Public Interest Review

EVALUATION OF A PROPOSAL FOR EXPANSION OF CHILD AND ADOLESCENT PSYCHIATRIC BED CAPACITY IN BROOKLYN PARK, MINNESOTA

MDH Minnesota Department *of* Health
HEALTH ECONOMICS PROGRAM

Public Interest Review: Evaluation of a Proposal for Expansion of Child and Adolescent Psychiatric Bed Capacity in Brooklyn Park, Minnesota

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Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

June 1, 2017

The Honorable Michelle Benson
Chair, Health and Human Services Finance and Policy Committee
Minnesota Senate
Minnesota Senate Building, Room 3109
95 University Avenue West
Saint Paul, MN 55155-1606

The Honorable Jim Abeler
Chair, Human Services Reform Finance and Policy Committee
Minnesota Senate
Minnesota Senate Building, Room 3215
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The Honorable Joe Schomacker
Chair, Health and Human Services Reform Committee
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Room 509, State Office Building
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The Honorable Matt Dean
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To the Honorable Chairs:

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

In the summer of 2016, PrairieCare, a privately-held clinician organization delivering mental health services to patients under 21 years of age, submitted a plan to the Minnesota Department of Health (MDH) to expand bed capacity at their existing psychiatric hospital in Brooklyn Park, Minnesota. Under the proposal, PrairieCare would raise the number of licensed beds from 50 to 71 beds by converting 21 rooms from single to double-occupancy status.

The purpose of this letter is to provide the Legislature with the Department's findings from its review. The findings are based on quantitative analyses of actual and projected capacity and demand for inpatient psychiatric services in the hospital service area; discussions with Minnesota experts on the delivery system for pediatric mental health care; and public comments received on the proposal.

Based on the review, MDH finds that the hospital bed expansion is in the public interest.

In addition to presenting our analysis that form the basis of our finding, this report to the Legislature includes a discussion on conditions the Legislature may wish to consider as it deliberates whether to grant an exception to the proposal. In addition, the report includes observations by MDH from a number of public interest reviews focused on mental health bed capacity in Minnesota, noting that gaps in broader understanding of mental illness and the delivery system may lead to short-term fixes for long-term needs.

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

Sincerely,

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Section 1: Overview of Minnesota's Hospital Public Interest Review Process

Since 1984, Minnesota law has prohibited constructing new hospitals or expanding bed capacity at existing hospitals without specific 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, and the statute currently includes 26 exceptions.

In 2004, the Minnesota State Legislature established a new procedure for reviewing proposals for exceptions to the hospital moratorium statute.[2] Under this policy, hospitals that seek an exception to the moratorium must submit a plan to the Minnesota Department of Health for the completion of a "public interest review."

The law requires that the Minnesota Department of Health review each plan and issue a finding on whether the plan is in the public interest. This review is based on a minimum of five factors outlined in Minnesota Statutes, section 144.552:

- **Factor 1**: Whether the new hospital or hospital beds are needed to provide timely access to care or access to new or improved services;
- **Factor 2**: The financial impact of the new hospital or hospital beds on existing acute-care hospitals that have emergency departments in the region;
- **Factor 3**: How the new hospital or hospital beds will affect the ability of existing hospitals in the region to maintain existing staff;
- **Factor 4**: The extent to which the new hospital or hospital beds will provide services to nonpaying or low-income patients relative to the level of services provided to these groups by existing hospitals in the region; and
- **Factor 5**: The views of affected parties.

The statute requires the completion of public interest reviews within 90 days. The Minnesota Department of Health may use up to six months for a review if there are extenuating circumstances present; public interest reviews cannot start until necessary application materials are complete. Authority to approve exceptions to the hospital moratorium still rests with the Legislature.

This document and additional information about the proposal under review for an exception to the hospital construction moratorium, as well as documents related to previous reviews by the Department, are available online: http://www.health.state.mn.us/divs/hpsc/hep/moratorium/.

[1] Minnesota Statutes, section 144.551.
[2] Minnesota Statutes, section 144.552.

Section 2: PrairieCare's Proposal for an Expansion of Hospital Bed Capacity

In August 2016, PrairieCare initiated a request of the Minnesota Department of Health to conduct a public interest review on their proposal to increase the number of licensed hospital beds at an existing facility in Brooklyn Park. In the months that followed, PrairieCare provided additional information and points of clarification in response to questions the Department raised about the application. PrairieCare described how their proposed project would address perceived unmet need of inpatient psychiatric care, the criteria for determining patient placement in new hospital beds, recent data on serving low-income and nonpaying patients, and other information relevant to the proposed expansion.[3]

Project Description

PrairieCare and PrairieCare Medical Group are privately owned organizations that provide a continuum of psychiatric care to youth (aged 20 years or younger) in Minnesota. Through a 50-bed acute care psychiatric hospital in Brooklyn Park, which opened in September 2015, PrairieCare delivers short-term inpatient treatment for patients experiencing a mental health crisis. In addition, PrairieCare Medical Group operates six clinics in the Twin Cities and in Rochester, where it delivers outpatient services through a variety of delivery mechanisms.

Before delivering inpatient psychiatric services for children at the current site in Brooklyn Park, PrairieCare operated a 20-bed facility in nearby Maple Grove, which they now use for outpatient psychiatric care. The establishment of that facility was permitted under an exception to the hospital moratorium law, passed by the Minnesota Legislature in 2009.[4,5] The new $23.5 million dollar hospital in Brooklyn Park, built under the same exception, opened in fall 2015.

PrairieCare proposes to expand the available inpatient psychiatric bed capacity for children at the facility in Brooklyn Park by converting 21 existing single-occupancy rooms to double occupancy, effectively increasing the total number of hospital beds from 50 to 71. PrairieCare anticipates that nine of the new beds will be dedicated to older adolescents (14 years of age

[3] All application materials can be found on the following Minnesota Department of Health website: http://www.health.state.mn.us/divs/hpsc/hep/moratorium/prairiecarebrooklynpark/index.html

[4] Minnesota Statutes, Chapter 144.551, subd. 1, paragraph b, clause (24).

[5] An earlier proposal, by then Prairie St. Johns, for a facility in Woodbury, Minnesota, was found by MDH to not be in the public interest, following a review.

and older), six beds to younger adolescents (12 and 13 years old), and six beds to children under the age of 12.

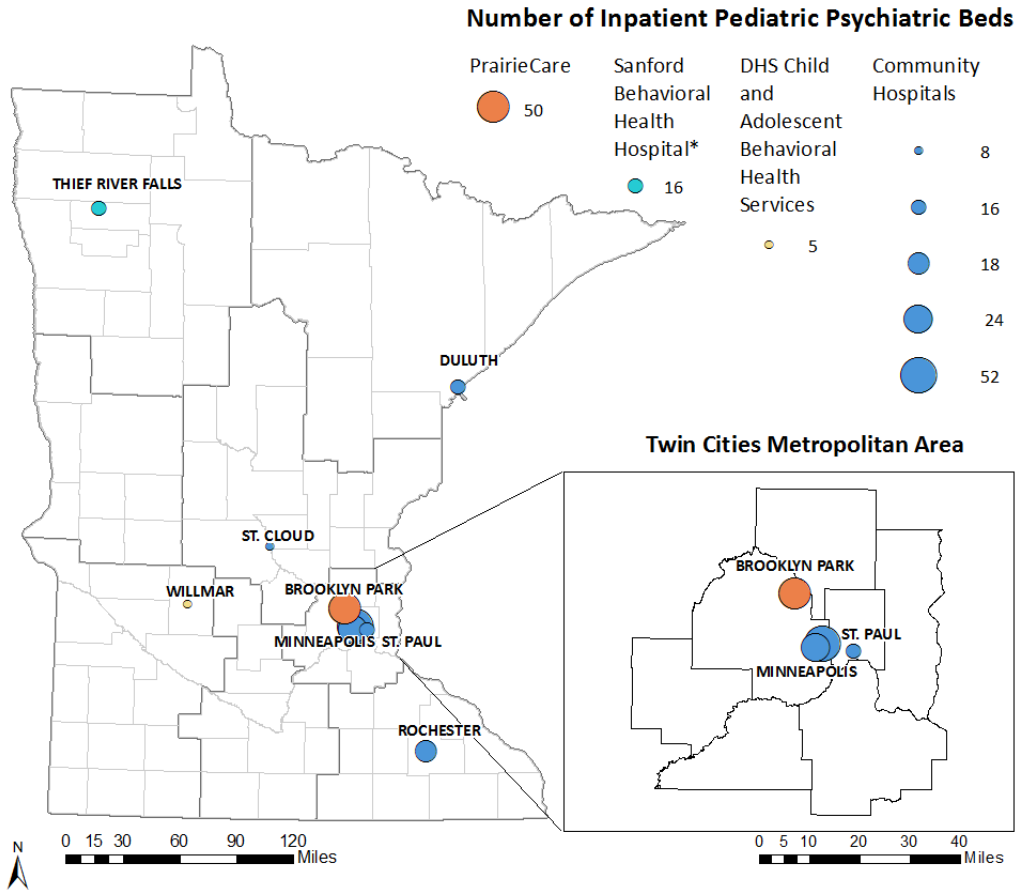
According to PrairieCare, the additional 21 beds would serve an estimated 840 patients per year once expanded staffing and new furniture is in place. This assumes an occupancy rate of 90 percent and an average length of stay of 8.2 days. In our analysis, the 2015 occupancy rate was lower and the average length of stay longer than PrairieCare's proposal assumed; using MDH's estimates, the added bed capacity would serve about 750 patients per year.[6]

[6] Minnesota Department of Health analysis of PrairieCare hospital billing records from 2012 from January 2012 through mid-October 2016. This estimate is the average length of stay excluding admissions with the 10 percent highest and lowest lengths of stay. Further information about data sources used in this report can be found in Appendix A.

Section 3: Capacity and Use of Inpatient Pediatric Psychiatric Care in Minnesota

In Minnesota in 2015, there were 1,075 inpatient psychiatric beds for adult and pediatric patients operated by 34 community hospitals.[7] A very high percentage (82.9 percent) of these beds are limited to adult psychiatric care. As shown in Figure 1, there were 184 available psychiatric beds dedicated to pediatric patients at the following seven hospitals:

FIGURE 1: LOCATION OF AVAILABLE PEDIATRIC PSYCHIATRIC BEDS IN MINNESOTA, 2015



*Sanford Behavioral Health Hospital in Thief River Falls, MN offers combined inpatient psychiatric care to children, adolescents, and adults.

Source: MDH analysis of data from the Hospital Annual Report.

[7] The term 'pediatric' used in this report and analysis includes all patients less than 18 years of age consistent with definitions used in Hospital Annual Report Instructions found here: http://www.health.state.mn.us/divs/hpsc/dap/hccis/harinst16.pdf. It is important to note, however, that PrairieCare serves patients under the age of 21 at their hospital facility in Brooklyn Park. The total bed count does not include beds at hospitals operated by the Minnesota Department of Human Services (DHS) or the Veterans Health Administration.

