DEPARTMENT OF HEALTH

Public Interest Review

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

01/28/2022

Public Interest Review: Evaluation of a Proposed Expansion of Child and Youth Inpatient Psychiatric Bed Capacity in Brooklyn Park, Minnesota

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As requested by Minnesota Statute 3.197: The preparation of this report cost approximately $36,566.90. As required by Minnesota Statutes, section 144.552, paragraph (a), item (2), the applicant bore that cost.

Contents

Overview of the public interest review process

Since 1984, Minnesota law has prohibited the construction of new hospitals or expansion of bed capacity at existing hospitals without specific authorization from the Legislature.[1] As originally enacted, the law included specific exceptions to the moratorium on new hospital capacity.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 30 exceptions.

In 2004, the Minnesota State Legislature established a 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 (MDH) for the completion of a "public interest review." The purpose of the public interest review was to provide an assessment to the Legislature regarding whether or not the additional beds were in the public interest. The Legislature could then consider the report in their final determination of whether or not to grant an exception.

On June 29, 2021, Minnesota Session Laws Chapter 7, House File 33, was signed into law granting two exceptions to the hospital construction moratorium in advance of a public interest review. Specific to this document, the law authorized a 30-bed licensed bed expansion at an existing psychiatric hospital in Hennepin County serving patients who are under the age of 21; the exception, effective on June 29, 2021, required that MDH conduct a public interest review.

In conducting a public interest review, Minnesota Statutes, section 144.552 directs the MDH to consider all relevant factors but, at a minimum, the following five specific ones:

- **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 MDH to complete a public interest review within 150 days of a complete application. Public interest reviews cannot start until necessary application materials are

[1] Minnesota Statutes, section 144.551.

[2] Minnesota Statutes, section 144.552.

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 MDH, are available online: (https://www.health.state.mn.us/data/economics/moratorium/index.html).

PrairieCare's Proposal for Expansion in Hospital Bed Capacity

Project Description

On July 30, 2021, PrairieCare initiated a request of MDH to conduct a public interest review on their proposal to increase hospital capacity from 71 to 101 beds at their existing facility in Brooklyn Park. Officials from PrairieCare estimated that the expansion would cost an estimated $18 million to add 30 new patient rooms, clinical practice space, staff offices, and medical equipment.[3] In the weeks 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 for 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.[4] At around the same time, PrairieCare also sought a temporary waiver from MDH to convert five single occupancy rooms to double occupancy to immediately expand capacity because adding 30 new beds would require construction lasting until fall of 2022.[5]

PrairieCare Service Profile and Patient Population

PrairieCare and PrairieCare Medical Group are privately owned organizations that provide a continuum of psychiatric care to children and youth under age 21 in Minnesota. Through the 71-bed acute care psychiatric hospital in Brooklyn Park, which initially opened as a 50-bed facility in September 2015, PrairieCare delivers short-term inpatient treatment for patients experiencing a mental health crisis. In addition, PrairieCare Medical Group operates clinics in the Twin Cities, and in the Mankato/Rochester areas, where it delivers outpatient services through a variety of delivery mechanisms.

PrairieCare inpatient hospitalizations for the most recent three years shown in Table 1 display the following characteristics:

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[3] These initial cost estimates are from MDH correspondence with PrairieCare in December of 2021.

[4] All application materials can be found on the following Minnesota Department of Health website: https://www.health.state.mn.us/data/economics/moratorium/prairiecarebrooklynpark2021/index.html

[5] Providing inpatient psychiatric care to more than one pediatric patient per room is relatively common practice at the Minnesota hospitals that provide these services in the state. PrairieCare has operated with both single and double occupancy rooms without substantiated complaints for the past two years.

- They were predominantly for female patients;
- Nearly two-thirds of patients were between 14 to 19 years old and a similar proportion were from the Twin Cities Metro area;
- Most of the hospital stays had a principal diagnosis of depressive disorders, while the next largest volume of diagnoses was for trauma and stressor-related disorders, other specified and unspecified mood disorders, and disorders related to anxiety and fear;
- Public and private coverage accounted for a nearly even split of payers for these hospital stays;[6]
- Like insurance coverage statewide, there were more hospital stays from the Metro Area with private health insurance (51.6%), than for stays from Greater Minnesota (42.3%) (not shown in table). During 2019, 65.7% of children 0 to 17 statewide had private health insurance, compared to 68.7% in the Twin Cities Metro area and 61.9% in Greater Minnesota.[7]

The average and median number of patient days per hospital stay for patients at the PrairieCare facility are longer than equivalent patients at other Minnesota hospitals with similar specialized hospital beds: 10.5 days, on average, compared to 7.2 days, and a median of eight days compared to six days.[8]

Table 1: Characteristics of PrairieCare Inpatient Hospital Patients (August 24, 2018 to August 24, 2021)[9]

Number of Hospital Stays	**6,375**
Gender female	71.2%
Gender male	28.7%
Gender unknown	0.1%
Age of Patient at Discharge	
Age 4-8	2.0%
Age 9-13	33.4%
Age 14-19	64.6%
Primary Payer	
Private payer	49.8%
Public payer	49.1%
Self-pay or unknown payer	1.1%

Length of Stay	
Average patient days	10.5
Median patient days	8
Geographic Region of Minnesota	
Metro	65.3%
Central	14.4%
South Central	6.0%
Southeast	4.5%
Northeast	2.9%
Southwest	2.1%
West Central	1.1%
Northwest	0.9%

[6] Hospital stay data supplied to MDH from PrairieCare was for the expected payer, but secondary analysis using paid claims largely confirmed the payer mix.

[7] MDH analysis of the Minnesota Health Access Survey from 2019.

[8] MDH analysis of data from PrairieCare and the Minnesota Hospital Association.

[9] Source: MDH analysis of hospital administrative discharge data from PrairieCare.

Out of State/Unknown Origin	2.9%
Disease Categories for Primary Diagnosis	
Depressive disorders	74.9%
Trauma- and stressor-related disorders	9.4%
Other specified and unspecified mood disorders	3.7%
Anxiety and fear-related disorders	3.4%

Neurodevelopmental disorders	2.4%
Disruptive, impulse-control and conduct disorders	1.9%
Schizophrenia spectrum and other psychotic disorders	1.5%
Bipolar and related disorders	1.2%
All other mental or substance-related conditions	1.5%

Previous Expansions and Context for Inpatient Mental Health Landscape

Before delivering inpatient psychiatric services for children and youth at the current site in Brooklyn Park, PrairieCare operated a 20-bed facility in nearby Maple Grove; this facility is now used for residential mental health treatment. The establishment of that facility was permitted under an exception to the hospital moratorium law, passed by the Minnesota Legislature in 2009.[10,11] A 50-bed hospital was established in Brooklyn Park under the same exception and subsequently expanded by 21 beds by converting existing single occupancy rooms to double occupancy under an exception in 2017.[12]

With 71 beds, the Brooklyn Park hospital is the largest inpatient psychiatric care facility for youth in Minnesota, accounting for over one third of the 206 total beds in the state devoted to providing behavioral health services for youth. The other locations, shown in Figure 1, include Sanford Health Behavioral Health Center in Thief River Falls Minnesota (7 beds)[13], Essentia Health-Duluth (18 beds), CentraCare St. Cloud Hospital (5 beds), Minnesota Department of Human Services Child and Youth Behavioral Health Hospital in Willmar (16 beds), Abbott Northwestern Hospital in Minneapolis (24 beds), M Health Fairview University of Minnesota Medical Center in Minneapolis (32 beds), United Hospital in St. Paul (15 beds), and Mayo Clinic Hospital in Rochester (18 beds).[14]

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

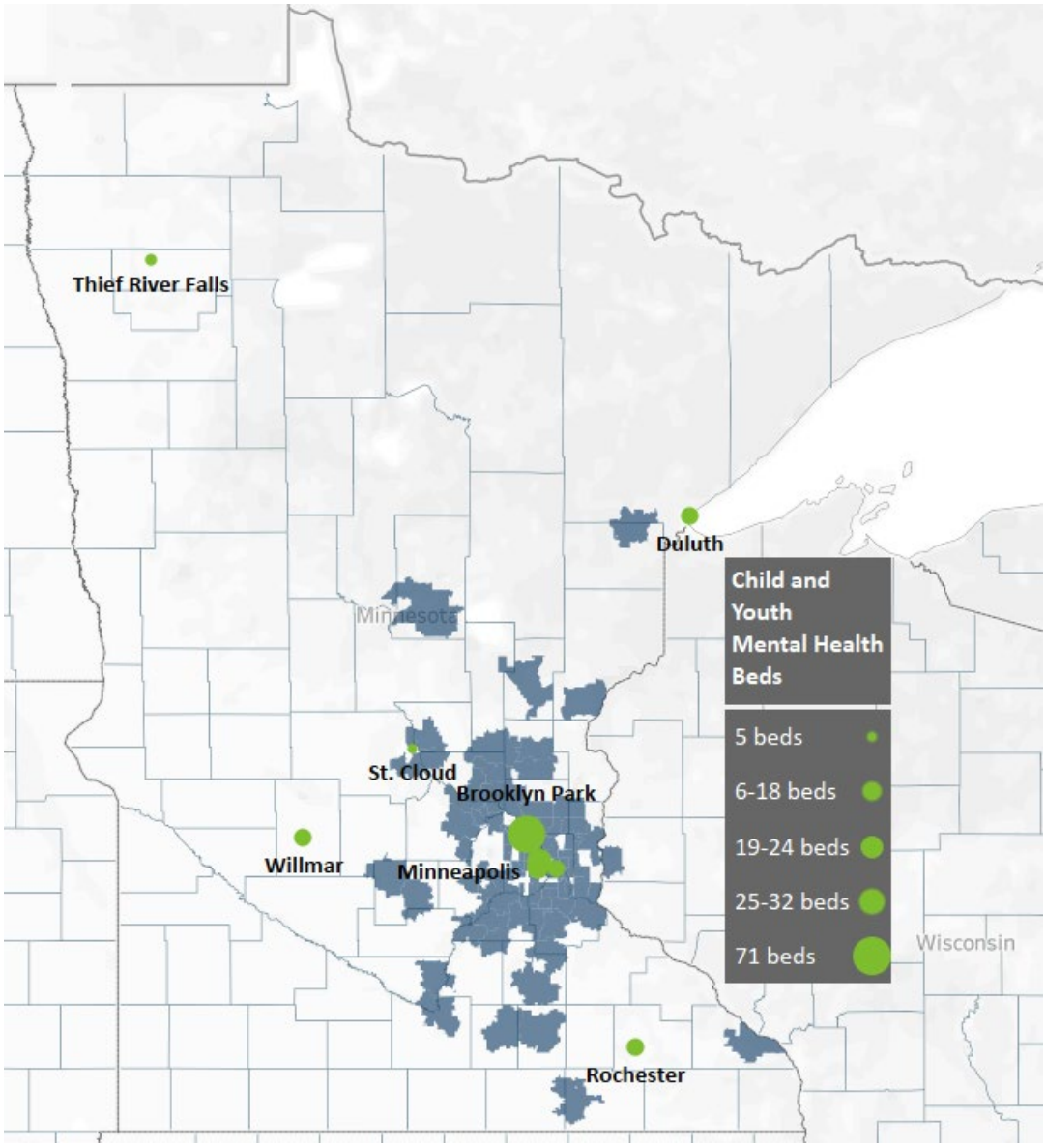
[11] An earlier proposal, by then Prairie St. Johns, for a facility in Woodbury, Minnesota, was found by MDH to not be in the public interest, following a review.

