MNA – Additional Information for MDH

## HealthEast Closures

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

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

> At the end of 2019 M Health Fairview announced the partial closure of Bethesda hospital while warning that St. Joe's was also at risk of closing. Just a few months later, we entered into a global pandemic and Bethesda was converted to a standalone COVID hospital. I worked at Bethesda until the COVID unit transitioned to St. Joe's after just 6 months. This was a pivotal moment of transition for St. Joe's, with existing med surg and ICU units, the converted COVID units along with the closing of the emergency room, leaving only the mental health units. These closures left St. Paul's population of 300K with just 2 adult emergency rooms.
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> When the COVID units closed, there were 4 Mental Health units and a separate unit of 15 beds from the previous Bethesda left. Local hospitals had been getting overwhelmed even with the downturn in COVID numbers and the staffing crises was starting to worsen. As COVID picked up again in the fall of 2021, things began to get dire once more.
>
> Critically ill patients are still being kept in the ER for many hours and even days due to lack of hospital beds; mental health patients are also waiting days for a bed to open. There are not enough mental health beds for those who need them. Yet M Health Fairview is moving forward with the closure of those 4 mental health units.

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

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

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

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

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

## Fairview's Plans for the University of Minnesota Medical Center

Fairview executives' decision to close Bethesda and St. Joseph's have been critiqued widely and publicly. MDH's data[1] shows that St. Joseph's has been over capacity with regard to mental health beds since 2018 (104% as of 2020[2]) in a poor payer mix area.

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

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

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

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

[1] Statistics gathered from Minnesota Department of Health's data set, "Mental Health and Chemical Dependency," available at https://www.health.state.mn.us/data/economics/hccis/data/stndrdrpts.html.
[2] Calculated as Inpatient Mental Health (Psychiatric) Patient Days / (Inpatient Mental Health (Psychiatric) Available Beds * 365 days).
[3] Funding gathered from Blue Ridge Institute for Medical Research, available at http://www.brimr.org/NIH_Awards/2021/default.htm.

# Impact on the Community

## Training Tomorrow's Physician Leaders

With the closure of St. Joseph's[4] and Bethesda, where are intern and resident programs going to go and how does this affect the funding the University of Minnesota's psychiatry department?

## Location

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

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

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

# Examining the "Union Premium"

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

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

# Continuity of Care

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

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

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

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

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

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

## Optimizing Profitability

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

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

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

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

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

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

# Quality Standards

## Fairview

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

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

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

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

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

## Acadia

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

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

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

[7] Available at https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html.
[8] Compiled from ProPublica Nursing Home Inspect, available at https://projects.propublica.org/nursing-homes/.

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

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

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

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

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

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

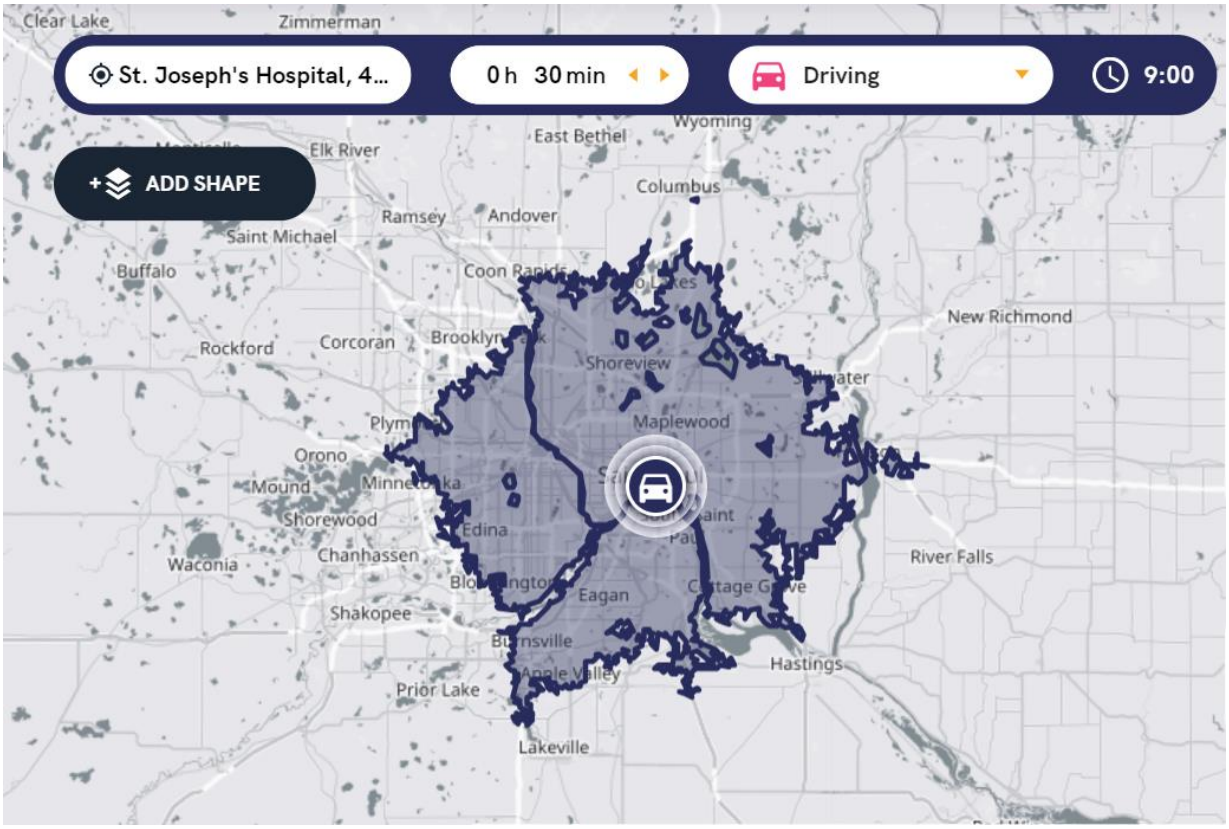
[9] Compiled from Quality Reports, available at https://www.qualitycheck.org/.