- Abbott Northwestern in Minneapolis (24 beds)
- CentraCare St. Cloud Hospital in St. Cloud (8 beds)
- Essentia Health Hospital in Duluth (16 beds)
- Mayo Clinic Hospital in Rochester (18 beds)
- PrairieCare Hospital in Brooklyn Park (currently 50 beds)
- United Hospital in St. Paul (16 beds)
- University of Minnesota Medical Center in Minneapolis (52 beds)

There are also five beds at the Willmar Community Behavioral Health Hospital dedicated for use by children with severe mental illness, operated by the Minnesota Department of Human Services (DHS). In addition, Sanford Health Behavioral Health Hospital in Thief River Falls provides inpatient mental health care to both pediatric and adult patients, with 16 total beds.[8] Some children with inpatient behavioral health needs are also admitted to facilities without dedicated pediatric psychiatric beds or in beds not dedicated for psychiatric care. Finally, in some instances, Minnesota children with psychiatric health care needs are admitted in facilities at neighboring communities outside of Minnesota.

Inpatient hospital care for children and adolescents with mental health diagnoses are critical treatment components in a mental health crisis, whether or not the crisis could have been prevented. Oftentimes, hospitalizations are accompanied by medical needs, including from injury. In all cases, however, the experience of a mental health crisis is a jarring event for parents and caregivers and frightening for children and adolescents. Understanding capacity gaps and the factors underlying them, therefore, is critical to ensuring the availability of services for vulnerable patients.

Although the rate of mental illness is relatively low and the need for psychiatric hospitalizations for this population relatively rare, inpatient admissions for children and adolescents with mental health diagnoses account for a sizable portion of hospital care for young Minnesotans. More specifically, around six percent of children aged nine to 17 are estimated to experience severe emotional disturbances,[9] and a subset of these children and adolescents account for one or more of the nearly 7,500 psychiatric hospital admissions that took place for this population in 2015. These inpatient stays accounted for 14.9 percent of the approximately 44,500 total pediatric hospitalizations that took place in Minnesota, and were second only to perinatal conditions.[10]

[8] We do not include the beds at Willmar Community Behavioral Health Hospital in our analyses as these hospitalizations represent a population with different health needs. Sanford Behavioral Health Hospital in Thief River Falls is not included in occupancy calculations because the beds are not limited to pediatric patients, making the conclusions unclear.

[9] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Drug and Alcohol Services Information System, Uniform Reporting System (URS) SMI/SED Prevalence Estimates for 2014 accessed January 29, 2017 at: https://wwwdasis.samhsa.gov/dasis2/urs.htm. The figure is from state level estimate with a level of functioning score of 50 for Minnesota residents age 9 to 17.

[10] Minnesota Department of Health analysis of data from PrairieCare, the Minnesota Hospital Association and the Hospital Annual Report for specialty hospitals. This does not include normal newborns (3M-APR-DRG 640).

Table 1 shows the characteristics of child and adolescent patients hospitalized for mental illness at Minnesota hospitals with pediatric psychiatric units.[11] Many of the hospital stays (71.2

TABLE 1: CHARACTERISTICS OF HOSPITAL STAYS AT MINNESOTA PEDIATRIC PSYCHIATRIC UNITS, 2015

Characteristic	Percent
Primary Diagnosis Category	
Mood disorders (e.g., depressive disorders)	71.2%
Anxiety disorders	6.7%
Adjustment disorders	5.7%
Attention-deficit, conduct, and disruptive behavior disorders	4.8%
Disorders usually diagnosed in infancy, childhood, or adolescence	4.3%
All other conditions	7.4%
Patient Gender	
Female	65.2%
Male	34.8%
Patient Age	
11 and younger	9.2%
12 – 13 years	16.7%
14 – 17 years	74.0%
Expected Primary Payer[1]	
Medicaid	39.8%
Private/Commercial Insurance	56.6%
Other	3.6%
Geographic Region of Minnesota[2]	
Central	15.1%
Northeast and Northwest	7.3%
South Central	2.6%
Southwest and West Central	1.0%
Southeast	11.7%
Twin Cities Metropolitan Area	62.2%

Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare. 'Primary diagnosis category' is from the Clinical Classifications Software for ICD-9-CM and ICD-10 developed by the US Department of Health and Human Services Agency for Healthcare Research and Quality. Based on 6,645 discharges from Minnesota Hospitals with pediatric psychiatric units.

1 Expected payer is the insurer the hospital expects will cover services at discharge. The actual payer could differ from what was expected and would emerge in the process of adjudicating hospital bills.

2 The information on geographic region includes data from Minnesota hospitals and for Minnesota residents at hospitals in North Dakota, Iowa, and South Dakota. It does not include data from Wisconsin hospitals that do share data with Minnesota.

[11] Over 85 percent of pediatric inpatient psychiatric hospital stays at Minnesota hospitals occurred in a hospital that operated a dedicated pediatric psychiatric unit.

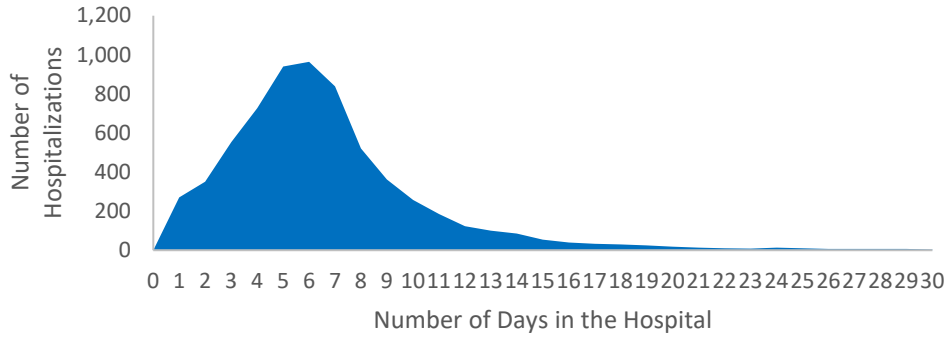
percent) were for pediatric patients admitted with a diagnosis of mood disorders, such as depression and bi-polar disease. Female patients accounted for twice the number of hospitalizations for mental illness than male patients overall; however, the reverse is true for those 11 and younger (not shown in table). Older adolescents (ages 14 through 17) accounted for about three in four (74.0 percent) inpatient hospital stays for psychiatric care.

Commercial insurance was the largest expected payer, covering over half (56.6 percent) of pediatric inpatient psychiatric stays, followed by Medicaid with more than a third (39.8 percent) of stays, and other types of coverage for the remainder. This is consistent with the distribution of insurance coverage for pediatric inpatient care, more generally.

Table 1 also shows that the majority of pediatric patients who received inpatient psychiatric care were disproportionately from the Twin Cities Metropolitan Area. Pediatric patients from the Twin Cities accounted for 62.2 percent of these hospitalizations, while children under age 18 accounted for 55.3 percent of the statewide total.[12] Similarly, patients from the Central, Northeast and Southeast regions are over-represented.

The median length of stay for pediatric patients during an inpatient psychiatric hospitalization in 2015 was just under one week (six days). Figure 2 shows that most (about 95 percent) pediatric patients who were admitted to a psychiatric unit were discharged from the hospital within two weeks. In some cases, however, patients stayed admitted for longer than 30 days; these hospital stays represented less than one percent of total pediatric psychiatric hospital admissions.

FIGURE 2: DISTRIBUTION OF HOSPITAL LENGTH OF STAYS AT MINNESOTA PEDIATRIC PSYCHIATRIC UNITS, 2015



Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare. Note: does not include data from the Minnesota Department of Human Services Child and Adolescent Behavioral Services hospital in Willmar. The longest hospital stay in 2015 was 167 days; there were 78 hospital stays that lasted longer than 60 days.

[12] MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare and population data from the U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates.

Section 4: Evaluation of the Proposal

The Minnesota Department of Health (MDH) evaluated PrairieCare's proposal to add 21 hospital beds in Brooklyn Park by focusing primarily on the five factors specified by Minnesota Statutes, section 144.552 and listed above on page 2. In addition, we considered other factors relevant to this specific proposal, and the context of the current mental health care environment.

Factor 1: Whether there is a need for new hospital beds to provide timely access to care or access to new or improved services

As mentioned earlier, there were 184 inpatient beds in Minnesota specifically dedicated for use by pediatric psychiatric patients, and 6,645 stays in these beds in 2015, 6,390 of which were for Minnesota residents.[13] To determine potential capacity issues at both the hospital and statewide level, the Minnesota Department of Health considered the following metrics:

1. The number of days a hospital operated at 90 percent or more of bed occupancy;
2. The average daily occupancy in pediatric psychiatric units;
3. The frequency that patients traveled outside of their region of residence for inpatient psychiatric care; and
4. The number of pediatric psychiatric stays that occurred outside of specialized units.

Using these metrics, our analysis found evidence that, while overall there was unused bed capacity in Minnesota for children and adolescents with mental health needs,[14] there appeared to be significant capacity constraints:

- In certain areas of the state, and
- At specific hospitals.

Table 2 shows that some Minnesota hospitals, including PrairieCare's current facility in Brooklyn Park, operated their psychiatric units for children and adolescents at or above 90 percent occupancy for parts of 2015; three facilities that primarily served the greater Twin Cities market operated 100 or more days at very high capacity. Rates of occupancy at these

[13] There were a total of 7,342 pediatric psychiatric hospitalizations of Minnesota residents in 2015; 6,390 of these admissions (87.1%) were in hospitals with pediatric psychiatric units. There were an additional 28 hospitalizations of Minnesota residents at the DHS hospital in Willmar.

[14] In 2015, there were about 67,000 available bed days in pediatric units for children and adolescents with psychiatric health care needs. That year, about 55 percent of bed days (about 37,000) were associated with a patient stay.

TABLE 2: NUMBER OF DAYS AT OR ABOVE 90 PERCENT OCCUPIED FOR MINNESOTA INPATIENT PEDIATRIC PSYCHIATRIC UNITS, 2015

Hospital	Number of Days
PrairieCare	*145*
University of Minnesota Medical Center – Fairview[1]	120
Mayo Clinic Hospital – Rochester	109
Abbott Northwestern Hospital[2]	98
United Hospital[2]	32
Essentia Health - Duluth	6
CentraCare St. Cloud Hospital	1

Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare. Occupancy rates were calculated as number of patients with primary psychiatric diagnosis in the hospital each day divided by number of pediatric psychiatric beds in the hospital. The data does not permit identifying when a specific discharge overlapped with an admission, nor if a patient occupied a bed on a psychiatric unit or in general medicine. As such, these estimates should be viewed as *overestimates* of capacity constraints.
[1] University of Minnesota Medical Center – Fairview has noted that there were only 28 days during 2015 when occupancy in the pediatric psychiatric unit was at or above 90 percent.
[2] Allina Health has noted that in 2015 there were 113 days at Abbott Northwestern Hospital and 100 days at United Hospital when occupancy in the pediatric psychiatric unit was at or above 90 percent.

levels can increase the likelihood of medical errors and other patient safety issues, and may result in patients spending extended time in the emergency department.[15]

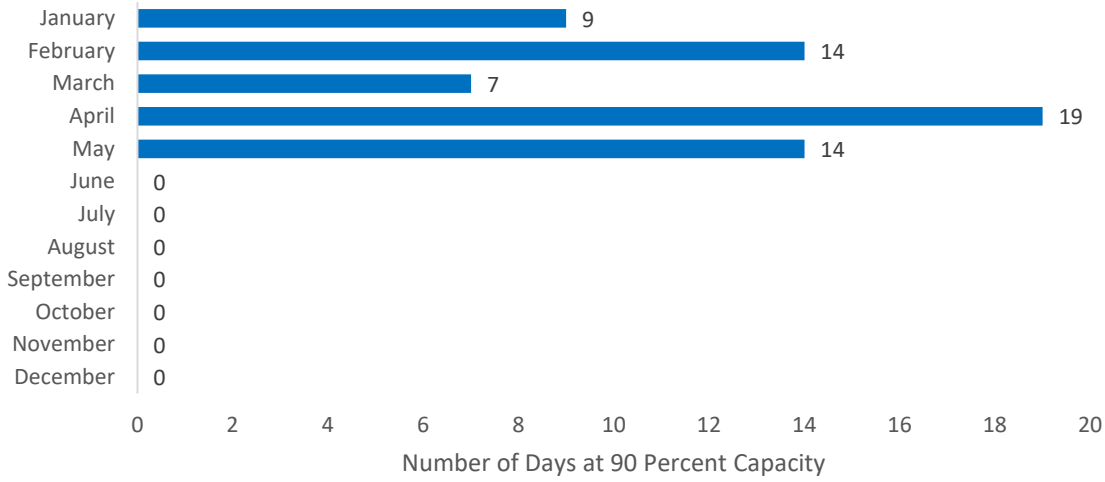
High-occupancy days were not distributed evenly throughout the year. Even though psychiatric crisis for children and adolescents tend to occur at certain stress-points throughout the year, most of the hospitalization bottlenecks occurred during the first half of 2015 (January through May), as shown in Figure 3.[16] Furthermore, for over half the days in April 2015, 90 percent of all hospital beds for children's psychiatric care in Minnesota were filled, meaning patients would have had a difficult time finding a bed anywhere in the state.

