Sanford Medical Center Thief River Falls

Public Interest Review

Prepared by Sanford Medical Center Thief River Falls

March 23, 2014

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Introduction and Cover Letter

To the Office of the Commissioner of Health:

Enclosed is an application from Sanford Medical Center Thief River Falls requesting a public interest review of a proposal to expand access to psychiatric inpatient services in Minnesota, specifically in Northwest Minnesota, by establishing a free standing psychiatric hospital with 16 licensed beds at 120 Labree Avenue South, Thief River Falls, MN.

It is our intent to seek an exception to the moratorium law permitting the issuance of these 16 bed licenses. Enclosed you will find the information requested for the public interest review process.

If you have any questions, or need any further information, please contact Casey Johnson, Chief Financial Officer of Sanford Health TRF, at:

120 LaBree Ave S
Thief River Falls, MN 56701
E: casey.johnson@sanfordhealth.org
P: (218) 683-4636

We realize that this year's legislative session will be underway shortly, so please do not hesitate to let us know if there is any way in which we can expedite the review process. Thank you in advance for your time and attention in this matter.

Sincerely,

Casey R. Johnson, CFO
Sanford Medical Center Thief River Falls

Brian Carlson, CEO
Sanford Medical Center Thief River Falls

Sanford Medical Center TRF Psychiatric Inpatient Expansion Project – Executive Summary

1. **Project and Organizational Overview**
   - In order to better meet the regional need for psychiatric inpatient services, Sanford TRF would like to license a separate psychiatric hospital with 16 beds, to be located in a portion of the current downtown campus after the existing medical inpatient and outpatient services are transitioned to the new medical campus being constructed along Highway 32, all in Thief River Falls.
   - The project essentially requires legislative action to allow a newly licensed hospital to add 16 bed licenses, given the moratorium statutes in place in the state of Minnesota.
   - The newly licensed hospital, like the medical facility relocating to Highway 32, would remain wholly owned and operated by Sanford Health, based in Sioux Falls, South Dakota.
   - Sanford Health in Thief River Falls currently operates a 10 bed psychiatric inpatient unit as a distinct part unit of the Critical Access medical center. The newly licensed facility is necessary to expand the beds, as regulations do not allow for a Critical Access facility to operate any more than 10 beds for a psychiatric distinct part unit.

2. **Objectives**
   - The objective of the project is consistent with the mission of Sanford Health, which is a dedication to health and healing in the communities we serve. Given the market information available to us, we feel that our resources would be best used improving access for patients in the region to inpatient psychiatric services. This project is all about expanding our current capacity in this area. Our data shows that our average daily census could easily be at 14 patients per day, rather than the current 8, if we increase capacity by adding these beds.

3. **Phases/Timeline**
   - The first phase in the proposed project would be to fully transition the current medical inpatient and outpatient services from the current hospital located in downtown Thief River Falls to the new facility on Highway 32. This will likely occur during the Fall of 2014. This would not include the psychiatric inpatient unit.
   - Next, the newest portion of the downtown campus will be remodeled to house current inpatient and outpatient psychiatric and psychology services, as well as our community based mental health services. There will also be some medical services offered in the remaining portion of the downtown campus.
   - Concurrently, we will be working on obtaining a license for a separate psychiatric hospital in Thief River Falls, with 16 bed licenses to expand the inpatient unit.
   - When remodeling is complete, the afore-mentioned services will be moved to the newest portion of the downtown campus, and the remaining portions of the downtown campus will be demolished or sold. This will conclude the relevant phases of the project, and could be completed as early as spring of 2015.
   - If unable to obtain the hospital license or bed licenses, the only change in the project would be the remodeling would not include 16 beds, rather the existing 10. All current services would still be offered under the Critical Access hospital, but we'd be unable to expand access to the psychiatric inpatient service.

4. **Summary**

Our project is aimed at meeting the need of the communities we serve. One common challenge in our area is access to mental health services, and we're currently implementing an organizational strategy to take on those challenges. As one of the few facilities in Northwest Minnesota capable of serving patients with complicated psychiatric diagnoses, we are in a unique position to take on this challenge, but we need some flexibility to add beds. As we will demonstrate, rates of admission per capita in the state of Minnesota are currently 44% higher than that of Northwest Minnesota, and we turn down many admissions because of capacity. We believe the rates of admission are lower here than state averages because of access, and have several letters of support from referring agencies that agree with our assessment. The best chance these potential patients have for recovery to productive and contributing lives, is access to the services they need as close to their existing support system as possible. We realize that this is a highly acute and costly service to provide, but we provide a broad range of inpatient, outpatient, and rehabilitative services across the cost and acuity spectrums, and are expanding those to meet the same objective.