[12] Minnesota Statutes, Chapter 144.551, subd. 1, paragraph b, clause (27).

[13] Sanford Behavioral Health Center in Thief River Falls, MN offers combined inpatient psychiatric care to children, youth, and adults. This count reflects recent occupancy for youth at the facility from MDH analysis of inpatient hospital discharge records from 2019 and 2020.

[14] Minnesota Department of Health analysis of data from Hospital Annual Reports.

Figure 1. Minnesota Child and Youth Inpatient Mental Health Beds and PrairieCare Brooklyn Park Hospital Primary Service Areas



Note: The blue shaded areas of the map are resident ZIP codes where most hospital stays (75th percentile) originate for PrairieCare Brooklyn Park Hospital.

In addition to hospitals providing specialty care listed above, some children with inpatient behavioral health needs are also admitted to Minnesota inpatient facilities without dedicated pediatric psychiatric beds or in beds not specifically dedicated for psychiatric care. In some instances, Minnesota children with psychiatric health care needs are also admitted in facilities at neighboring communities outside of Minnesota. There is also a relatively new treatment option called psychiatric residential treatment

facilities (PRTFs),[15] currently covered only by Minnesota Health Care Programs, that offer an inpatient level of care for patients once inpatient hospitalization is no longer medically necessary.

Together, these pediatric hospital beds represent 1.7 percent of the total 11,700 available hospital beds, 1.4 percent of admissions, and 2.2 percent of patient days at Minnesota hospitals for the most recent five years (2016 through 2020). Nonetheless, inpatient hospital care for children and youth are critical treatment components for patients in a mental health crisis, whether or not the crisis could have been prevented with early diagnosis and timely, high-quality medication therapy and outpatient services. Hospitalizations are often 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 youth. Understanding capacity gaps and the factors underlying them, therefore, is critical to ensuring the availability of services for vulnerable patients.

While the total reach of mental illness in children and youth in the state is not well understood, national estimates suggest that about five to seven percent of Minnesotans aged nine to 17 suffer from severe emotional disturbances.[16] These children and youth likely account for many of the approximately 7,000 psychiatric hospital admissions that took place annually for this population in 2019 and 2020.[17] More recent surveys of students and families during February of 2021 reveal that mental health support was the third most commonly reported challenge among all other issues related to the COVID-19 pandemic,[18] suggesting that mental health may pose an even greater burden in the near future.[19]

Although the percent of children and youth suffering from mental illness appears relatively low, and the need for inpatient psychiatric stays are a small proportion of all hospitalizations as noted above, hospital admissions for mental health diagnoses account for a sizable portion of inpatient hospital care for young Minnesotans. Inpatient stays for mental diseases and disorders were the leading major diagnostic category, accounting for 35 percent of the approximately 35,000 total hospital discharges for youth aged 4 to 17 that took place in Minnesota for those two years. There were about 22,000

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[15] For more information on PRTFs, please visit the Minnesota Department of Human Services website: https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/prtf/.

[16] 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 2018 accessed November 8, 2021 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 aged 9 to 17.

[17] Minnesota Department of Health analysis of data from Hospital Annual Reports.

[18] University of Minnesota, WMCC Spring Minnesota Safe Learning Survey Report (August 2021) accessed online at https://www.cehd.umn.edu/research/safe-learning-survey/.

[19] Additional insight into how the pandemic might have influenced mental health issues in school-age Minnesotans will be collected through an anonymous triennial student survey conducted by the Minnesota Department of Education and Minnesota Department of Health between January and June 2022. For more information, please visit the Minnesota Department of Health website: https://www.health.state.mn.us/data/mchs/surveys/mss/index.html.

emergency department visits per year for mental health conditions; as a proportion of total emergency department visits, mental health emergency department visits for youth aged 4 to 17 grew in 2020 relative to a year earlier (from 11.4 percent to 13.7 percent).[20]

Evaluation of the proposal

In this section, we assess the proposal to add 30 hospital beds in Brooklyn Park relative to the public interest criteria, focusing on each of the five factors specified by Minnesota Statutes, section 144.552 and listed above on page 4.

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

To evaluate the need to add 30 inpatient mental health beds, it is important to identify the potential for capacity constraints for the patient population served by PrairieCare, and thus, whether these additional beds would lead to improvements in access to care or patient experience. The following measures were used by MDH to identify inpatient constraints for patients served by PrairieCare and other hospitals using secondary data, as well as data made available by PrairieCare:

- The number of days inpatient units operated at high levels of patient occupancy,
- The number of child and youth mental health stays that occurred outside of specialized units,
- Observed patient travel patterns such as the frequency of patients leaving geographic region to receive inpatient mental health care, and
- Additional need for hospital beds due to expected population growth.

These measures represent available information. Other important factors for which, to our knowledge, no data exist, include: the status of workforce availability to treat patients; the factors affecting admissions to care at facilities without specialty staff; the extent to which bottlenecks in outpatient care, residential treatment, or aftercare affect inpatient hospitalization;[21] and noticeable trends in hospital transfer requests that may indicate shortage of beds elsewhere in the state.

There is limited information to draw firm conclusions on how certain occupancy rates affect the quality and safety of delivering psychiatric inpatient care. Evidence from one study suggests that when more

[20] Minnesota Department of Health analysis of hospital discharge records from 2019 through 2020 for patients ages 4 through 17.

[21] Resulting in delays of treatment and limiting the chance to prevent acute care needs or unnecessarily lengthening inpatient stays because step-down care alternatives are not available.

than 85 percent of beds at a facility are in use there might be safety and effectiveness challenges as well as a greater potential for turning away patients that need care.[22]

Table 2 shows that all Minnesota hospitals with inpatient mental health units for children and youth, including PrairieCare's facility in Brooklyn Park, operated at or above 85 percent occupancy for parts of 2019 and 2020. In some cases, including the PrairieCare Brooklyn Park facility, the number of higher occupancy days was lower in 2020; in other cases, hospitals with these units saw an increase in the number of higher occupancy days. This indicates a mixed picture about how the first year of the COVID-19 pandemic might have affected capacity for inpatient child and youth mental health beds. More importantly, four hospital facilities that primarily served the greater Twin Cities market operated 100 or more days at high occupancy levels in at least one of the two years.

Table 2. Number of Days at or above 85 Percent Occupied for Minnesota Inpatient Pediatric and Youth Mental Health Beds, 2019 and 2020

Hospital	2019	2020
PrairieCare Brooklyn Park Hospital	*197*	*166*
Abbott Northwestern Hospital	129	56
CentraCare St. Cloud Hospital	122	67
Essentia Health - Duluth	151	195
Mayo Clinic Hospital - Rochester	108	65
Sanford Health Thief River Falls Behavioral Health Center*	10	9
United Hospital, St. Paul	74	23
M Health Fairview U of M Medical Center	32	42

Source: MDH analysis of hospital administrative discharge data from the Minnesota Hospital Association and PrairieCare. Occupancy rates were calculated as number of patients with hospital revenue center room and board charges for psychiatric care, or hospital stays assigned to the CMS major diagnostic category of mental diseases or disorder, where each day was divided by number of pediatric psychiatric beds in the hospital. The dates of admission and discharges were tabulated for each hospital discharge record with the date of discharge set to zero unless it was the same day as admission. These data did not permit identifying when a specific discharge overlapped with an admission, nor did they permit us to assess if available beds were staffed. As such, these estimates could be viewed as overestimates of capacity constraints in terms of overlapping dates of admission and discharge or viewed as an underestimate in terms of the assumption that all available beds were staffed. Figures for Essentia Health – Duluth were changed to reflect actual counts after preliminary disclosure.