Even measured across the year, daily occupancy was high at PrairieCare and five other pediatric psychiatric units at community hospitals in Minnesota (see Figure 4). Across all hospitals, average daily occupancy was 75.9 percent; most hospitals averaged above 70 percent full and PrairieCare's average was at 81.7 percent. The three hospitals with the highest average occupancy rates are located in the Twin Cities Metropolitan Area.

[15] Litvak, E., & Bisognano, M. (2011). More Patients, Less Payment: Increasing Hospital Efficiency in the Aftermath of Health Reform. *Health Affairs*, 30(1), 76-80.

[16] Minnesota Department of Health analysis of hospital administrative data from PrairieCare and the Minnesota Hospital Association. These data are at the hospital stay level based on when a patient is discharged and therefore may undercount hospitalizations at the end of the year.

FIGURE 3: BED CAPACITY CONSTRAINTS IN PSYCHIATRIC UNITS FOR CHILREN & ADOLESCENTS, BY MONTH (2015)



Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare. 'At or near full capacity' is greater than or equal to 90 percent occupied. Occupancy rates was calculated as number of patients with primary psychiatric diagnosis in the hospital each day divided by number of pediatric psychiatric beds in the hospital. The data does not permit identifying when a specific discharge overlapped with an admission, nor if a patient occupied a bed on a psychiatric unit or in general medicine. As such, these estimates should be viewed as *overestimates* of capacity constraints.

In the fall of 2015, an additional 20 beds were added to overall capacity when PrairieCare moved to their new facility; the increase in capacity may be related to lower occupancy in the latter part of 2015.

Oftentimes, bed capacity constraints are evaluated with data from Minnesota's mental health service locator website, operated by the Minnesota Hospital Association.[17] For the purpose of assessing the *availability* of staffed beds in the system, the site provides important evidence. For example, for more than half of the days during a given month in late 2015 and early 2016, there were zero mental health beds available for children and adolescents—particularly in the Twin Cities Metropolitan Area.

In contrast, the information from the site as currently recorded adds little firm evidence for assessing the need for additional *physical bed capacity* in the state. From multiple investigations and anecdotal evidence we know that the lack of available beds can be driven by factors that would not be affected by the addition of new beds, including:

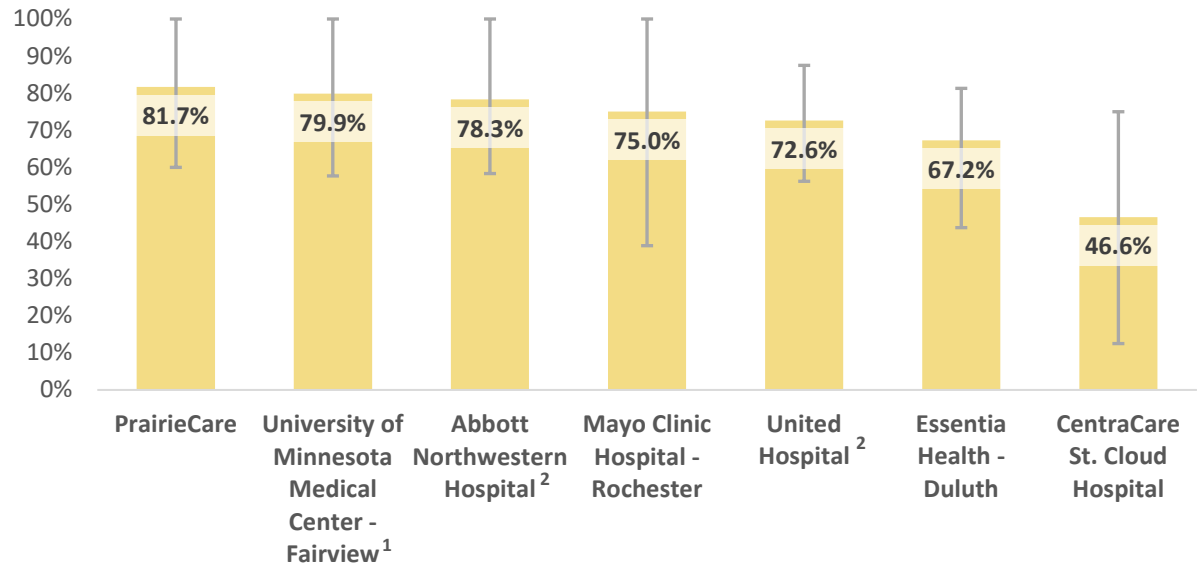
- Business decisions to operate available beds at certain levels of capacity;
- Workforce shortage of specialty staff that prevent operating beds;

[17] The mental health service locator site was designed by the Minnesota Department of Human Services and the Minnesota Hospital Association, and is found here: https://www.mnmhaccess.com/. PrairieCare notes in application materials that information on there are concerns regarding the complete accuracy of self-reported bed availability data due to acuity, staffing, or transportation issues.

- Lack of community services that prevent the discharge of patients to more appropriate step-down services.

In addition, lack of existing bed capacity in one area of the state may contribute to capacity constraints elsewhere, as has been shown in the past.[18] Although there are a number of reasons why patients seek care away from their home region, including proximity to family and place of employment, preference for a particular health care provider, location at which a crisis occurred, travel patterns for patients who need psychiatric care speaks, to some extent, to bottlenecks for inpatient care in the area served by PrairieCare's Brooklyn Park facility.

FIGURE 4: AVERAGE DAILY OCCUPANCY RATE FOR INPATIENT PEDIATRIC PSYCHIATRIC UNITS AT PRAIRIECARE AND OTHER MINNESOTA COMMUNITY HOSPITALS, 2015



Gray bars represent the daily occupancy for the highest (90th percentile) and lowest (10th percentile) in each hospital during the year.
Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare. Occupancy rates was calculated as number of patients with primary psychiatric diagnosis in the hospital each day divided by number of pediatric psychiatric beds in the hospital. The data cannot determine if a patient was in a bed on a psychiatric unit.

[1] University of Minnesota Medical Center – Fairview has noted an average daily occupancy of 48.2 percent in 2015 for their pediatric psychiatric unit.

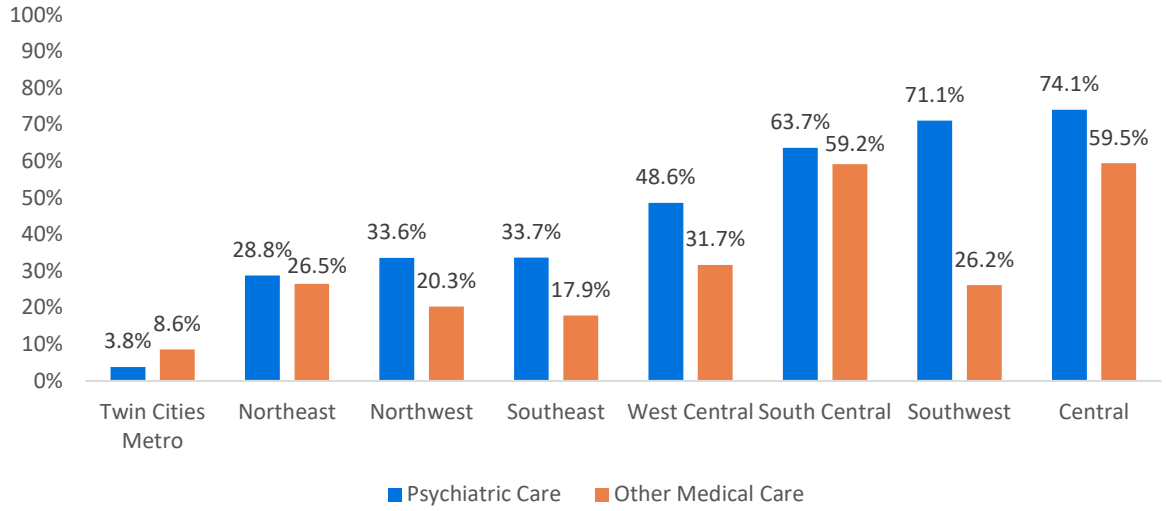
[2] Allina Health has noted that in 2015 the pediatric psychiatric unit daily occupancy rate was 79.3 percent at Abbot Northwestern Hospital and 80.3 percent at United Hospital.

[18] See for example: Minnesota Department of Health, Health Economics Program, "Minnesota Hospital Public Interest Review: Proposal for a Specialty Psychiatric Hospital in Woodbury, Minnesota," Report to the Legislature, February 2008

To understand the volume of travel for needed care, we analyzed hospital to identify when a patient leaves their home region for purpose of seeking inpatient health care services for psychiatric care. As patients near the border of one region may be nearer to facilities outside their region of residents, this analysis can only serve as a proxy for volume of travel. We found that, on average, one in five (22.7 percent) pediatric patients traveled outside their region of residence for inpatient care in a pediatric psychiatric unit in 2015.[19] This is roughly twice the extent of travel compared with other types of inpatient care.

Rates of travel was particularly high for patients outside of the metro area, as shown in Figure 5. More than half (53.9 percent) of pediatric patients who resided outside of the Twin Cities Metropolitan area traveled outside of their region for care in 2015. Most of these nearly 1,800 admissions (59.7 percent) where home in Central and Southwest Minnesota, the two regions with the greatest rate of travel for psychiatric inpatient care for children and adolescents (74.1 and 71.1, respectively).

FIGURE 5: PERCENT OF MINNESOTA PEDIATRIC PATIENTS RECEIVING HOSPITAL CARE OUTSIDE OF THEIR OWN REGION, 2015



Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare; includes Minnesota patients under the age of 18 for Minnesota, Iowa, North Dakota, and South Dakota hospitals. 'Other medical care' does not include normal newborns (3M APR-DRG 640). Includes 7,446 psychiatric care discharges as 37,003 discharges for other medical care.

[19] These figures are based on data from Minnesota residents at Minnesota, Iowa, North Dakota, and South Dakota hospitals. The region of residence is defined by the State Community Health Services Advisory Committee (SCHSAC) regions found here: http://www.health.state.mn.us/divs/opi/gov/maps/docs/schsac.pdf. See also Appendix B for a map of the Minnesota regions.