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

## Additional Information

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

# Appendix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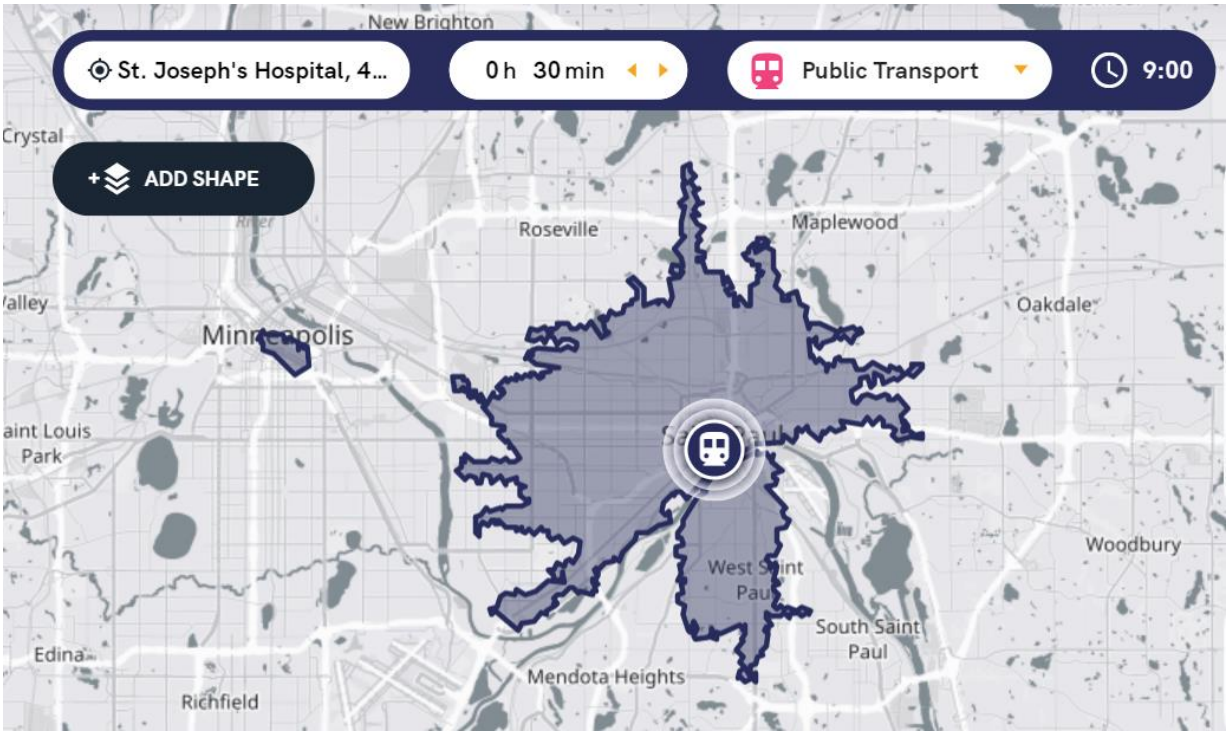
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