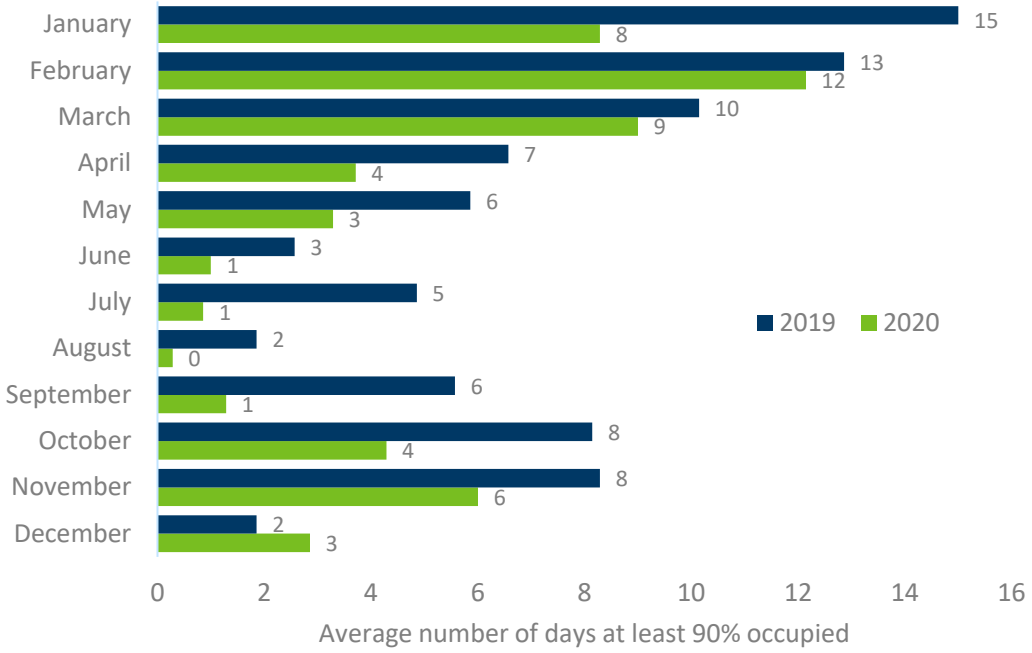
* Sanford Health Thief River Falls Behavioral Health Center operated combined units for children and adults, so the maximum was used as the bed count for youth during each year.

High-occupancy days were not distributed evenly throughout the year. Even though psychiatric crises for children and youth occur in all months of the year, there appear to be certain stress-points when higher levels of hospitalizations took place. As shown in Figure 2, the months of January, February, and

[22] Jones, R. Optimum bed occupancy in psychiatric hospitals. Psychiatry On-Line; 2013. Note: this study referenced adult mental health beds yet may be more generalizable to pediatric mental health care than non-mental health specific studies.

March have the greatest number of days at high occupancy levels.[23] Furthermore, for nearly half of January and February in 2019, occupancy across the system, in aggregate, was at or greater than 90 percent. This means that patients would have had significant difficulty finding timely inpatient care anywhere in the state, let alone near where they and their caregivers lived. Figure 2 also shows that there were decreases in the number of occasions that hospital beds were at or near capacity in 2020 relative to 2019; we don't currently have data to assess if this trend continued into 2021.

Figure 2. Average Number of Days Minnesota Dedicated Child and Youth Inpatient Mental Health Beds Were at Least 90 percent Occupied, 2019 and 2020



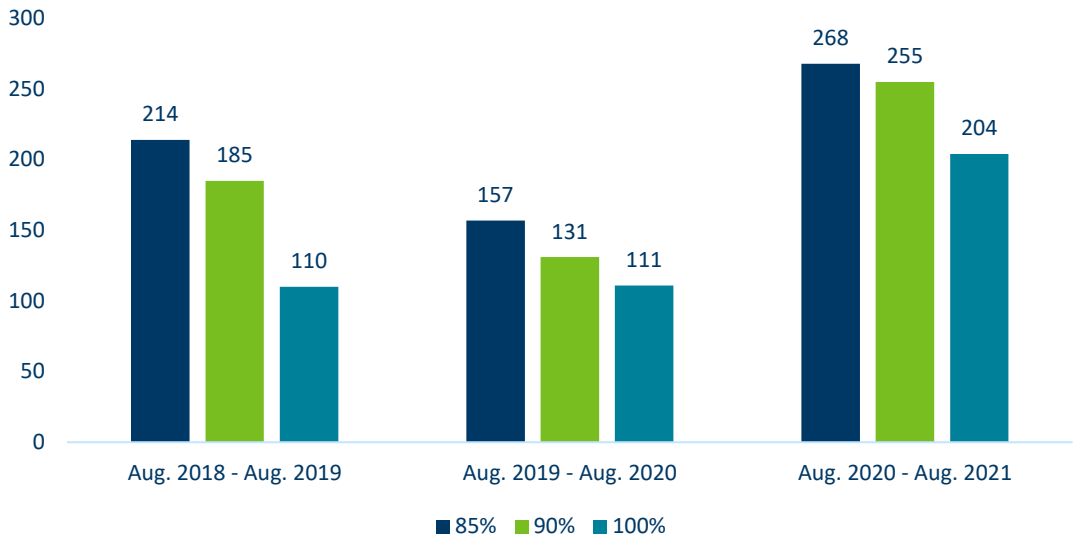
Source: MDH analysis of hospital administrative discharge data from the Minnesota Hospital Association and PrairieCare. Excludes the Minnesota Department of Human Services Child and Youth Behavioral Health Hospital in Willmar.

More recent data from PrairieCare demonstrate that capacity was higher from August 2020 to August 2021 than before the pandemic (see Figure 3).[24] The facility appears to have operated at or near full capacity most of the time during the recent 12-months, perhaps indicating greater need for mental health services, constraints across the spectrum of care delivery, a change in utilization during the COVID-19 pandemic, or all of these.

[23] Minnesota Department of Health analysis of hospital discharge 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. Annually reported available bed counts may also fluctuate throughout the year leading to a possible overestimate of whether beds are fully staffed and able to treat patients.

[24] Occupancy data for 2021 is not yet available for other Minnesota hospitals.

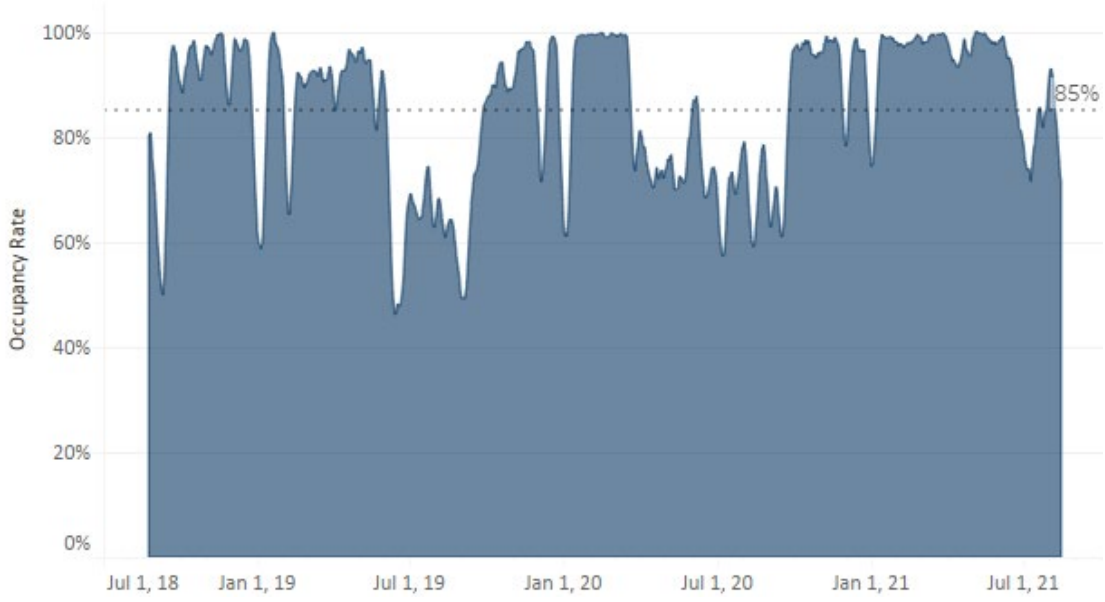
Figure 3. Number of Days Occupancy Rates Are Above 85%, 90%, and 100% at PrairieCare Brooklyn Park Hospital, August 24, 2018 - August 24, 2021



Source: MDH analysis of hospital administrative discharge data from PrairieCare.

PrairieCare's Brooklyn Park hospital has tended to have higher rates of occupancy than other similar units across the state (Table 2). Over the past three years, occupancy rates at PrairieCare's Brooklyn Park Hospital averaged well above 85 percent—particularly in fall/winter months of the year (Figure 4). Furthermore, Figure 3 also shows that occupancy at the hospital was at or near 100 percent more than half of the time, on average, during the most recent 12 months.