Description of Services

The important distinction to make, as we discuss the proposed project, is that our request applies solely to the additional psychiatric beds to serve patients with complex psychiatric diagnoses that require hospitalization. As we move forward with the rest of our master facilities and strategic plans, we will surely offer other new and expand existing services related to mental and behavioral health. The expansion of our inpatient unit hinges on the additional bed licenses and the licensure of a psychiatric hospital. In summary, proposed services would mean the expansion of psychiatric services from 10 beds to 16, though 16 new bed licenses would be required, given the fact that we cannot transfer the licenses from the Critical Access facility to the potentially newly formed psychiatric hospital.

If the additional licenses are approved, and the new hospital is able to be licensed, there certainly would be some changes in which services are provided under which hospital license. We would likely seek to offer most psychology and psychiatry professional services under the new psychiatric hospital, given the location and interoperability of the units. We would also probably move most of our community based services under the psychiatric facility, for similar reasons. Otherwise, those services would remain, as they are today, offered under the license of the Critical Access facility.

Bed Licensure Specifics

The bed licenses requested are 16 psychiatric licenses for a new psychiatric hospital. Our current facility, under a Critical Access license, can only operate 25 medical/surgical beds, and a 10 bed psychiatric distinct part unit. Currently, we use those 10 beds for psychiatric inpatient needs in our region. If we wish to expand, we cannot do so under the licensure of a Critical Access hospital. Ironically, our Critical Access facility pays for and currently holds 99 bed licenses. Unfortunately, based on statutes, we can’t simply transfer from one hospital to another. Therefore, we need to license a psychiatric hospital, and be given 16 new bed licenses in order to achieve the level of access we’re trying to provide. In doing this, we would no longer utilize the 10 bed distinct part unit under the Critical Access facility, so the net sum additional beds available would be 6.

Provider Affiliation

Professional provider affiliation is perhaps the most important aspect of this request. A major limiting factor in our region to mental and behavioral health services is the availability of professionals. Currently, we have 3 MD level psychiatrists. Up until July of 2013, we had only one. This core level of providers is essential in expanding services.

As we mentioned before, Critical Access facilities can have up to 10 beds for a distinct part unit, which can be used for psychiatric inpatient unit. If there is a need, why don’t Critical Access facilities in the region we’re describing use this exception to provide psychiatric services? The reason is that you need a psychiatrist, and they’re hard to come by. For the most part, it is risky to start the service because it’s tough to recruit a psychiatrist without an established base of business, and tough to start up a unit without stability in the area of professional psychiatry. At Sanford Thief River Falls, this is another reason we are in a unique position to fill the need.

Project Site, Plans, and Budget

The site where the particular beds in question will be used is in the currently occupied downtown location. The initial plans were to sell or demolish the location, but a decision was made to utilize the newest portion of the downtown location due to the value and economic efficiency of repurposing the space.

As it is situated now, the newest portion of the downtown campus is about 80,000 square feet split into three levels: ground floor, first floor, and the second floor. On the first floor, currently, we have lab and radiology, the gift shop, and dialysis. We would propose to keep dialysis, and replace the rest with our work therapy and community based services for Pennington county program. The rest of the existing services would move to the new Critical Access campus on Highway 32.

The first floor has outreach clinic services, finance and business office services, and other administrative services. Some of the first floor would likely remain for administrative services, but would mainly be used for outpatient psychiatric and psychology services, as well as some community based services space.

The second floor currently holds our entire 25 medical and surgical inpatient unit. This will be relocated to the Highway 32 campus, and replaced by the psychiatric inpatient unit of either 10 or 16 beds. If we are not granted the new psychiatric hospital licensure with 16 beds, we would remodel for 10 beds, and look at the additional space as potential for future expansion of other services.

The only question for us, again, is whether or not we should remodel for 10 or 16 patient beds. The economies of scale for the project are such that it would not take much more financial commitment from us to add the 6 beds, which is why we see this as such an efficient opportunity to add capacity for our region in this regard. Below are budgetary estimates at this point for the project. Current schematic drawings are also enclosed as attachments to the review.