TABLE 3: NUMBER OF ADMISSIONS FOR CHILDREN AND ADOLESCENTS WHO TRAVEL TO THE TWIN CITIES AREA FOR PSYCHIATRIC CARE (2015)

Area	*Number of Admissions*
Central	652
Northeast	97
Northwest	10
South Central	103
Southeast	217
Southwest	23
West Central	22
All areas	**1,124**

Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare; includes Minnesota patients under the age of 18 for Minnesota, Iowa, North Dakota, and South Dakota hospitals

In the Twin Cities, where much of the state's inpatient bed capacity is located, the rate of travel was minimal, by comparison. Only 3.8 percent of all psychiatric admissions for children and adolescents, or 174 individual events, took place outside Twin Cities.[20] Yet, the admissions of pediatric patients in the Twin Cities from outside the metro, but particularly Central or Southwest Minnesota, contributes to bottlenecks (Table 3). Family members of these patients, even if they are at relatively near proximity to the Twin Cities area, likely experience greater burden in being part of the care solution than if these services were available closer to them.

Finally, there were 952 stays, comprising a total of 4,430 patient days, in which pediatric patients were hospitalized primarily for psychiatric diagnoses outside of specialized pediatric psychiatric units. This accounted for 12.5 percent of total stays at Minnesota hospitals. For these stays, patients were admitted mainly for mood disorders, suicide and intentional self-injury and miscellaneous mental health disorders. While we cannot infer from available data to what extent these patients would have been better served in dedicated psychiatric settings (with medical services available in the facility) and how often these admissions occurred because of lack of psychiatric beds for children or adolescents, it is clear from comments that "boarding" in medical units is a practice that concerns many providers

In conclusion, the data presented above provides evidence that, at certain times during the year, there are inpatient capacity constraints for pediatric psychiatric patients that express themselves in the need to travel, in high occupancy rates and, to some extent, in boarding of patients on medical units. As most patients who require immediate inpatient psychiatric care are experiencing a crisis, having inpatient hospital beds available in a timely manner is important to a functioning mental health system.

Of particular concern are the high rates of travel for psychiatric inpatient care for children and adolescents outside the metro area. While creating inpatient capacity in the Twin Cities may be of value, these additional resources for certain patients across Minnesota will come with the requirement for lengthy travel.

[20] Although this analysis included data on Minnesota residents at hospitals in bordering states, it does not include data from Wisconsin hospitals. This may underestimate the number of patients leaving the state to receive inpatient psychiatric care.

As noted, what these data are not able to show are to what extent factors other than the existence of inpatient beds contribute to observed bottlenecks. For hospitals with both medical and psychiatric units, occupancy rates may be overstated; however, this does not negate the fact that patients are traveling for care.

The issue of travel for patients in greater Minnesota is quite concerning, as it restricts capacity for patients in the Twin Cities to receive care where they live and causes patients across the state to receive care outside of specialized units. Regardless of whether adding new inpatient beds immediately is in the public interest, the Legislature may want to consider increasing capacity in greater Minnesota, especially in Central, Southwest, and South Central Minnesota.

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

The hospital expansion at the PrairieCare Brooklyn Park facility could draw patients that would otherwise go to another hospital to receive pediatric inpatient psychiatric care. The financial impact of this change, which we review in this section, depends on the volume of the potential loss of patients and their composition.

Figure 6 shows that in 2015 pediatric inpatient psychiatric care is estimated to have accounted for a small share of net patient revenue across hospitals with pediatric psychiatric units (between 1.7 and 0.1 percent). While this might suggest a negligible impact, the two hospitals that, because of the proximity to the Brooklyn Park facility, might be most directly affected –the University of Minnesota Medical Center and United Hospital – derive higher amounts of revenue from their pediatric inpatient psychiatric services; they are also located in the Twin Cities region and are most likely to share a common patient population with the expansion facility.

To determine the financial impact on other hospitals, we also assessed to what extent the new bed capacity might disproportionately draw patients with certain types of insurance coverage to PrairieCare. Patients enrolled in public health insurance programs generate lower margins than commercially insured patients do.

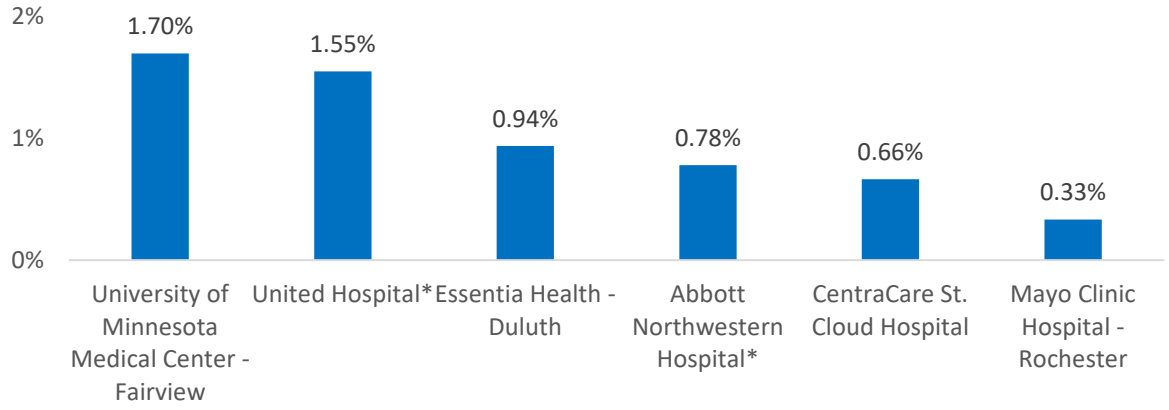
Figure 6 illustrates that there is relatively little variation in payer distribution among hospitals with pediatric psychiatric units. Patients covered by Medicaid ranged from 35.7 percent of patients at PrairieCare to 49.2 percent of patients at United Hospital in Saint Paul.

Given the narrowness of the expansion,[21] the small share of hospital revenue associated with pediatric psychiatric inpatient care, the relatively small difference in payer distribution among

[21] The additional beds represent a small share of the overall capacity for inpatient psychiatric care for children or adolescents in the state or the Twin Cities area (21/184 and 21/142, respectively).

hospitals and the lack of concerns raised by other facilities in MDH's request for input, we believe it is unlikely that the additional beds will substantially impact other hospitals financially.

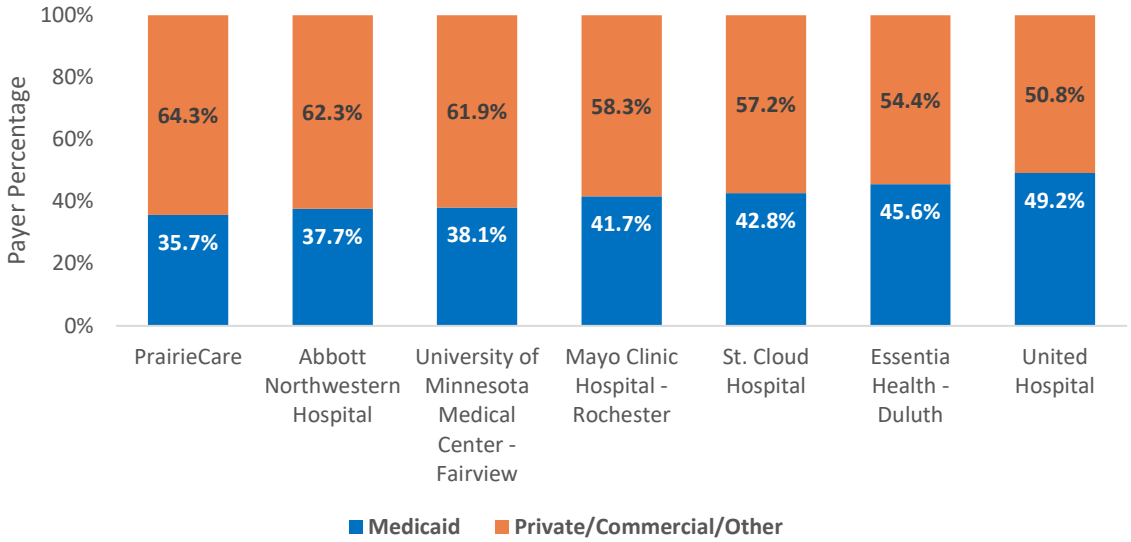
FIGURE 6: PEDIATRIC INPATIENT PSYCHIATRIC CARE AS A PERCENT OF HOSPITAL NET PATIENT REVENUE, 2015



Source: MDH analysis of the Hospital Annual Report and hospital administrative data from the Minnesota Hospital Association and PrairieCare. Net patient revenue is based on total 2015 charges were taking from hospital administrative data, and then adjusted by a cost-to-charge ratio calculated for each hospital from the Hospital Annual Report.

*Allina Health has noted that in 2015 the net hospital patient revenue from inpatient pediatric psychiatric care was 1.23 percent at Abbot Northwestern Hospital and 1.09 percent at United Hospital.

FIGURE 7: PERCENT OF PEDIATRIC PSYCHIATRIC HOSPITAL ADMISSIONS BY PAYER TYPE, 2015



Source: MDH analysis of hospital administrative data from the Minnesota Hospital Association and PrairieCare, based on expected payer and adjusted by a cost-to-charge ratio to reflect cost.

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

Governor Dayton's Task Force on Mental Health, convened from July to November 2016, identified mental health workforce concerns as a significant challenge to an effective mental health system in Minnesota, including:

- There are severe shortages of psychiatrists in most parts of the state, and particularly so for child psychiatrists;
- About half of the state's practicing psychiatrists are over 55 and likely to retire in the coming decades, thereby exacerbating staffing challenges.

Greater Minnesota in particular is experiencing shortages of mental health professionals across the spectrum of licensure. According to a 2016 report, only 9.2 percent of psychologists in Minnesota work in hospitals, and the vast majority of them practice in the Twin Cities Metro Area (72 percent).[22] In the Twin Cities, there is one psychologist to every 1,257 people, but in rural or isolated areas that number increased to one psychologist to every 10,662 people.[23] In a 2012-2013 report, only 10.4 percent of licensed social workers reported a hospital as their primary working location; the majority of social workers also practiced in the Twin Cities.

Because of the existing workforce constraints, it is critical to understand how new bed capacity may impact the ability elsewhere in the delivery system to attract and retain qualified staff to treat children and adolescents with psychiatric conditions.

In its proposal, PrairieCare estimates that the hospital bed expansion will require two full-time equivalent (FTE) child and adolescent psychiatrists, 10 FTE registered nurses, two FTE masters-level psychotherapists, and two bachelors-level social workers. PrairieCare also notes that they are expecting to develop the mental health workforce at their current facility through a number of strategies, which could address the potential impact on other hospitals. According to PrairieCare, the Brooklyn Park hospital generally recruits personnel from outside of the state and has already attracted out-of-state doctors to work at the facility.

For the expansion, PrairieCare expects to recruit new hires from its training program for new child and adolescent psychiatrists that it implements under affiliation agreement with the University of Minnesota Medical School. Additionally, PrairieCare serves as a training site for family medicine residents, medical students, post-doctoral psychology interns, social workers and nurses.

[22] Minnesota Department of Health. (2016). *Minnesota's Psychology Workforce, 2016*. Retrieved January 29, 2017 from: http://www.health.state.mn.us/divs/orhpc/workforce/mh/2016psy.pdf

[23] Ibid. Minnesota Department of Health. (2016).