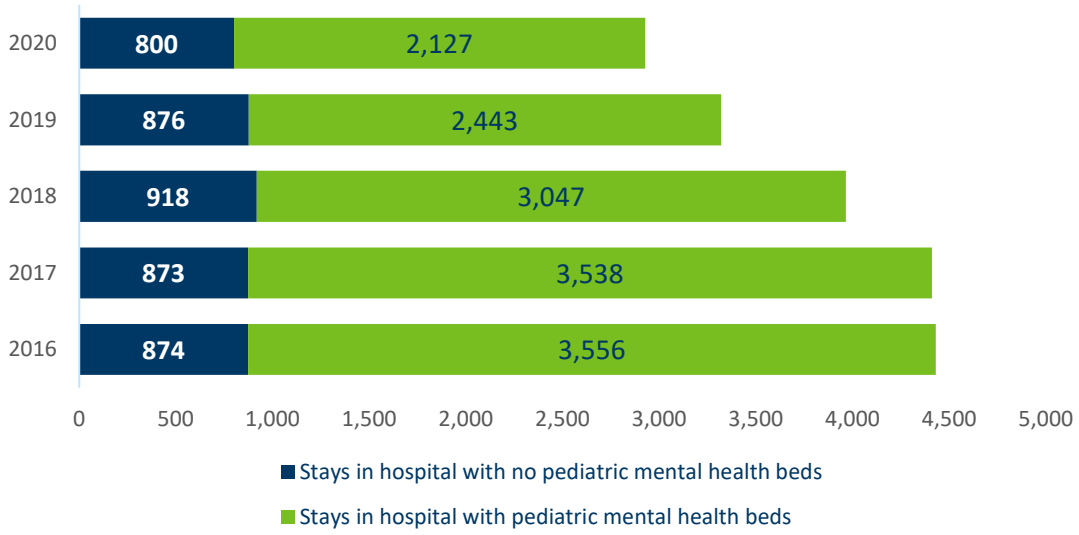
Figure 4. Seven-day Average Occupancy Rate for PrairieCare Brooklyn Park Hospital for discharges from August 24, 2018 through August 24, 2021



Source: MDH analysis of hospital administrative discharge data from PrairieCare.

An examination of hospital stays outside of dedicated specialty beds by MDH further demonstrates the potential for capacity constraints: throughout the year, patients who appeared to have needed inpatient care for mental health concerns were admitted to facilities without the necessary pediatric mental health specialties, although it is not clear whether the choice for admission may have been affected by acute care needs. As Figure 5 shows, between 800 to 900 times per year pediatric and youth patients from PrairieCare's service areas had inpatient stays at hospitals without inpatient pediatric specialty beds.

Figure 5. Pediatric Inpatient Mental Health Hospital Stays at Hospitals without Pediatric Mental Health Beds in PrairieCare's Primary Service Area from 2016 through 2020



Source: MDH analysis of hospital administrative discharge data from the Minnesota Hospital Association.

There were an additional 966 times in 2019 and 903 times in 2020 when pediatric and youth patients with mental health conditions from PrairieCare's primary service area were boarded in emergency departments at hospitals[25] with no pediatric specialty mental health beds. These patients were not ultimately admitted for inpatient care.[26] The cumulative inpatient hospital stays and emergency

[25] PrairieCare does not operate an emergency department, though they do receive request for admission from other emergency departments; an emergency department offers more direct access to services, and hospitals with emergency departments are required to provide care. Under the federal Emergency Medical Treatment and Labor Act (EMTALA), and associated regulations, hospitals are required to stabilize and treat patients referred to the facility from emergency rooms regardless of insurance status and ability to pay.

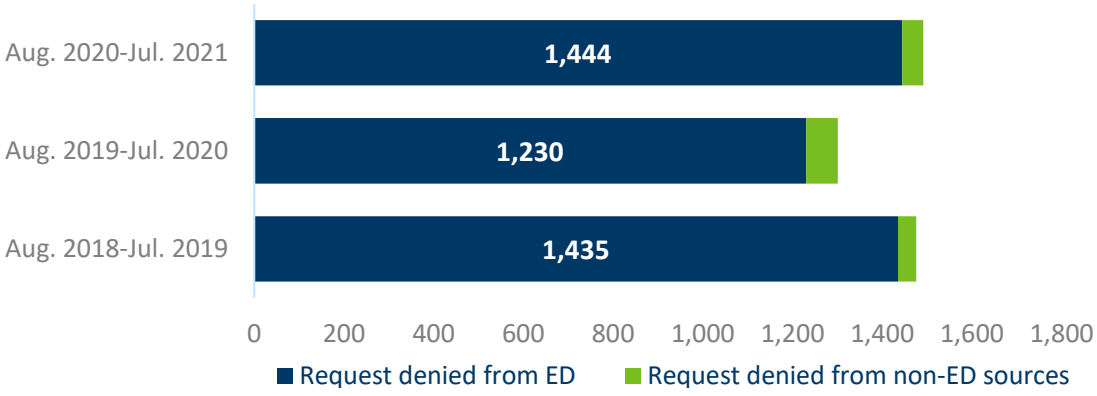
[26] MDH analysis of hospital discharge records from the Minnesota Hospital Association with any of the first three diagnoses being categorized as mental health from Zima BT, Gay JC, Rodean J, et al. (2020). Classification System for International Classification of Diseases, Ninth Revision, Clinical Modification and Tenth Revision Pediatric Mental Health Disorders. *JAMA Pediatrics*; 174(6):620–622.

department visits at hospital facilities without these specialized services to treat mental health crises totaled 1,842 in 2019 and 1,703 in 2020.

We cannot infer from available data to what extent these patients, whether admitted or not, would have been better served in dedicated psychiatric specialty settings and how often these admissions occurred because of lack of psychiatric beds for children or youth. However, it is clear from public comments that "boarding" in medical units is a practice that concerns many providers. It is also something that troubles families and caregivers. Being in a hospital unit that is not dedicated to pediatric mental health can also be full of distressing sights and sounds that may worsen some patients' symptoms or behaviors.

We observed that there were many occasions where other hospitals with children and youth in the emergency department sought to transfer patients to PrairieCare Brooklyn Park Hospital. According to information supplied by PrairieCare, between August of 2018 and August of 2021, there were over 1,200 transfer requests per 12-month period from other facilities that PrairieCare had to deny for capacity reasons, with over 1,400 in the most recent 12 months. Again, it is unknown if these patients were better served somewhere else, but additional bed capacity could have served at least some of these patients.

Figure 6. 12-month Count of Denied Transfer Requests from Emergency Department and non-Emergency Department Sources from August 24, 2018 - August 24, 2021



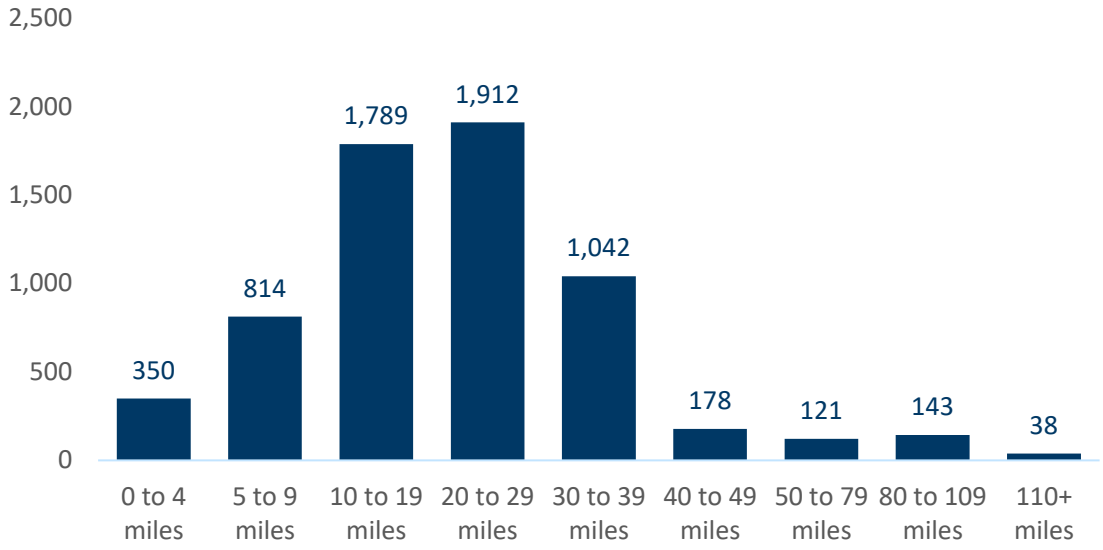
Source: MDH analysis of hospital administrative discharge data from PrairieCare.

A third measure of capacity constraints considers to what extent there are geographic barriers to access, perhaps related to the proximity of inpatient care for children and youth to where they reside in Minnesota. A limited supply of appropriate mental health beds in one part of the state, for example, may displace patients there, resulting in an outflow of patients to facilities in other parts of the state. MDH tested this by enumerating the outflow of patients from the PrairieCare primary service area, which may indicate that there are limitations on the existing facilities in that geographic region.

Figure 7 shows that 4,865 hospital stays for child and youth with mental health conditions occurred less than 30 miles of the patient's residential ZIP code, representing most (76.2 percent) of

approximate distances traveled during 2019 and 2020. However, there were also 1,220 hospital stays (19.1 percent) that required traveling 30 to 49 miles, and 302 (4.7 percent) that traveled 50 to 110 miles or more during those two years. These combined distances were substantially higher than distances traveled for non-mental health pediatric inpatient stays (not shown).

Figure 7. Approximate Distance Traveled for Twin Cities Resident Child and Youth Inpatient Mental Health Hospital Stays in 2019 and 2020



Source: MDH analysis of hospital administrative discharge data from the Minnesota Hospital Association and PrairieCare. Distances are calculated using ArcMap 10.5 from the geographic center of the resident ZIP code to the hospital location.

Similarly, the limited supply, or 'bottleneck,' of available mental health beds can be seen by an inflow of patients from outside the Twin Cities. Table 3 illustrates that over one in four hospital stays for youth at Twin Cities area hospitals with pediatric mental health beds were for patients who resided outside of the Twin Cities. This reflects the very limited pediatric inpatient capacity outside a few key locations in Minnesota, illustrated earlier in Figure 1. Over 1,100 youth mental health hospital stays in the Twin Cities during 2019 and 2020 came from regions of Minnesota where patients, on average, traveled over 60 miles. This included patients from all regions other than the Metro Area and Central Minnesota.