Downtown Campus Remodel Budget			
FYs 2015-2016			
	Column2	10 Bed	25 Bed
Architecture/Engineering/Overhead		125,000	125,000
Construction/Remodeling		1,050,000	1,050,000
Mechanical Systems		800,000	800,000
Site Work		125,000	125,000
FFE		250,000	325,000
Contingency		150,000	150,000
Totals		**2,500,000**	**2,575,000**

If we only had 10 licensed beds for psychiatric inpatient services in this location, the impact on the overall budget would be minimal. Because of the existing infrastructure, you could only subtract about $50k from the budget assumptions, which represents the capital equipment, mainly beds and security infrastructure, for fewer beds.

Project Rationale and Market Based Analysis

Given the nature of the moratorium statutes, it's safe to say that the rationale for the need for the 6 additional beds is central to the necessity of the legislative action. Key to this rationale is the demographics and their access to these specific services.

For the calendar year 2012, we had 471 admissions. Just more than 51% of those admitted had Medicaid, Medicare, or PMAP coverage. An additional 15.7% were under "other" payors, most of which were billed to individual counties directly for 72-hour holds, or civil commitments. See the table below for more details.

AR Current Balance	(All)					
Revenue Division	Mental Health Inpatient					
	Quarter					
Payor	2012-Q1	2012-Q2	2012-Q3	2012-Q4	Grand Total	Annual Mix %age
BCBS MN	14	21	11	8	54	11.5%
BCBS ND		1	2		3	0.6%
HealthPartners	2	2	2	6	12	2.5%
Medica	3	1	1	5	10	2.1%
Medicaid	44	25	34	26	129	27.4%
Medicare	22	21	24	16	83	17.6%
Medicare Advantage			4	1	5	1.1%
MSHO	7	7	9	8	31	6.6%
Other	19	15	15	25	74	15.7%
PMAP	14	9	14	15	52	11.0%
Preferred One	3	1	1		5	1.1%
Private Pay		3	2	4	9	1.9%
Sanford Health Plan	1		2	1	4	0.8%
Grand Total	129	106	121	115	471	100.0%

Of the 471 admissions in 2012, 383 of the admissions were from our primary market area for psychiatric inpatient services. We define this area as Beltrami, Clearwater, Kittson, Lake of the Woods, Mahnomen, Marshall, Pennington, Polk, Red Lake, and Roseau counties. The complete breakdown by county and by quarter for 2012 is below.

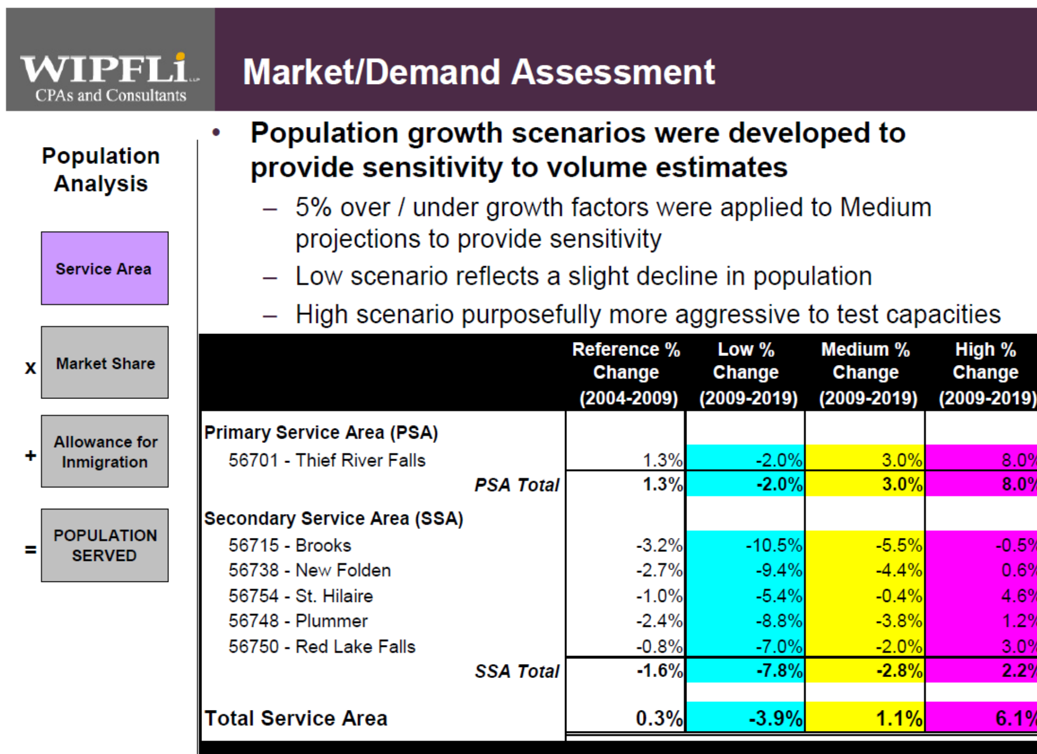
County of Origin	Sum of 2012-Q1	Sum of 2012-Q2	Sum of 2012-Q3	Sum of 2012-Q4	Sum of Grand Total
BELTRAMI	18	12	21	11	62
CLEARWATER	3	2	3	3	11
KITTSON	2	2	2		6
LAKE OF THE WOODS	2	1	2	1	6
MAHNOMEN	6	6	4	4	20
MARSHALL	7	9	6	4	26
PENNINGTON	37	30	26	31	124
POLK	14	7	22	12	55
RED LAKE	6	8	4	5	23
ROSEAU	17	11	9	13	50
Primary Market Total	**112**	**88**	**99**	**84**	**383**
Other	17	18	22	31	88
Grand Total	**129**	**106**	**121**	**115**	**471**