There is little empirical information with which to assess the impact of the proposed expansion on staffing elsewhere in the state. However, three factors suggest a limited, to small impact:

1. The number of added beds under the proposal is small relative to the available capacity. Consistently, the potentially affected workforce would be small relative to staff currently working on supporting the treatment of psychiatric care for children and adolescents. Even if shifts in workforce were to occur because of this facility, it would likely not be larger than natural turnover.
2. PrairieCare's workforce strategy to recruit staff from outside the state or among recent graduates, while not systematically evaluated, should limit any resulting impact on other facilities.
3. Lastly, other hospitals did not raise any concerns regarding staff retention in response to MDH's request for feedback on its review.

Factor 4: The extent to which the new hospital beds will provide services to nonpaying or low-income patients

PrairieCare's facility in Brooklyn Park differs from other hospitals in its obligation to serve nonpaying or low-income patients in three key ways:

- Because the facility lacks an emergency department, it would less routinely be required to stabilize patients consistent with federal requirements to provide emergency stabilizing treatment regardless of patients' ability to pay.[24]
- As a for-profit facility, the hospital does not face the same obligation under state and federal tax laws to offer free and discounted care or community benefit.
- PrairieCare is not a current signatory to the voluntary agreement between hospitals and the Minnesota Attorney General that commits them to offering discounts to the uninsured.

That said, in its proposal PrairieCare commits to extending the same charity care policies and discounts to uninsured or underinsured patients in new beds as it offers to other patients. While not a signatory to the agreement with the attorney general, PrairieCare voluntarily follows the requirements of the agreement in its policies.[25] Like many hospitals, PrairieCare's charity care is based on a sliding scale, providing discounted or no-cost care for certain patients and their families. For example, uninsured patients with family income up to 60 percent above the federal poverty guidelines ($39,360 for a family of four in 2017) are eligible to receive free care. PrairieCare provides sliding scale discounts for patients with incomes up to 400 percent of the Federal Poverty Guidelines (FPG) ($98,400 for a family of four in 2017).

[24] However, under the Emergency Medical Treatment and Labor Act (EMTALA) and associated regulations, PrairieCare, as a specialty hospital, is required to stabilize and treat patients referred to the facility from emergency rooms regardless of insurance status and ability to pay.

[25] Personal telephone communication from PrairieCare to Minnesota Department of Health.

As shown in Table 4, there are some differences among hospitals in the eligibility criteria for charity care. There are also differences among facilities in how patients are informed of the availability of charity care and whether the hospital, as in the case of PrairieCare, makes social workers available to help patients complete their applications.

TABLE 4: HOSPITAL CHARITY CARE INCOME LIMITS, 2017

Hospital	Full Discount	Upper Income Limit
Allina Health	275% FPG	275% FPG
Essentia Health	160% FPG	310% FPG
CentraCare Health	175% FPG	250% FPG
Fairview Health Services	275% FPG	275% FPG
Mayo Clinic	200% FPG	400% FPG
PrairieCare	160% FPG	400% FPG

'FPG' is federal poverty guidelines. Allina's full discount for uninsured can vary, and has an upper limit for annual income of $125,000. Fairview's discount only applies to self-pay balance.

In aggregate, PrairieCare reported in 2015 it provided $478,545 in uncompensated care to patients at its Brooklyn Park and Maple Grove hospitals.[26] As a percent of operating expenses, PrairieCare's hospital uncompensated care ranks above that of Abbott Northwestern and Fairview University Medical Center and below the other four facilities studied for this review (Table 5).[27]

TABLE 5: HOSPITAL UNCOMPENSATED CARE AS A PERCENTAGE OF TOTAL OPERATING EXPENSES, 2015

Hospital	Charity Care	Bad Debt	Total Uncompensated Care
Mayo Clinic Hospital – Rochester	0.78%	0.72%	1.50%
Essentia Health – Duluth	0.61%	2.31%	2.91%
United Hospital	0.47%	0.79%	1.26%
St. Cloud Hospital	0.47%	0.45%	0.92%
PrairieCare	0.46%	1.44%	1.90%
Abbott Northwestern Hospital	0.27%	0.56%	0.83%
University of Minnesota Medical Center – Fairview	0.19%	0.35%	0.54%
All Minnesota Hospitals	**0.63%**	**0.99%**	**1.61%**

Source: MDH analysis of Hospital Annual Report data and information provided by PrairieCare. Dollars are adjusted by a cost-to-charge ratio.

[26] Uncompensated care is a combination of charity care – services which were provided but for which no payment was expected – and bad debt – care for which payment was expected but no received. For more recent information on hospital uncompensated care in 2015 visit the following link: http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/HospitalUncompensatedCare15ig.pdf

[27] The financial figures shown in Table 4 for PrairieCare include both hospital facilities in Maple Grove and Brooklyn Park during calendar year 2015, and include all units of other respective hospitals (not just inpatient pediatric psychiatric units).

In aggregate, it seems that PrairieCare's approach to providing services to non-paying or low-income individuals based on patients admitted for care is largely consistent with practices at other facilities. In some areas, PrairieCare's policies appear more generous, in others, other hospitals likely provide greater support to needy patients.

Factor 5: The views of affected parties

As part of the public interest review, MDH solicited the views of affected parties by requesting comments in a letter sent all administrators of Minnesota hospitals that offer psychiatric care and placing a notice in the State Register inviting feedback. We received 10 responses from hospitals, professional medical associations, health care providers and individuals.[28] Generally, all responses were supportive of PrairieCare's plans to expand bed capacity. A few of the comments raised considerations policymakers may wish to consider when making their decision.

Responses in support of PrairieCare's bed expansion suggested the proposal was in the public interest because of:

- The sense of inadequate and uneven supply of inpatient psychiatric beds in Minnesota;
- The extent to which patients have to endure wait times in emergency rooms before being admitted to an inpatient psychiatric facility; and
- Broad challenges to providing appropriate and timely mental health care.

The concerns raised in public comments fell into the following themes:

- The conversion from single- to double-occupancy rooms could result in lower patient satisfaction and compromised opportunity for parents and other family members to engage in the direct hospital treatment of children and adolescents;
- The most significant unmet need is for adolescents, especially those *not* covered by commercial insurance, and it is not clear the proposal best addresses this need; and
- The focus only on inpatient beds misses important needs for improvements in care coordination and transition to community-based services.

Additional Considerations

The public interest review law specifies that MDH must consider any factors relevant to a proposal in its assessment and not limit itself to those specified in statute. In the course of reviewing materials and speaking with Minnesota experts, we considered the following additional factors in our analysis of PrairieCare's proposed bed expansion:

[28] In addition, PrairieCare's proposal included letters of support from two community members and stakeholders.

- **The expected impact on patient experience:** If there is a need for new hospital beds, how does this specific proposal meet the needs of the patients that the hospital expects to serve?
- **Changes in the mental health environment**: How might new developments in the Minnesota mental health system affect whether the proposal is in the public interest?
- **Existing commitments to providing inpatient psychiatric care**: Would the need for the proposal change if commitments from another hospital in the area were to expand the number of inpatient psychiatric beds?

The Expected Impact on Patient Experience

By converting a number of single-occupancy rooms to double occupancy, PrairieCare's proposal has the potential to change patient and caregiver experience while receiving hospital psychiatric care.

Providing inpatient psychiatric care to more than one pediatric patient per room appears to be relatively common practice at the Minnesota hospitals that provide these services in the state.[29] Although operating multi-bed psychiatric rooms is common practice in other hospitals in Minnesota—five out of the six community hospitals offer single-occupancy rooms on rare occasions based on the determination of clinical staff or when logistical challenges are present—it is worth noting that there are potential challenges associated with this practice:

- Most *new* inpatient hospital beds are in single-occupancy rooms,[30] primarily to preserve privacy, keep patient satisfaction high,[31] and potentially reduce the risk of hospital-acquired infections.[32]
- Recent trends in pediatric inpatient care have emphasized the benefit of single-occupancy rooms to allow for more family involvement.
- There is concern that double-occupancy rooms can result in capacity constraints or the need to shift patients throughout a stay related to the need to separate patients by sex.
- Finally, anecdotal clinical evidence indicates that not all children and adolescents are suited to double occupancy. Particularly patients in crisis with aggressive, violent behaviors may exacerbate the mental health strain of others.

[29] For the purpose of this review, MDH contacted all facilities with dedicated psychiatric beds for children and adolescents and determined all but the Mayo facility operate double-occupancy rooms in their units.

[30] Facilities Guidelines Institute and The AIA Academy of Architecture for Heath Guidelines for Design and Construction of Health Care Facilities, Washington, DC: The American Institute of Architects Academy of Architecture for Health, 2006.

[31] Boardman, A., & Diane, F. (2011). A Benefit-Cost Analysis of Private and Semi-Private Hospital Rooms. *Journal of Benefit-Cost Analysis*, *2*(1), 1-27.

[32] van de Glind, I., de Roode, S., & Goossensen, A. (2007). Do Patients in Hospitals Benefit from Single Rooms? A Literature Review. *Health Policy*, 84(2), 153-161.

On the other hand, double-occupancy rooms are thought to reduce the social isolation that children and adolescents often face when hospitalized.[33,34]

PrairieCare has a written policy in place that includes assessment protocols to help determine appropriate placement of patients into double-occupancy rooms.[35] At this point, the policy does not include an option for family members to opt out of staff recommendations for double occupancy.

In the proposal, PrairieCare notes that it has prior experience with converting single-occupancy rooms to double occupancy, resulting from a temporary waiver it received from MDH in the latter half of 2013 for the Maple Grove site. As required, PrairieCare tracked several indicators, including staff reporting of adverse occurrences,[36] hospital-acquired infections, inappropriate interactions between roommates, and seclusion/restraint minutes. PrairieCare submitted a status report in July 2014 in which it concluded there were no meaningful differences between single- and double-occupancy rooms.

Although the analysis showed some elevated adverse occurrences after double-occupancy rooms was implemented, PrairieCare suggested that the difference in outcomes from this change were largely inconclusive.[37] There is no independent data on the experiences of patients and their families in double-occupancy rooms or analysis comparing experiences of patients in different settings.

In conclusion, it seems important to monitor the impact of double-occupancy rooms on health outcomes and patient/family caregiver experience. Giving families a role in the decision-making process appears equally important. However, these considerations apply to all facilities operating double-occupancy rooms for children and adolescents with mental health needs.

Changes in the Mental Health Environment

Short-term acute hospitalizations for mental illness are only one part of the continuum of care that spans from early diagnosis to timely treatment to availability of social supportive services. In addition, some hospitalizations are likely evidence of breaks in the system to effectively and

[33] Ibid, van de Glind et al (2007).

[34] Miller, N. O., Friedman, S. B., & Coupey, S. M. (1998). Adolescent Preferences for Rooming During Hospitalization. *Journal of Adolescent Health*, 23(2), 89-93.

[35] PrairieCare October 14, 2016 letter to the Minnesota Department of Health.

[36] PrairieCare defines the term 'occurrence' as "any happening or alleged happening not consistent with the routine care and/or operation of the facility; an unexpected or undesirable event that may have caused harm or had the potential to cause harm."

[37] PrairieCare October 14, 2016 letter to the Minnesota Department of Health.

timely care for children with mental health services needs. Therefore, it is important to consider the proposed expansion in light of developments along the spectrum that might reduce the need for hospitalizations.