Table 3. Child and Youth Mental Health Stays in Twin Cities Metro Hospitals, by Geographic Region of Residence, 2019 and 2020

Region of Residence	Hospital Stays	Share of Stays	Average Distance traveled from home to hospital (Miles)
Metro	6,121	71.3%	19.8
Central	1,123	13.1%	55.5
Southeast	381	4.4%	73.2
South Central	331	3.9%	87.8

Region of Residence	Hospital Stays	Share of Stays	Average Distance traveled from home to hospital (Miles)
Northeast	220	2.6%	185.7
Southwest	100	1.2%	140.0
West Central	50	0.6%	166.6
Northwest	43	0.5%	246.2
Out of State/Unknown	218	2.5%	

Source: MDH analysis of hospital administrative discharge data from the Minnesota Hospital Association and PrairieCare. Distances are calculated using ArcMap 10.5 from the geographic center of the resident ZIP code to the hospital location.

We also projected population growth and inpatient demand to assess the relationship between the expanded bed capacity and future demand. Assuming population growth continues as modeled and the utilization rate by age remains largely unchanged, additional hospitalizations will occur in the primary service area simply because of population growth.[27]

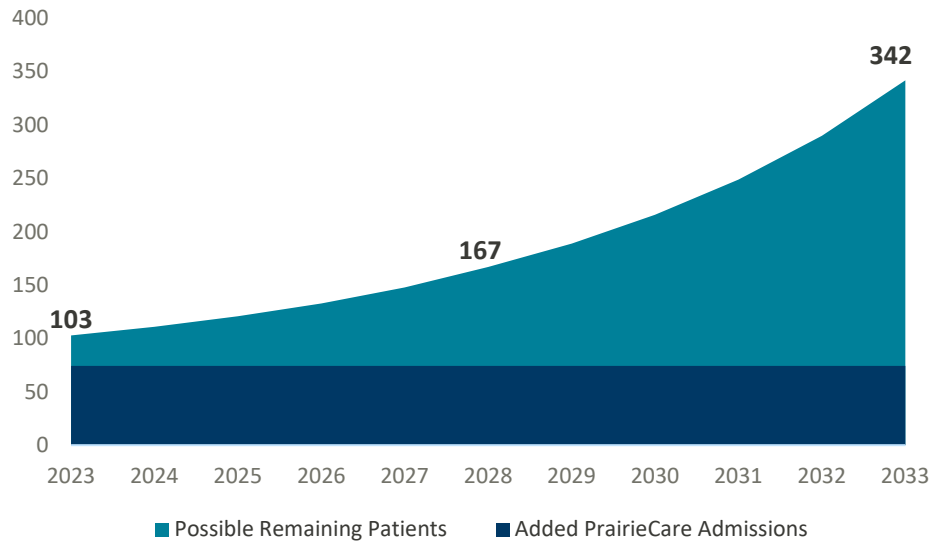
When the additional beds become available, there will be a total 40,150 possible bed days (101 multiplied by 365 days) at the PrairieCare Brooklyn Park site, but only 29,492 days if occupancy averages 80 percent. This would approximate 2,900 admissions at PrairieCare per year, assuming an average length of stay of 10.2 days (based on the past five years of data from PrairieCare's hospital annual reports) and result in an increase of about 74 admissions compared to 2020 (2,826 admissions).

Figure 8 displays that, although 74 additional admissions at PrairieCare Brooklyn Park would be made available, the projected population growth rate from counties in PrairieCare's primary service area might result in the number of admissions growing from 4,751 to 4,854 in 2023, 4,918 in 2028, and 5,093 in 2033. Thus, with existing rates of hospitalizations and patient flow patterns in place, an estimated 29 child and youth patients from the PrairieCare primary service area would need to be hospitalized elsewhere in 2023, with that number increasing to 167 in 2028, and 342 by 2033.[28]

[27] Population projections obtained from the Minnesota State Demographic Center on November 8, 2021 at https://mn.gov/admin/demography/data-by-topic/population-data/our-projections/. Population projections are based on historical and recent patterns in birth, death, and migration.

[28] This assumes the share of the child and youth population that need inpatient mental health care does not change.

Figure 8. Projected New Child and Youth Inpatient Mental Health Admissions in Primary Service Areas Served by PrairieCare Due to Population Growth, 2023 to 2033



Source: MDH analysis of hospital administrative discharge data from the Minnesota Hospital Association and PrairieCare. Each primary service area ZIP code is expanded to include an entire county for county-level population projections.

Our analysis of high rates of occupancy, boarding at other hospitals in both inpatient and emergency settings, denied transfer requests, and long distances traveled by patients all point to significant shortages across the system of care that affect patients, families, and their providers.

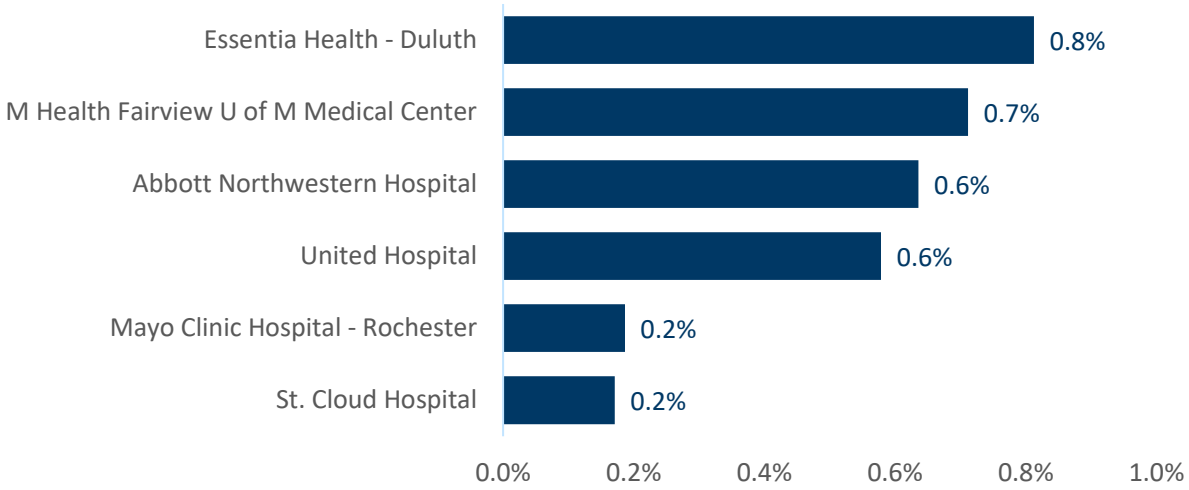
Factor 2: The financial impact of the new hospital beds on existing acute-care hospitals that have emergency departments

The hospital expansion at the PrairieCare Brooklyn Park facility would draw some 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 relative volume of the potential loss of patients and the composition of patients that are hospitalized. For example, private health insurance may pay higher rates than state public programs and higher severity or longer lengths of stay may incur higher charges.

Data from the most recent year indicate that the 30-bed increase would have a negligible impact on the overall financial position on any single hospital, and hospitals' comments on the proposal, which MDH considered as part of this review, did not reveal revenue concerns. Figure 9 shows that pediatric inpatient mental health services represent less than one percent of overall revenue generated from patients at hospitals with similar services. The hospitals most impacted would likely be the three hospitals in the Twin Cities due to the overlap in patient populations (Abbott Northwestern Hospital, M Health Fairview University of Minnesota Medical Center, and United Hospital). However, even if there

was a loss of patients at these hospitals, the projection analysis suggests that increased inpatient demand is expected, and therefore any losses would be small and diminish over time.

Figure 9. Pediatric Inpatient Mental Health Care as a Percent of Hospital Net Patient Revenue, 2020



Source: MDH analysis of hospital annual reports.

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

Minnesota is facing significant challenges in mental health staffing across the state, and particularly in Greater Minnesota. Four out of five Minnesota counties (80 percent) are designated mental health shortage areas by the federal government.[29] This means the supply of health care providers is disproportionately distributed across geographic regions of the state—including where PrairieCare is located. According to recent data, board-certified psychiatrists are highly concentrated, with a rate of 18 per 100,000 in Southeast Minnesota, 15 per 100,000 in the Twin Cities Metro Area, and just 7 per 100,000 elsewhere in the state.[30] It is also notable that only about one in four psychiatrists practice primarily in a hospital setting (26 percent).

Furthermore, workforce data show that only 9 percent of psychologists in Minnesota work in hospitals, and the vast majority of these practitioners overall are in the Twin Cities area (68 percent).[31,32] In the

[29] US Department of Health and Human Services, Health Resources & Services Administration Shortage Designation. Accessed online November 16, 2021 at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.

[30] MDH analysis of data on actively licensed psychiatrists from December 14, 2021 and population data from the 2020 census.

[31] Minnesota Department of Health, Health Care Workforce Data Portal. Accessed online November 16, 2021 at https://www.health.state.mn.us/data/workforce/hcwdash/index.html

[32] According to the 2020 Census, the Counties in the Twin Cities had 55 percent of the Minnesota population.

Twin Cities, there are 8 psychologists to every 10,000 people, but in Greater Minnesota that number decreases to 5 psychologists to every 10,000 people.[33] Additionally, only 11 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 youth with psychiatric conditions. Two of the public comments from Minnesota hospitals (Children's Minnesota and Hennepin Healthcare) specifically mention staffing issues and concern over potential competition for staff in an environment that has been exceedingly difficult in the fall of 2021. Hennepin Healthcare also notes that as a non-profit safety-net hospital they are at a disadvantage compared to facilities like PrairieCare, which are able to devote more resources to paying for staff time due to their higher proportion of private payers.

