnosis, treatment, or care to patients with mental disorders, or Institutions for Mental Diseases (IMD). Over the years, policy changes have allowed federal funds to be used for IMD hospitalizations of no more than 15 days for patients covered by Medicaid managed care[15]—which is the predominant payment mechanism for Medicaid in Minnesota. Minnesota has determined that the cost of IMD stays fee-for-service Medicaid enrollees and Medicaid managed care enrollees of more than 15 days should be part of the Medicaid program, and therefore these costs are 100% state funded (no federal match).

We estimate that, at maximum, 45.2 percent 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);[4] the additional, state-only expenses are estimated to be approximately $2.4 million per year.[16]

The changes resulting from this proposal are not expected to substantially change community benefits provided at Fairview hospitals.

Among hospitals providing inpatient mental health services, Fairview is one of the leading hospital systems in terms of the volume of community benefit per acute admission. However, as noted elsewhere, the majority of these overall expenditures, similar to statewide trends, are dedicated to providing care to patients covered by state health care programs (Medicaid) that represented about $1,460 out of approximately $2,800 of estimated community benefit per admission; a large portion of the remaining benefit was provided in education expenses for about $1,000 per acute admission.[17] As such, the volume of services intended to improve health in communities and increase access to health care at Fairview (and other hospital systems) is actually fairly negligible.[18]

The closure of St. Joseph's Hospital, which was referenced in the proposal for this new facility, 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 hospital 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.

Most comments received by MDH on the proposal emphasized the need for additional inpatient mental health beds, yet there were significant concerns that access to the new facility might be limited and did not fully integrate mental health with physical health needs.

Support for additional bed need. The most common theme among comments and feedback MDH received was support for an increase in staffed mental health beds in Minnesota. This view was also 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 hospital and look to MDH to monitor that access is provided consistent with community standards and expectations.

Opposition to the proposed facility: 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 commentors 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, and how the lack of a charitable mission – of the facility and its majority partner, Acadia – would impact the health care market fabric. A number of individuals expressed a concern that the need to generate a profit might affect provider safety and quality of care.

Fairview as a trusted partner. Multiple social services organizations expressed support for Fairview as a trusted community partner. Some comments expressed support for the proposed facility to care for underserved populations with mental health needs.

The proposed facility is expected to arrange for treatment of medical needs among mental health patients.

The facility, as a freestanding mental health hospital, would not have the full array of medical services available to adult mental health inpatients as those at general acute care hospitals. 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."[19]

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 relying on medical specialties at other 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. These providers are expected to 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 onsite 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.

The proposed staffing levels at the new facility represents a substantial departure from both current inpatient mental health unit staffing levels in Minnesota, and other apparent norms at psychiatric hospitals nationwide.

The proposal calls for 55 nurse and 55 mental health technician full-time equivalents (FTE) to serve as floor staff to five units with 120 beds. At an estimated ideal usage of 85% average capacity, this would result in a ratio of approximately four patients per clinical floor staff on an average shift, while at maximum capacity this would represent approximately five (4.58) patients per clinical floor staff. Under the proposed staffing plan, at least one nurse would work in the intake and assessment area, which means the patient-to-staff ratios would be even higher.

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.[20] 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 staffing plan calls for 200 total employee FTE, or approximately 0.60 beds per FTE, almost double the volume of comparable national facilities.

The uniquely high numbers of patients or beds per staff planned at the new hospital may pose safety risks and impact the quality of care. Although there is a lack of clear guidance from the research literature on the dynamics between staffing levels and quality,[21] 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.[22] Fewer staff may represent a reduced ability to prevent and appropriately respond to instances of violence against patients or staff,[23] or self-injurious behavior. Therefore, the staffing levels and their proposed impact on outcomes and safety will be a key component of monitoring the implementation of the proposal.

Most hospitals operated by Acadia in other states were at or above national average for three of four quality measures according to recent data, yet there were underperforming hospitals that cause concern.

Many Acadia facilities perform at comparatively high levels of quality. The public 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. 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.[24]

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.

There are important gaps in knowledge about barriers to care and inefficiencies in care that must be closed to better understand inpatient mental health care in Minnesota and in order to design systems that are working effectively for patients.

Evaluating this proposal, as alluded to above, included several areas of uncertainty regarding how the provision of inpatient care might change with the establishment of a new, 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 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 could include the identification of 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 mental health bed availability 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.

In finding the project in the public interest, a key element was the recognition 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.[25] The collection of this and other information from various partners across Minnesota will be important to fully understand the impact that this new hospital has on Minnesotans that need 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 essential care to those who need it.

References

[1] Fairview Health Services and Acadia Healthcare formed a joint venture called Acadia St. Paul JV, LLC to own and operate the proposed facility.

[2] MDH survey of hospitals in the proposed service area for May 18, 2022.

[3]The occupancy level of 85 percent was found to be a standard ceiling cited in the literature and has the potential to reduce bottlenecks and patient flow issues related to limited hospital capacity. For more information see: 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.

[4] 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.

[5] Recent 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.

[6] Morris, D. W., Ghose, S., Williams, E., Brown, K., & Khan, F. (2018). Evaluating psychiatric readmissions in the emergency department of a large public hospital. *Neuropsychiatric Disease and Treatment*, *14*, 671.

[7] The new 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.

[8] 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.

[9] Horwitz, J. R. (2005). Making profits and providing care: comparing nonprofit, for-profit, and government hospitals. *Health Affairs*, 24(3), 790-801.

[10] The initial submission of the proposal stated that there were historically 105 inpatient mental health beds at St. Joseph's Hospital. M Health Fairview has also reported to MDH that Fairview Southdale Hospital had an 18-bed mental health until 2020. In addition, St. Joseph's Hospital staffed as many as 239 total inpatient mental health beds as recently as 2019.

[11] Minnesota Department of Health, Office of Rural Health and Primary Care. "Pandemic-Provoked Workforce Exits, Burnout, and Shortages."

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

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

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

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

[16] 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 patients from the service area 2016-2019), there would be 13,987 patient days about 1,316 hospitalizations. This also assumes that the new hospital would have same distribution of fee-for-service (FFS) Medicaid of 34.2% from 2016-2019 as M Health Fairview Hospitals calculated from hospital discharge data for expected primary payer, and 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.

[17] MDH analysis of Hospital Annual Reports from 2016-2020.

[18] Minnesota Department of Health, Health Economics Program. "Hospital Community Benefit Spending in Minnesota, 2016 to 2019", A Report to the Minnesota Legislature, March 2022. www.health.state.mn.us/data/economics/docs/hospcmtybenefitrpt.pdf

[19] Minnesota Session Laws 2022, Chapter 99 - HF2725 (revisor.mn.gov).

[20] 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.

[21] 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.

[22] 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.

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

[24] MDH staff identified 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.

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