Among the most far-reaching developments in the mental health capacity space is the current implementation of Psychiatric Residential Treatment Facilities (PFTFs) by the Minnesota Department of Human Services (DHS). These facilities, which are intended to provide intensive inpatient services[38] to children and adolescents under age 21 with complex mental health conditions, are expected to be available in two stages: 50 beds are expected to come online in the summer of 2017, with another 100 beds by 2018.

These PRTF beds are expected to be distributed across the state, but exact locations are not available at this time. PRTFs offer similar services as hospital inpatient psychiatric care facilities except for two main differences: 1) admissions are non-acute (PRTF patients have a planned admission and/or are not in a state of crisis); and 2) patients are expected to have longer stays (e.g., two to three months at a PRTF instead of one to two weeks stays at a hospital).

The Governor's Task Force on Mental Health, which had strongly supported the creation of PRTFs, also recommended developing an urgent care for mental health model for children and adolescents experiencing a mental health crisis. Such model of care would include crisis response and urgent access to psychiatry and medication and offer the possibilty for reducing the need for hospitalizations in crisis.[39] To date, there is limited experience in Minnesota with urgent care for mental health services, and its potential impact on health care use by children and adolescents is not well understood.

While both models hold promise to reduce the need for hospitalization—either by preventing a crisis or intervening in a timely, intentional fashion at a point of crisis, or acting as resources that could shorten the need for longer hospitalizations[40] -- there is currently too little experience with either model in Minnesota to predict a tangible impact on needed hospital capacity.

Existing Commitments to Providing Inpatient Psychiatric Care

The Minnesota Legislature required that Maple Grove Hospital, jointly owned and operated by North Memorial Health Care and Fairview Health Services, provide inpatient psychiatric services as a condition of granting the moratorium exception in 2005.[41] Currently, the hospital does not

[38] Centers for Medicare & Medicaid Services website Psychiatric Residential Treatment Facility Providers, What is a PRTF? https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/WhatisaPRTF.pdf accessed online on January 27, 2017.

[39] For more information on the urgent care model for mental health see page 58 of the Governor's Taskforce on Mental Health Final Report here: https://mn.gov/dhs/assets/mental-health-task-force-report-2016_tcm1053-263148.pdf

[40] "Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot." St. Paul: Wilder foundation, July 2016, 1.

[41] Minnesota Statutes, Section 144.551 subd. 2 (b)(20)(iv)(C)

operate dedicated inpatient psychiatric care beds. However, it does offer a range of behavioral health services and has admitted patients with behavioral medical needs. In correspondence with MDH staff in 2012, hospital leadership suggested that, at the time, their facility saw too few patients with behavioral health needs in their emergency department to justify establishing psychiatric bed and staffing capacity at its site.

In a letter of support for PrairieCare's proposal in 2016, leadership at Maple Grove Hospital observed that there was a need to address the perceived shortage of psychiatric beds in the state and the resulting practice of boarding patients in crisis for multiple days on medical units needs to be addressed. While Maple Grove Hospital has no immediate plans to establish dedicated psychiatric inpatient beds at its site, the hospital is currently conducting a strategic planning process. Adding psychiatric beds at the Maple Grove Hospital, thereby complying with the requirement in law establishing the moratorium exception, could somewhat change the currently observed need for hospital beds in the surrounding community.

Section 5: Discussion and Findings

Since 2004, the Minnesota Legislature has sought input and analysis from MDH when considering whether an expansion of inpatient hospital beds is in the public interest. As part of this task, the Department must consider the factors listed in Section 1 of this report. This particular review was also informed by a range of discussions in the state about the need to make improvements to our mental health care system. Our review also overlaps with several coordinated and comprehensive efforts to refine the system for providing mental health patients with care and support at the right place and right time:

- In 2015, the Minnesota Legislature invested more than $50 million in new funding to address multiple aspects of the mental health care system, with a particular emphasis on community-based services.
- In 2016, the Minnesota Department of Human Services began implementing behavioral health homes for Medicaid beneficiaries and developing community behavioral health clinic certification.
- The Minnesota Department of Health is administering a federal grant to better coordinate care across health care, mental health, social services and ancillary care.

In some ways, the 2016 Governor Dayton's Task Force on Mental Health[42] that recommended an initial roadmap toward system improvements is a synthesis of years of discussions on capacity needs for mental health services. The Task Force viewed inpatient or acute psychiatric care as an important part of the mental health continuum of care. But in its report, it described the current bottleneck of inpatient beds for psychiatric care as a 'patient flow' problem, as much as an access problem.[43]

The report emphasized that bottlenecks associated with inpatient psychiatric care are not just a problem of too few hospital beds, but often the result of inadequate infrastructure of community-based services and recovery support. For example, the lack of proper crisis response often results in hospitalization. Conversely, patients who are ready to be discharged may lack access to supportive services for continued recovery, often resulting in extended hospital stays.

[42] For more information on the Governor's Taskforce on Mental Health Final Report please visit the following website: https://mn.gov/dhs/mental-health-tf/

[43] Minnesota Department of Human Services. (2016). Governor's Taskforce on Mental Health Final Report; page 45.

MDH's findings concerning the proposed expansion of hospital beds at PrairieCare's facility in Brooklyn Park, which represents a narrow slice of the larger mental health delivery system, are as follows:

1. While in aggregate capacity seems to be sufficient, there is evidence that the current supply of pediatric psychiatric inpatient hospital beds in Minnesota appears to be associated with capacity constraints for certain hospitals providing these services. These constraints seem to be concentrated at certain times of the year.

    - There were at least 63 days where there was limited to no capacity in pediatric psychiatric inpatient units, as measured by rates of occupancy.
    - Some capacity issues are related to patients from regions with great capacity concerns (especially Central and Southwest Minnesota) traveling to the Twin Cities for hospitalization (17 percent of bed days are from patient in these areas).
    - This contributes to a lack of available beds for patients in the Twin Cities area, (pediatric patients left the region for inpatient care 174 times in 2015).
    - The capacity issues likely contributed to the 13 percent of pediatric psychiatric hospitalizations taking place outside of specialized pediatric psychiatric units.

2. The financial impact on other hospitals and health care costs, more generally, is expected to be modest for three reasons:

    - The proposed expansion of hospital beds is small relative to overall bed capacity;
    - Revenue from psychiatric services accounts for a small share of total patient revenue (0.1 percent to 1.7 percent); and
    - The expansion requires limited capital investments, because the expansion is accomplished by transitioning some single-occupancy rooms to double-occupancy status.

3. The hospital bed expansion is expected to serve low-income children and adolescents, albeit possibly at slightly lower levels than other hospitals. In addition, the policies in place for free and discounted care are largely comparable to policies used by other hospitals.

4. The use of double-occupancy beds in pediatric psychiatric inpatient settings is common in Minnesota, and does not appear to have documented negative impacts on overall patient experience. However, systematic data to evaluate this is currently not available in Minnesota.

5. Despite ongoing innovations to the mental health care environment in the state, it is not clear that they will be able to free up bed capacity bottlenecks in the immediate future.

FINDING:

For the reasons listed above, the Minnesota Department of Health finds that **PrairieCare's 2016 proposal to expand hospital beds at its Brooklyn Park facility from 50 to 71 beds, by transitioning 21 rooms to double-occupancy capability, is in the public interest**.

However, in its deliberations about whether and under what conditions to grant an exception to the moratorium, the Legislature may wish to consider whether patients and family caregivers could benefit from clearly and publicly articulated policies that 1) define criteria for determining when patients are eligible for double-occupancy inpatient care; and 2) provide a mechanism for opting out of double-occupancy care. It may also be of value to continue monitoring adverse occurrences, as was done by PrairieCare in 2013.

CONCLUDING COMMENTS:

This marks the fourth time MDH has reviewed a proposal to expand psychiatric hospital bed capacity since 2004 when Minnesota law began requiring a public interest review. While most proposals—only some of which MDH found to be in the public interest—differed from each other in a number of ways, we did encounter two consistent challenges:

- Each proposal addressed the question of perceived inpatient bed capacity constraints for psychiatric services not from a system perspective, but by narrowly aiming at a target population, a geographic area, or a single component of inpatient health care needs.
- For most proposals, there was limited empirical information available to unequivocally assess which aspects of system constraints—workforce, early identification and treatment, availability of support services, accessibility of community resources, or alignment of the type of services with patient needs—were the primary factors for bottlenecks in care delivery.

These challenges limit us to viewing questions of mental health capacity largely on an ad hoc basis and through the narrow lens of specific proposals that offer short-term remedies to a set of complex problems. This may have resulted in capacity building in places with business opportunities rather than where the greatest suffering for mental health patients and their families is experienced or in ways that aren't likely to create flexibility to address long-term needs.

When weighing future proposals to expand inpatient mental health capacity, the Legislature may wish to systematically consider the broader context of mental illness, socio-demographic and economic factors, social support needs and strategies for prevention or early diagnosis. The 2016 Governor's Task Force on Mental Health reached a similar conclusion when it expressed frustration over the limited information available to inform mental health capacity decisions in a systemic, intentional way.

The following information would help with pursuing an intentional approach toward developing an effective mental health delivery system and estimating the costs associated with break points in the system:

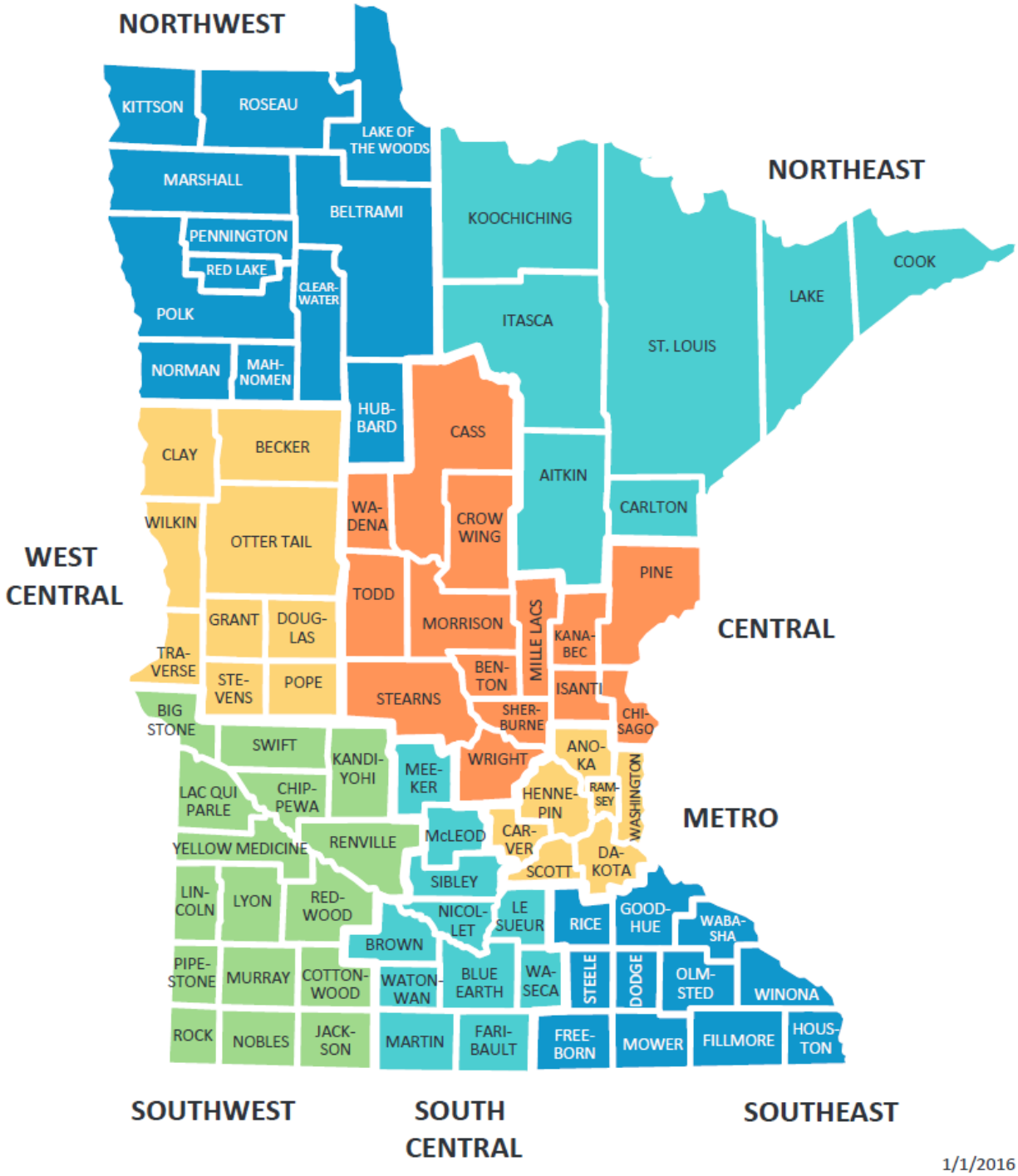
- An assessment of hospital stays for patients with a mental health diagnosis to determine if the stay could have been prevented with high-quality, timely health care and the stay shortened with appropriate community resources.
- Daily information on factors that are responsible for not making available hospital beds dedicated for psychiatric services to patients.
- Detail on the life-cycle of mental health patients' needs and their interactions with health care and community support services.
- Data on the prevalence and type of mental illness across Minnesota and associated services use.
- Evidence on the admission of patients during a stay in medical and psychiatric beds, and factors that contribute to the choice of service use.
- Volume of travel for patients in the process of seeking inpatient health care services by family care givers and ambulances.