In its proposal, PrairieCare estimates that the hospital bed expansion will require 4 additional full-time equivalent (FTE) child and youth psychiatrists, 1.5 FTE primary care consultants, 11 FTE registered nurses, 5 FTE masters-level psychotherapists, and 8 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 would limit the potential impact on other hospitals. Further, according to PrairieCare, the Brooklyn Park hospital generally recruits personnel from outside of the state and has attracted out-of-state doctors to work at the facility in the past.

For the expansion, PrairieCare expects to recruit new hires from its training program for new child and youth 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. In sum, PrairieCare expects no impact of its planned bed expansion on the staffing of other facilities.

Factor 4: Provision of services to nonpaying and 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.[34]

[33] Ibid. Minnesota Department of Health, Health Care Workforce Data Portal.

[34] 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.

- As a for-profit facility, the hospital does not face the same obligation under state and federal 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 guaranteeing best-payer discounts to the uninsured.

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. 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 ($42,400 for a family of four in 2021) 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) ($106,000 for a family of four in 2021).

Generally, federal law prohibits the use of federal Medicaid funds for services provided at hospitals with more than 16 beds that are primarily engaged in treatment of mental health conditions.[35] However, federal law allows for two exceptions. The first is an exception both individuals under age 21, and the second concerns individuals aged 65 and older. Under the first exception, referred to as the "psych under 21", services furnished by hospitals such as PrairieCare may be eligible for reimbursement by Medical Assistance, MinnesotaCare, and other federal sources of payment may be covered by these funds.[36]

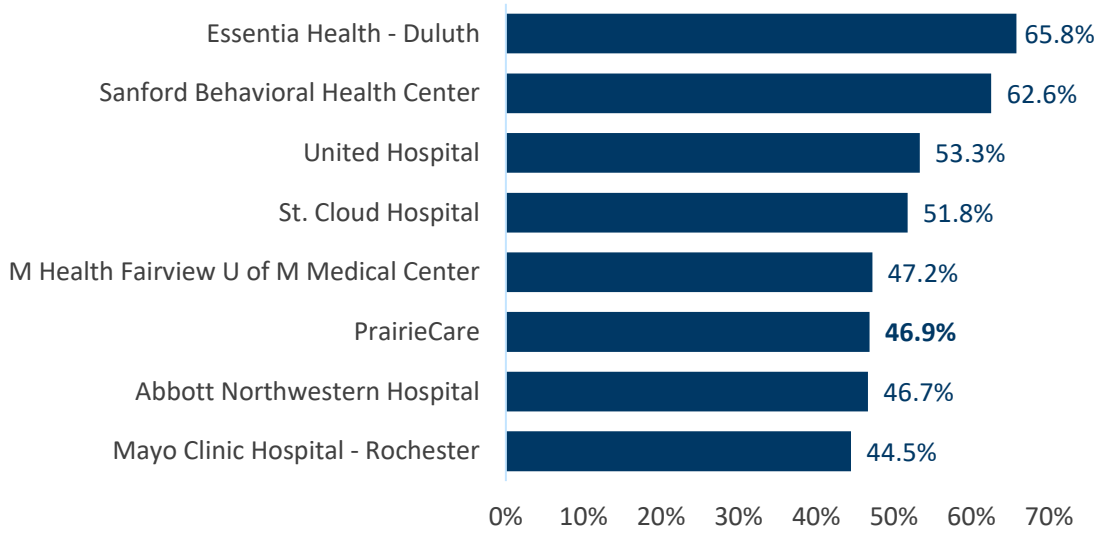
Data provided by PrairieCare indicated that in 2019 and 2020 less than half of admissions (47.2 percent) were for patients who held Minnesota public programs coverage [37] or were self-pay patients; self-pay patients are more likely to lack insurance coverage. Compared to child and youth patients at other facilities with inpatient mental health units, PrairieCare ranked in the lower third by volume, as shown in Figure 10. This suggests that while the hospital does not overwhelmingly serve low-income patients, it is also not exclusively serving private-pay patients (with higher reimbursement).

[35] The exclusion of the federal payment of medical assistance to an institution for mental diseases is found in section 1905 of the Social Security Act [42 U.S.C. 1396d].

[36] Inpatient psychiatric services for individuals under age 21, Title 42 C.F.R. § 440.160 (2010). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.160

[37] These programs include Medical Assistance, MinnesotaCare, Minnesota Family Planning Program, and others. For more information please visit the following website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/

Figure 10. Percent of Minnesota Public Program and Self-Pay Admissions for Child and Youth Mental Health Hospital Stays in 2019 and 2020



Source: MDH analysis of hospital annual reports from PrairieCare and administrative discharge data from the Minnesota Hospital Association. Note: data analyzed pre-adjudicated claims that were 'expected payer' and not processed claims.

Factor 5: 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 to all administrators of Minnesota hospitals and placing a notice in the State Register inviting feedback. We received four responses from health care systems, which are available in Appendix A. Generally, the responses were supportive of PrairieCare's plans to expand bed capacity. A few of the comments raised perspectives policymakers may wish to consider when assessing broader policy issues about health care capacity.

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

- The sense of inadequate supply of inpatient mental health beds for children and youth in Minnesota;
- The extent to which patients must endure wait times in emergency rooms before being admitted to a hospital with specialized inpatient mental health services; and
- Broad challenges to providing appropriate and timely mental health care.

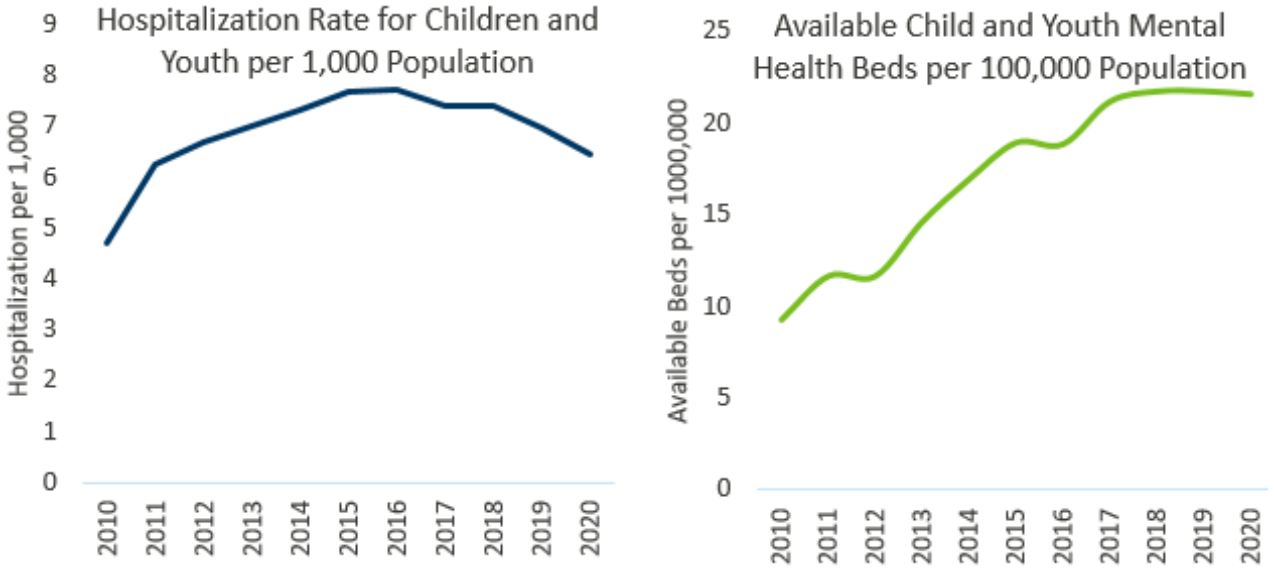
Finally, one response noted that the expansion in inpatient care is a reaction to a short-term problem, which is insufficient in the larger context of mental health treatment outside of the hospital that also requires attention and investment. The next section will briefly explore non-acute approaches to improving mental health as they relate to this specific expansion.

Discussion

Beyond the inpatient mental health constraints noted above, it is also important to consider access to care across the spectrum of mental health treatment for the patient population served by PrairieCare. 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 timely care for children and youth with mental health needs.

Recent measures from a child and family consumer survey at the statewide level[38] indicate that the percent of patients who sought care from a broad array of mental health services, including inpatient care, is lower than the national rate (Minnesota rate of 85.5 percent vs. U.S. rate of 89.2 percent). It is unclear, however, how changes in the spectrum of non-acute mental health care in the state affect the need for inpatient beds. We also have an incomplete understanding of the relationship of inpatient demand (the need for hospitalizations) and supply (the available beds). For example, Figure 11 shows that the rate of child and youth hospitalizations began to decrease in 2016, while the supply of beds increased, all the while bottlenecks and adverse experiences for patients and care givers persisted.

Figure 11. Trends in Mental Health Hospitalization Rates and Available Mental Health Beds for Children and Youth, 2010 to 2020



Source: MDH analysis of hospital annual reports, hospital discharge data, and population data from the US Census Bureau. The number of hospital stays per year is reduced by the percent of non-Minnesota patients observed for each year in discharge data. 'Available beds' are the number of inpatient beds that are immediately available for use or could be brought online within a short period of time.

[38] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration Drug and Alcohol Services Information System, Minnesota 2020 Mental Health National Outcome Measures accessed November 8, 2021 at: https://wwwdasis.samhsa.gov/dasis2/urs.htm

Trends in hospitalization rates and supply of beds in Minnesota illustrated in Figure 9 might suggest that although there has been a limited bed supply to meet demand, it is possible that other factors impacted hospitalization rates. These could include business decisions to operate at less than full capacity, workforce shortages of specialty staff – a physical bed may not represent available capacity to serve a patient. Furthermore, other policies and investments made in the past five years may have reduced the demand for inpatient care such as intensive outpatient services, partial hospitalization programs, or other initiatives to address mental health crises. Without these, or other unknown factors, one would expect the rates of supply of beds and the number of hospitalizations to rise in tandem, or even an inverse relationship where the demand rises faster than supply.

Regardless of the underlying causes for this mismatch in the last several years, there were concerted efforts during this time to improve mental health for patients across the state. For example, in 2016 Minnesota began implementing a variety of new approaches to improve health genearlly, and mental health specifically, in communities across the state. This included behavioral health home services to help coordinate care,[39] and a variety of other innovations in communities across the state that were part of a larger $45 million investment in a variety of health care improvement initiatives.[40] These initiatives included the following:

- Improved screening for mental health[41] and chronic conditions;
- Improved staffing models and workflows;
- Better discharge planning and post hospitalization care; and
- Increased referrals to non-medical providers.

It is possible that the rate of inpatient hospitalizations for children and youth will continue to abate due to alternative models of mental health care for these patients. The implementation of coverage for services in Psychiatric Residential Treatment Facilities (PFTFs) by the Minnesota Department of Human Services (DHS) was one of the most recent developments. These facilities, which are not inpatient hospitals, are intended to provide intensive inpatient-level services[42] to children and youth under age

[39] For more information on behavioral health homes, please visit the Minnesota Department of Human Services website: https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/behavioral-health-home-services/.

[40] Minnesota Department of Human Services. Minnesota Accountable Health Model. Accessed online November 18, 2021 at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=SIM_Home.

[41] Analysis of Quality Reporting System data by MDH indicates that clinical screening for mental health and depression rose from 83 percent of patients in 2017 to 91 percent of patients in 2020.

[42] 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 November 17, 2021.

21 with complex mental health conditions. PRTFs differ from inpatient psychiatric are facilities in two ways:

1. Patients can be admitted to a PRTF when there is a high level of risk to themselves or others, but not on an emergency basis that is often the case at inpatient hospitals.
2. Patients receive a high level of direct care and supervision yet are not provided the same services as an inpatient hospital.

About 178 PRTF beds have been established so far or are in the planning stages. All beds are slated to deliver care outside of the Twin Cities Metro Area, with more than half in Northern Minnesota.[43] As currently designed, the number of PRTF beds is expected to increase gradually over time to 300 beds by 2023.

Officials at DHS emphasize that this modality of care delivery is appropriate when an individual patient no longer requires inpatient care as provided at the PrairieCare Brooklyn Park Hospital. However, after initial implementation, concerns have emerged about the ability of the current PRTF facilities to provide care for patients with acute mental health needs; currently, these facilities struggle in accepting and serving youth with highly complex mental health conditions alongside severe aggression or other risk factors. The new supply of PRTF mental health beds would therefore complement, rather than supplant, intensive psychiatric and therapeutic care delivered at PrairieCare Brooklyn Park Hospital and other hospital-based locations serving children and youth in Minnesota. Nevertheless, this expansion in new models of care may eventually shorten lengths of stay of some children and youth and lessen the need for patients from Northern and Western Minnesota to travel to Brooklyn Park for care, thereby somewhat alleviating capacity constraints at PrairieCare.

Previous mental health task forces, which had strongly supported the creation of PRTFs, also recommended developing an urgent care model for mental health for children and youth 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.[44] 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 youth is not well understood. Similarly, the advent of telemedicine during the COVID-19 pandemic for many forms of health care, including mental health,[45] may or may not reduce the need for inpatient care.

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[43] Minnesota Department of Human Services, Psychiatric Residential Treatment Facilities. Accessed online November 17, 2021 at https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/prtf/.

[44] 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

[45] Cantor, J. H., McBain, R. K., Kofner, A., Stein, B. D., & Yu, H. (2021). Availability of outpatient telemental health services in the United States at the outset of the COVID-19 pandemic. *Medical Care*, 59(4), 319.

Innovative 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.[46] However, there is currently too little known about modalities to predict whether or how they might affect bottlenecks experienced by PrairieCare. Furthermore, also unknown is the extent to which the short-term and long-term mental health demands associated with the lasting COVID-19 pandemic may affect hospitalization rates and the need for hospitalizations in the PrairieCare service area and beyond.[47]

Concluding Comments

This report marks the sixth time that MDH has reviewed a proposal to expand inpatient mental health care since 2004 when Minnesota law began requiring a public interest review; it is the third time MDH has been asked to review a proposed expansion by PrairieCare. While the proposals—only some of which MDH found to be in the public interest—differed from each other in a number of ways, we do encounter a number of persistent challenges in conducting a rigorous review and delivering to the Legislature findings based on definitive evidence. Therefore, MDH presents the following additional observations to the Legislature:

- Under current Minnesota Administrative Rules,[48] psychiatric specialty hospitals such as PrairieCare are not required to annually disclose the same financial and statistical information to MDH as other community acute care hospitals and do not regularly share administrative discharge data with MDH. While PrairieCare has been a collaborative partner in supplying necessary data for the review, these data typically represent a snapshot, inhibiting conducting longer-term trend analyses.
- Each proposal concerns itself with the question of perceived inpatient bed capacity constraints for psychiatric services at a specific site, for a target population, a geographic area, or a single component of inpatient health care needs. This is in conflict with the call for coordination across the spectrum of care delivery for the vulnerable patients.
- For most proposals, there was limited empirical information available to 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.

[46] "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.

[47] Racine, N., McArthur, B. A., Cooke, J. E., Eirich, R., Zhu, J., & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19: a meta-analysis. *JAMA Pediatrics*, *175*(11), 1142-1150.

[48] Minnesota Administrative Rules, Part 4650.112 subpart 3.

In addition, the extent to which public interest reviews can offer answers to bigger questions about mental health capacity and the effectiveness of the delivery system is affected by several of their characteristics. These characteristics are:

- Conducted on an ad hoc basis,
- Focused through the narrow lens of specific proposals for one type of service (that may offer short-term remedies to a complex set of problems), and
- Typically, responsive to individual health care provider needs and local business opportunity, rather than reflective of broader, statewide health care infrastructure needs.

Given the inherent limits of a public interest review to address critical questions beyond the focus of a given project, this review still raised some larger questions. Thus, we submit the following observations for consideration by the Legislature:

1. **Broader context:** 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.
2. **Comprehensive evidence base:** Previous working groups of experts have consistently expressed frustration over the limited information available to inform mental health capacity decisions in a systemic, intentional way. Broader policy discussion, as well as future public interest reviews, could benefit from information about the day-to-day challenges of workforce bottlenecks in the availability of care capacity,[49] the geographic origin of requests from emergency rooms for placements of patients, the number of patients who cannot be discharged because lack of available follow-up care capacity (i.e., patient flow) and the number and geographic distribution of Minnesotans who require mental health services at various levels of treatment and support.
3. **Data from specialty hospitals:** As mentioned earlier, even before this current proposal, PrairieCare has been the single largest provider of inpatient mental health care services to children and youth in the state. Yet, Minnesota lacks systematic data for this key provider of critical services in the state, because as a specialty hospital, PrairieCare currently is not required report on financial performance, uncompensated care, workforce, and other metrics. This makes it challenging for payers, advocates, policymakers and analysts to assess the functioning of the delivery system and identify trends in the health care fabric that provides critical care to children and youth in the same way we do for other hospitals.

[49] While MDH has an array of data elements from pre-adjudicated and paid claims, as well as administrative information on bed availability collected by hospitals, there are currently no data being collected regarding if admissions are declined by hospitals or reasons for not accepting patients. PrairieCare has helpfully provided transfer request data as part of this review, and information like this will help inform access restrictions for mental health and other inpatient care if made available to MDH staff in the future.

4. **Revisit the recommendations made by earlier mental health task forces**[50]**:** Nearly five years prior to this report a group of individuals and families with lived experiences of mental illness, mental health advocates, service providers, counties, courts, law enforcement, corrections, public health, education, housing, and legislators were convened to offer a vision and set of principles to improve mental health across Minnesota. While this effort may have served as a catalyst for certain incremental changes in subsequent years, there is still much work to be done that can draw upon this aspirational roadmap to provide young Minnesotans a chance to live in a state where their well-being is prioritized.

   The following recommendations that materialized from that prior work offer goals and areas of focus for state-level transformation:

   - Create a comprehensive mental health continuum of care;
   - Strengthen governance of Minnesota's mental health system;
   - Use a cultural lens to reduce mental health disparities;
   - Develop Minnesota's mental health workforce;
   - Achieve parity;
   - Promote mental health and prevent mental illnesses;
   - Achieve housing stability; and,
   - Implement short-term improvements to crisis response.

[50] See for example: https://mn.gov/dhs/mental-health-tf/

Finding

On June 29, 2021, Minnesota Session Laws Chapter 7, House File 33, was signed into law. This legislation authorized an exception to the hospital construction moratorium[51] that permitted an existing psychiatric hospital exclusively serving children and youth located in Hennepin County to expand the number of licensed beds from 71 to 101. As part of this exception, the Legislature required that the hospital, PrairieCare Brooklyn Park Hospital, to submit a proposal to the Minnesota Department of Health for public interest review consistent with Minnesota Statutes, Section 144.552.