Appendix A: Data Sources used in this Report

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

- Hospital Annual Report:
    - *Available beds*: All hospitals in Minnesota file annual reports to the Minnesota Department of Health for the number of 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. Data used in this report includes the following source:
    - Section 53: Available Beds in Dedicated Specialty Units.
    - *Charity care, bad debt, and other hospital financial information:* Acute care hospitals in Minnesota file annual financial reports to the Department 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 & Uncollectibles
        - Section 21: Community Benefit Summary
- **Minnesota Hospital Association (MHA) Hospital Discharge Data**: MHA 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 stays, or discharges at short-term, non-Federal, non-State, and non-specialty, general acute care hospitals. Inpatient psychiatric hospital stays were identified using the following sources:
    - 3M All Payer Refined Diagnosis Related Groups (APR-DRGs),
    - Hospital billing codes developed by the National Uniform Billing Committee, and
    - The patient's principal diagnoses identified by Heslin KC, Elixhauser A, Steiner CA. Agency for Healthcare Research and Quality (2015). Hospitalizations Involving Mental and Substance Use Disorders Among Adults, 2012. HCUP Statistical Brief #191.
- **PrairieCare Hospital Discharge Data**: the Minnesota Department of Health obtained administrative billing records from PrairieCare for hospital stays. These data included similar data fields to the Minnesota Hospital Discharge Data, and stays were defined in a request from the Department dated September 28, 2016.

Appendix B: Minnesota State Community Health Services Advisory Committee Regions



Appendix C: Copies of Comments on the Proposal

January 3, 2017

Stefan Gildemeister
Division of Health Policy
Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882

Sent electronically to Stefan.gildemeister@state.mn.us

Dear Mr. Gildemeister:

On behalf of Allina Health, thank you for seeking community feedback on a request to expand services for psychiatric patients under the age of 21, as submitted by PrairieCare.

This year, I had the honor of serving on the Governor's Task Force on Mental Health, where we created a vision of high-quality, reliably accessible services across the spectrum of wellness to acute care. In service to the work of this Task Force, Allina Health encourages the Minnesota Department of Health (MDH) to use the recommendations of that task force as an evaluation lens for prioritizing and expanding services.

The Task Force recognized that the current capacity of the entire continuum of care is lacking, most notably with regard to intense community-based services. Therefore, highest priority for creating and sustaining a reliable continuum calls on the state to focus on building a community infrastructure necessary to adequately serve all our citizens.

While expansion of acute hospital beds may not fall into the category of community-based services, the Task Force did acknowledged the need for short-term services, including in-patient beds while the expansion of community-based services is under development. Within short-term services, the Task Force identified areas that warranted particular attention, including: improving care coordination and transition to community-based services, uneven access to inpatient care, and extremely limited options for families whose children need inpatient psychiatric hospitalization[1]. So long as PrairieCare can assure that these particular issues can be addressed, we would support their request to expand services.

Allina Health is not-for-profit network of hospitals, clinics, ambulance, hospice & home care, pharmacy and specialty care. Within mental health, we care for more than 100,000 patients through inpatient services in geriatric, adult and adolescent programs, outpatient services in ambulatory care, adult day treatment, and adolescent partial-hospital treatment. To your specific inquiry on occupancy: some of our sites do use double-occupancy rooms, when it is clinically appropriate. There are advantages with double-occupancy, however, we acknowledge that there are also challenges that can impact how many rooms can actually have two patients. While it does not occur frequently, our sites have experienced a need to close a unit at less than full occupancy if specific accommodations or needs cannot be met.

We appreciate the opportunity to provide feedback on this request. If you would like to discuss our comments in greater detail, please feel free to contact me.

Most sincerely,

Paul Goering, MD
Vice-President Mental Health Service Line
Allina Health

[1] https://mn.gov/dhs/assets/mental-health-task-force-report-2016_tcm1053-263148.pdf

Children's MINNESOTA

FOR THE MOST AMAZING PEOPLE ON EARTH.

January 10, 2017

Diane Rydrych
Director, Division of Health Policy
Minnesota Department of Health
PO Box #64882
St. Paul MN 55164-0882

Stefan.gildemeister@state.mn.us
sent via email to Stefan Gildemeister

Re: PrairieCare's proposal to expand beds/Brooklyn Park to serve psychiatric patients under age 21

Dear Ms Rydrych:

I am writing on behalf of Children's Minnesota in response to your letter dated December 16, 2016 concerning the above-referenced proposal.

Access to mental health services for pediatric patients in Minnesota is a significant problem. It is not unusual for Children's Minnesota to have patients who have been admitted to our hospitals waiting for more than a week for mental health inpatient placement due to a lack of available beds. It is a growing problem that will require additional facilities and services.

With respect to the proposal to convert single-occupancy rooms to double-occupancy rooms, our clinical leadership has provided the following input. While increasing access by doubling up existing patient rooms has the benefit of increasing access to mental health services, it erodes the efforts by children's hospitals nationally to recognize parents as vital members of the health care team. Children's hospitals nationally have removed parental visiting restrictions, engaged parents in daily medical rounds, created expectations for consistent care conferences with the hospital team and moved to single patient rooms on medical surgical floors and intensive care units, including neonatal intensive care units. These single bed rooms have been designed to include designated space for parents 24/7, including sleeping arrangements with the goal of parents as partners, comfortable and welcome in the hospital environment.

While PrairieCare's proposal does not provide the above described model, we believe the benefit in increased access for children in the community outweighs any negative impact of double occupancy rooms.

Thank you for the opportunity to provide comments on this proposal.

Sincerely,

Phillip M. Kibort, MD, MBA
Vice President Medical Affairs, Chief Medical Officer
phil.kibort@childrensmn.org
Tele # (612) 813-6165

Children's MINNESOTA

FOR THE MOST AMAZING PEOPLE ON EARTH.

September 9, 2016

Dr. Edward Ehlinger, Commissioner
Minnesota Department of Health
P.O. BOX 64975
St. Paul, MN 55164-0975

RE: PrairieCare's Proposal to Add 21 Beds to its Psychiatric Hospital for Children and Adolescents in Brooklyn Park

Dear Commissioner Ehlinger:

On behalf of Children's Hospitals and Clinics, I write in support of PrairieCare's proposal to add much needed capacity to the children's inpatient mental health system here in the Twin Cities by adding 21 beds to its current 50-bed facility in Brooklyn Park.

Each year thousands of children experience mental health emergencies. Many of these children wait hours or days in our emergency departments or on our pediatric units before they are able to access the few specialized units in the state able to provide the care they truly need. The added capacity provided by approving this proposal for 21 additional beds will have a real and meaningful impact on hundreds of children's lives each year.

Sincerely,

Phillip M. Kibort, MD, MBA
Vice President Medical Affairs
Chief Medical Officer

Cc: John Ryan, JD; 9400 Zane Ave N; Brooklyn Park, MN 55443

From: Jane Yank <janeyank@visi.com>
Date: September 12, 2016 at 5:45:54 PM CDT
To: <stefan.gildemeister@state.mn.us>
Subject: Prairie Care request to expand hospital beds

Dear Mr. Gildemeister,
I would like to express support for Prairie Care's request to expand its inpatient bed capacity for children and adolescents. I work for several hospital emergency departments. It is not unusual for an adolescent to spend four or more days in the emergency department while we are waiting for a bed to open. Sometimes we simply give up because keeping an adolescent in a small Emergency Department room without exercise or therapy (since we have no mental health services and no psychiatry associated with our hospitals) seems cruel and harmful.

In addition to the typically developing adolescent, we are seeing increased numbers of patients on the autistic spectrum that families cannot handle, particularly as they grow in size and strength. Hospital emergency departments without associated psychiatric services are often ill-equipped to serve the mental health needs of this group, particularly if the patient is non-verbal or has limited verbal abilities, and the patient's needs cause delays for other critical care patients.

For these reasons, I strongly support the request by Prairie Care to expand inpatient bed capacity. I am not associated with Prairie Care in any way; I make these remarks because I see the need for more services for children and adolescents in general and in particular for services targeted to a more acute population of children and adolescents.

Thank you very much for reading my remarks, and best wishes for success on the difficult work you do for our citizens in Minnesota.

Kind regards,
Jane Yank

From: Rislove, John
To: Gildemeister, Stefan (MDH)
Subject: adolescent bed expansion
Date: Friday, December 16, 2016 1:39:17 PM

Hi Mr. Gildemeister, My name is John Rislove and I am the Director of Behavioral Health at Winona Health in Winona, MN. We have a small 8 bed secure inpatient adult unit. Like most places we are full or on diversion much of the time. We would support the expansion of beds at PrairieCare for patients under 21 years of age. I'm sure the professionals thinking of this are diligently looking at double occupancy rooms from many angles which I think can be the challenge but I think it would be workable in a flexible system.

On your first bullet point on are new beds needed…..Yes! In Minnesota I was once told by a State of MN Medical Professional that on any given day we are short 60 beds for adults….If PrairieCare can take more 18-21 year olds this may help with the shortage of adult beds. Also we have at times a child we are managing in our ED or put on our Medical floor while waiting for a child/adolescent bed to open in the State.

Due to the distance that PrairieCare is from Winona I would see no negative impact on our hospital should this initiative move forward either financially or in loss of existing staff.

Lastly, as double-occupancy is not the idea it is significantly more beneficial to a child/adolescent to be in a treatment facility than sitting in an ED, on a Medical floor, or in a crisis type bed with a mobile response team. If the hospital is therapeutic and the patients are closely monitored this would have many more benefits to the child/adolescent and their caregivers.

Respectfully,

John Rislove
Winona Health Services
507-457-4112
jrislove@winonahealth.org

MAPLE GROVE HOSPITAL

November 14, 2016

Dr. Edward Ehlinger, Commissioner
Minnesota Department of Health
P.O. Box 64975
St. Paul, Minnesota 55164

RE: PrairieCare's Proposal to Add 21 Beds to its Psychiatric Hospital for Children and Adolescents in Brooklyn Park

Dear Commissioner Ehlinger:

I am writing to you on behalf of Maple Grove Hospital and our surrounding communities in support of PrairieCare's proposed 21 bed expansion of inpatient beds for children and adolescents. This proposal will increase their total number of beds from 50 to 71 at their Brooklyn Park facility.

This expansion will be a significant step towards addressing the shortage of psychiatric beds in the state and help treat those in psychiatric crisis that often end up boarding on medical units for days at a time or transferred far from home to receive care. Our state currently has inadequate capacity and a fragmented system for psychiatric care and PrairieCare's proposal will help address these shortcomings.

PrairieCare has established themselves as a premier psychiatric health system in the region offering a full continuum-of-care in psychiatry for all ages. They have continually demonstrated their ability to be a collaborative partner in the community, and are an ideal health system to be spearheading this expansion.

Thank you for your consideration.

Sincerely,

Andy Cochrane
Chief Executive Officer

A Partnership of North Memorial and Fairview

9875 Hospital Drive
Maple Grove, MN 55369

Phone: 763-581-1000
Fax: 763-581-1555
maplegrovehospital.org

MAYO CLINIC

200 First Street SW
Rochester, Minnesota 55905
507-284-2511
mayoclinic.org

September 19, 2016

Dr. Edward Ehlinger, Commissioner
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

Dear Dr. Ehlinger:

It has come to our attention that PrairieCare Hospital is seeking to increase the capacity of their inpatient child and adolescent psychiatric unit in Brooklyn Park by 21 inpatient beds. This letter is being written in support of PrairieCare's request.

Currently, due to the shortage of inpatient psychiatric beds for children and adolescents, patients may wait many days for an inpatient bed to open somewhere in the state of Minnesota. Children are frequently needing to be transported across the state, far away from their home community, and away from their families, which adversely affect the provision of care and the important involvement of families in the care of children with psychiatric symptoms. Increasing the number of beds in the state's most populous region will help to decrease this problem, not only in the Twin Cities area, but throughout the state, as it is very common for Twin Cities' patients to be transported to other hospitals throughout the state, adversely affecting the access to local beds when patients from the Twin Cities occupy beds in greater Minnesota.

Minnesota is facing a substantial shortage of the array of mental health services needed to provide adequate services for the citizens of Minnesota. The work being done by Governor Dayton's Task Force on Mental Health has underscored how access to inpatient psychiatric beds is of critical importance in the short-term as the State seeks longer-term solutions to the mental health care access problems facing Minnesotans. We believe there is a strong need for the additional beds proposed by PrairieCare and will help to close part of the gap in shortage of services for children and adolescents requiring inpatient care. We believe the quality of care provided by PrairieCare in all of its facilities, and specifically in the Brooklyn Park Hospital, is excellent and that this organization is well-positioned to provide adequate staffing models and overall complete inpatient services in a way that will meet the needs of the additional patients they will be serving on the inpatient unit.

Please do not hesitate to contact us if there are questions regarding our support of PrairieCare's request to increase the number of beds available within the hospital at PrairieCare.

Sincerely,

John E. Huxsahl, MD
Co-Chair, Division of Child and Adolescent Psychiatry and Psychology
Department of Psychiatry and Psychology
Mayo Clinic

Bruce Sutor, MD
Clinical Practice Chair
Department of Psychiatry and Psychology
Mayo Clinic

Mark A. Frye, MD
Professor and Chair, Department of Psychiatry & Psychology
Director, Mayo Clinic Depression Center
Mayo Clinic, Rochester, Minnesota

MINNESOTA MEDICAL ASSOCIATION

1300 Godward St. NE, Suite 2500
Minneapolis, MN 55413
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November 21, 2016

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

Via Email

Dear Commissioner Ehlinger:

On behalf of the Minnesota Medical Association, the professional association of Minnesota's physicians, medical residents, and medical students, I write to offer support for the public interest served by PrairieCare's proposal to increase by 21 beds the capacity of its Brooklyn Park inpatient child and adolescent psychiatric hospital. I urge the department to reach a similar finding as part of its public interest review process.

The need for additional child and adolescent psychiatric beds in Minnesota is acute and continues to grow. All too often, children in mental health emergencies are being made to wait in emergency rooms or in pediatric units of the state's hospitals. These facilities are simply not able to provide the right type of care for these children and their families. Furthermore, the shortage of adequate inpatient facilities in the metro area forces many children to receive care at great distances from their home, making difficult family situations all the more problematic. Adding 21 new beds at PrairieCare's Brooklyn Park facility will help relieve pressure in the metro, but also in Greater Minnesota, too.

Minnesota is facing a significant shortage of mental health resources, particularly for pediatric patients, and PrairieCare's expansion of its inpatient capacity will help to alleviate some of the shortfall. Thank you for your consideration.

Sincerely,

David Agerter, MD
President
Minnesota Medical Association

MAPA
PARTNERS IN HEALTHCARE

2355 Highway 36 West, Suite 400, Roseville, MN 55113 mapa@affinity-strategies.com

December 7, 2016

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

Dear Commissioner Ehlinger,

I am writing on behalf of the Minnesota Academy of PAs (MAPA) in support of the request by PrairieCare to add 21 child and adolescent psychiatric beds at their Brooklyn Park facility.

MAPA is the voice of over 2,000 practicing physician assistants in Minnesota. As you know, PAs are key players in providing both primary and specialty care to patients across the State. The three and soon to be four PA training programs in Minnesota are educating needed clinicians at a time when health care profession shortages are threatening timely access to care.

Minnesota's PAs are advocates for the patients we serve as well as their families. An ongoing challenge for Minnesota patients and families is the lack of child and adolescent inpatient beds for mental health patients. Patients in crisis and in need of hospitalization are too often warehoused in hospital emergency departments or sent back home because of the lack of a bed. When beds are available, they are often hundreds of miles away, far from families and support networks.

The Governor's Task Force on Mental Health recently issued a report that identified adding more beds as one element of addressing Minnesota's mental health crisis. PrairieCare's application to add 21 beds at its Brooklyn Park hospital is consistent with the Task Force's recommendations and Minnesota's PAs encourage you to find that PrairieCare's application is in the public interest.

Sincerely,

Becky Ness PA-C, MPAS

Becky Ness, PA-C
President, MAPA

MINNESOTA ASSOCIATION OF
County Health Plans

November 21, 2016

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

Dear Commissioner Ehlinger,

I am writing on behalf of the Minnesota Association of County Health Plans (MACHP) in support of the hospital moratorium exemption request submitted to the Department by PrairieCare.

MACHP represents Minnesota's three County-Based Purchasing (CBP) health plans serving 25 rural Minnesota counties and nearly 85,000 Minnesota Health Care Programs enrollees. Our primary interest is ensuring that rural counties have the ability to provide their residents in Minnesota Health Programs with timely access to quality health care.

One of the many challenges rural Minnesota faces is timely access to inpatient mental health services. Minnesota faces a shortage of mental health beds for both children and adults. Mental health patients in crisis that present in Emergency Departments are routinely forced to sit without care while waiting for a hospital bed to open. That bed may be hundreds of miles away from home because local beds are filled with non-area residents.

PrairieCare seeks to add 21 child and adolescent beds to its existing Brooklyn Park hospital. While these beds are in the Metro and our enrollees are in rural Minnesota, we support this application because expanded capacity in the Metro will reduce the number of Metro patients being transferred to rural hospitals and denying local patients the ability to receive care close to home.

We encourage the Department to find that PrairieCare's application is in the public interest.

Sincerely,

James A. Przybilla, Chair

North Memorial

December 23, 2016

Mr. Stefan Gildemeister
Minnesota Department of Health
P O Box 64882
St Paul MN 55164-0882

Dear Mr, Gildemeister:

We thank you for the recent request for feedback regarding PrairieCare's proposed plan to expand the number of licensed beds at their existing specialty hospital in Brooklyn Park. We are appreciative of PrairieCare's interest in providing more adolescent behavioral health services, as this is certainly an unmet need in the community.

In consideration of their request, we would hope that the Minnesota Department of Health might be willing to encourage PrairieCare that any increase in bed capacity in their facility would be made available to all adolescent patients in need, regardless of insurance carrier. We believe there is a significant unmet need for adolescents in the community and that this is not limited to those with commercial insurance. We would hope that PrairieCare would consider helping to meet this need.

Additionally, we would suggest careful consideration of moving to double-occupancy rooms. This may have an unintended consequence on customer experience. Whether the need to provide more access to adolescent mental health services outweighs this impact may be something for consideration.

Again, we thank you for the opportunity to comment on this proposal.

Sincerely,

Jeff Wicklander
President
North Memorial Medical Center

Jennifer Close
President and Chief Ambulatory Officer
North Memorial Health Care

northmemorial.com

Ridgeview MEDICAL CENTER

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November 14, 2016

Dr. Edward Ehlinger, Commissioner
Minnesota Department of Health
P.O. Box 64975
St. Paul, MN 55164

RE: PrairieCare's Proposal to Add 21 Beds to its Psychiatric Hospital for Children and Adolescents in Brooklyn Park

Dear Commissioner Ehlinger:

I am writing to you on behalf of Ridgeview Medical Center and Clinics in support of PrairieCare's proposed 21 bed expansion of inpatient beds for children and adolescents. This proposal will increase their total number of beds from 50 to 71 at their Brooklyn Park facility.

Each year thousands of youth and their families struggle to find necessary psychiatric services. PrairieCare's expansion will help alleviate this demand and allow many to receive high quality care closer to home, and without enduring long waits in local emergency rooms or general medical units. Our state currently has inadequate capacity and a fragmented system for psychiatric care and PrairieCare's proposal will help address these shortcomings.

PrairieCare has been a great partner in helping to meet the psychiatric needs in our communities. In addition to inpatient services, they also offer substantial community-based services which help prevent the need for emergency psychiatric treatment. PrairieCare is an ideal health system to lead these expansion efforts and we can confidently support their expansion.

Thank you for your consideration.

Sincerely,

Michael Phelps
Chief Operating Officer
Ridgeview Medical Center & Clinics

South Lake Pediatrics
Infant, Child & Adolescent Care

Minnetonka Office
17705 Hutchins Drive
Suite 100
Minnetonka, MN 55345
952-401-8300
Fax: 952-401-8242

Additional Locations:
Chaska
Children's West
Eden Prairie
Maple Grove
Plymouth

9/8/16

Dear Stephan Gildemeister,

I am writing this letting in support of increasing the number of hospital beds available at the PrairieCare Brooklyn Park Inpatient Unit from 50 to 71 beds. Child and Adolescent mental health remains at a crisis point with youth turned away or sent far from home for their care. The youth are our future and need to be prioritized in care to create healthy and contributing adults.

As a pediatrician who sees many, many youth in need, I strongly support this increase in available inpatient beds.

Sincerely,

JoAnne Hoffman Jecha, MD
Director of Mental Health Services