The purpose of this report 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 mental health services for children and youth in the hospital service area; financial and staffing information for affected hospitals; and public comments received on the proposal.

Over the past several years, there have been a number of efforts across the state to improve mental health care for children and youth. Promising new alternatives to inpatient hospitalization might offer many patients and families options closer to home and alleviate some of the capacity constraints we identified in our review. This, in turn, might reduce the need for a costly investment in physical capacity fixed at an existing location, such as the one proposed by PrairieCare. Yet, in the meantime, the need for inpatient care is pressing. Through our review, MDH has determined the following:

- There is evidence of a limited supply of mental health inpatient beds for children and youth served by PrairieCare, both within its service area and beyond.
- Many children and youth experience 'boarding' in hospital inpatient beds without specialized mental health services, and in hospital emergency departments that are not admitted to the hospital.
- A small percentage, but sizable number of children and youth, leave the Twin Cities and travel long distances likely due to the lack of available beds at the time they require admission; similarly, children from other parts of Minnesota travel long distances to be served in the Metro area.
- The financial impact of the bed expansion on other hospitals will be limited due to the size of the change relative to overall bed capacity and small share of revenue generated from these services at other hospitals.
- The staffing impact on other hospitals likely will be limited due to the size of the expansion and the staffing plan in place by PrairieCare; however, there are concerns among some non-profit hospitals with a disproportionate share of low-income patients about their ability to compete for staff with entities that have larger share of private pay patients.

[51] Minnesota Statutes, Section 144.551.

- The current policies in place for free and discounted care are largely comparable to policies used by other hospitals. With the new capacity, the hospital is expected to serve low-income and nonpaying children and youth at similar rates as is currently the place; however, these patients likely will continue to make up a small share of all patients served compared to several other facilities.
- The proposal has not garnered opposition among affected parties, and other Minnesota health care systems that provide inpatient mental health were supportive of the expansion.

For those primary reasons, the Minnesota Department of Health finds that **PrairieCare's 2021 proposal to expand hospital beds at its Brooklyn Park facility from 71 to 101 beds is in the public interest.**

Despite finding that the reviewed proposal is in the public interest, the review of available information leads us to conclude that on its own, this proposal cannot address all existing capacity constraints; guarantee that Minnesota children and youth will receive the kind of mental health care that ensures optimal possible health; nor, necessarily represent the best possible investment geographically and concerning the needed service. Significant additional innovation, investments, and collaboration will be needed.

Appendix A: Letters from Affected Parties

Allina Health

October 26, 2021

Stefan Gildemeister, Director Health Economics
Program Minnesota Department of Health
Submitted via email to Alisha Simon

Dear Mr. Gildemeister,

On behalf of Allina Health, thank you for the opportunity to comment on the PrairieCare proposal to add 30 licensed children and adolescent psychiatric beds at the PrairieCare Brooklyn Park Hospital.

Allina Health is committed to addressing the need for mental health services throughout the state and recognizes that Minnesota continues to see an increase in the need for in-patient child and adolescent mental health beds, especially as we routinely see children and adolescents coming to our emergency departments for care. We support the PrairieCare proposal and urge consideration of also including mental health emergency services.

Additionally, Allina Health remains supportive of the public interest review process, and its ability to provide lawmakers with additional perspective with which to evaluate the request of a single hospital within the context of a community's needs, as well as its existing capacity. We acknowledge the important role that the public interest review has in ensuring community voices are heard and their needs are met in a responsible and sustainable way.

Thank you for allowing Allina Health to comment on the proposed addition of beds at PrairieCare Brooklyn Park Hospital. Please reach out to Kristen McHenry, Director of Government Relations at kristen.mchenry@allina.com with any additional questions.

Sincerely,

Joseph L Clubb MSW LICSW

Joe Clubb
Vice President of Operations, Clinical Service Line
Allina Health

From: Maria Christu
To: MN_Health_PIR@state.mn.us
Subject: Public Interest Review - PrairieCare Brooklyn Park Hospital
Date: Thursday, November 4, 2021 2:51:57 PM

Ms. Simon,

I am providing this information in response to your letter to Dr. Gorelick dated September 24, 2021, on behalf of Children's Minnesota.

There is definitely a continuing need for additional inpatient behavioral health beds for children and adolescents in our community, and these additional beds at PrairieCare Brooklyn Park will help address that need. However, the addition of beds is only the first step. It is challenging to find staffing for pediatric behavioral health services at any time, but especially now during the current staffing shortage. Any expansion of behavioral health beds in the community, whether PrairieCare or elsewhere, will likely result in migration of staff from one system to another and persistent open positions in the region.

Thank you for the opportunity to provide input on this important issue.

Maria Christu (she/her/hers)
Chief Legal Officer, SVP Advocacy and Health Policy
Children's Minnesota
2525 Chicago Avenue
Minneapolis, MN 55404
(612)-813-6110 (office)
(612) – 251-0445 (cell)

Children's MINNESOTA

Essentia Health

November 4, 2021

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

Sent electronically to Stegan.gilfemeister@state.mn.us

Dear Mr. Gildemeister:

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, Minnesota, by 30 inpatient beds. Essentia Health is submitting this letter in support of PrairieCare's proposal.

Due to the current shortage of inpatient psychiatric beds for children and adolescents, patients often are forced to wait many days for an available inpatient bed to open somewhere in Minnesota or its neighboring states. These patients are frequently transported across the state, far away from their families and support systems, which adversely impact children with psychiatric symptoms. Essentia Health believes by increasing the number of beds in the Minneapolis-St. Paul metro area will help decrease this problem not only in the Twin Cities, but throughout greater Minnesota as well.

Minnesota continues to face a substantial shortage of the array of mental health services needed to provide adequate services for patients through the state. This shortage has been and continues to be exacerbated by the COVID-19 pandemic. We believe that there is a strong need for the additional beds proposed by PrairieCare and that these beds will help to address the shortage of services for children and adolescents requiring inpatient care. Essentia Health believes that 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 in the additional beds requested.

Thank you for the opportunity to provide these comments regarding PrairieCare's proposal for additional beds. Please do not hesitate to contact us if you have any questions.

Sincerely,

Jon Pryor, MD, MBA
President
Essentia Health – East

Bradley Beard, MHA, FACHE
Chief Operating Officer
Essentia Health - East

Fairview
HEALTH SERVICES

Alisha Simon
Minnesota Department of Health
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0992

Trasmitted via email

November 4, 2021

Dear Ms. Simon:

On behalf of Fairview Health Services, we appreciate the opportunity to provide feedback regarding the current public interest review process for adding 30 inpatient mental health beds at PraireCare in Brooklyn Park. We are supportive of the efforts to continue to increase mental health bed capacity in the Twin Cities. As the largest provider of inpatient mental health services in Minnesota, Fairview is committed to continuing to work with our hospital partners in making investments in the highly specialized inpatient mental health treatment. But just as importantly we are committed to continuing to invest in upstream mental health treatment that is so critical for patients and their families to ensure that hospitalization isn't their only treatment option.

The last eighteen months of the COVID-19 pandemic has exacerbated the mental health challenges for adults and children across the country, and we are seeing those challenges play out every day in our schools, our workplaces, our clinics and our emergency rooms. We know many of these families and children struggled well before the COVID-19 pandemic and will continue to do so into the future. The addition of inpatient adolescent mental health hospital bed capacity will help to solve some of these short term problems. But we need to ensure that long-term broad scaled investments continue to be made in our mental health system to ensure a robust continuum of mental health treatment options including crisis services, outpatient and inpatient treatment, EmPATH, transitional care services, intensive outpatient services and partial hospitalization programs are available when and where patients and families need them.

The entire team at Fairview Health Services looks forward to continuing to work with the Minnesota Department of Health and our provider and community partner colleagues to ensure we can best meet the mental health needs of all our children and families across Minnesota.

Sincerely,

Beth Heinz

Service Line Executive, Mental Health & Addiction Services; Women & Children Service Lines

HennepinHealthcare

November 4, 2021

Ms. Alisha Simon
Health Economics Program
PO Box 64882
St. Paul, MN 55164-0882

RE: Minnesota Hospital Moratorium Exception – Prairie Care

Dear Ms. Simon,

Hennepin Healthcare System has proudly served Minnesotans in need of critical mental health and recovery services for decades. Hennepin Healthcare offers 24/7 Acute Psychiatric Services (APS), partial hospitalization, day treatment and crisis respite services, as well as psychiatric consultations and outpatient therapies. Like many health systems, Hennepin Healthcare is experiencing significant pressures, placing programs at risk. We are supportive of the addition of psychiatric beds at Prairie Care, and we respectfully request your consideration of the following:

We support adding more psychiatric beds to meet the needs of the children of Minnesota. Our pediatricians and child mental health providers have frequent concerns about the lack of appropriate placement for children in need of acute mental health care. However, all children should be able to access these new beds and services, especially those on public programs. We request that Prairie Care collect and report the numbers of those they serve on public programs in their psychiatric services. We are concerned that if all children cannot access these services equitably, there will be further damage to health equity in Minnesota.

Like all health systems, we are experiencing staffing challenges. Competing with other systems whom have a greater commercial insurance source on the salaries they are able to pay their workforce is a significant challenge for our safety-net system. We ask that the state takes this imbalance into consideration and helps to ensure our safety-net system is able to staff to an adequate level to maintain the inpatient services that the state relies on to care for Medicaid patients.

Hennepin Healthcare System supports adding more mental health beds if it is done in an equitable manner, so children in Minnesota, regardless of the type of their health insurance, are able to access this service.

Sincerely,

Jennifer DeCubellis
Chief Executive Officer
Hennepin Healthcare System