We justify this definition of counties by the inpatient admission data gathered by the Minnesota Hospital Association and reported to the State of Minnesota's Department of Health on a quarterly basis to determine market share. As demonstrated in the table below, Sanford Thief River Falls holds at least a one-third market share for each county, and has the highest market

share of any facility in each county. It is also worth noting that many of the "Other Facility" admissions would likely be better served in Sanford Thief River Falls, as many of these are admissions that wind up in facilities without appropriate psychiatric staff as a result of lack of timely access to psychiatric beds in emergent situations.

Facility	BELTRAMI	CLEARWATER	KITTSON	LAKE OF THE WOODS	MAHNOMEN	MARSHALL	PENNINGTON	POLK	RED LAKE	ROSEAU	Grand Total
THIEF RIVER FALLS, SANFORD THIEF RIVER F	67	8	6	6	15	25	125	46	21	51	370
GRAND FORKS, ALTRU HEALTH SYSTEM	2		2	1		11	5	56	3	14	94
FARGO, SANFORD MEDICAL CENTER, FARGO	26	3	1		8		3	8		2	51
BRAINERD, ESSENTIA HEALTH ST. JOSEPH'S M	30									1	31
BEMIDJI, SANFORD BEMIDJI MEDICAL CENTER	22	4	1		1	1	3	4			36
All Other Facilities	42	8	5	3	3	2	3	6	1	6	79
Grand Total	189	23	15	10	27	39	139	120	25	74	661
Thief River Falls Market Share	35.4%	34.8%	40.0%	60.0%	55.6%	64.1%	89.9%	38.3%	84.0%	68.9%	56.0%

The demographics of the area are relatively stable. As illustrated by the table, the most likely scenario is a slight uptick (1.1%) in the population in the selected zip codes, with the trend being that the more rural areas in Northwest Minnesota migrating away from the area, but the larger towns in the region, such as Thief River Falls, seeing slight increases in population. The net impact is shown here as a potential gain by 2019. This information was the result of a market study performed by Wipfli in 2010. We anticipated more robust projections by county from the State Demographer's office, but results that were slated to be released on December 30th of 2013 have not yet been posted. We are waiting for response to our specific request for information from staff at the demographer's office. For the purposes of this review, we will at this point assume a flat population projection until further information is available.



	Reference % Change (2004-2009)	Low % Change (2009-2019)	Medium % Change (2009-2019)	High % Change (2009-2019)
Primary Service Area (PSA)				
56701 - Thief River Falls	1.3%	-2.0%	3.0%	8.0%
PSA Total	**1.3%**	**-2.0%**	**3.0%**	**8.0%**
Secondary Service Area (SSA)				
56715 - Brooks	-3.2%	-10.5%	-5.5%	-0.5%
56738 - New Folden	-2.7%	-9.4%	-4.4%	0.6%
56754 - St. Hilaire	-1.0%	-5.4%	-0.4%	4.6%
56748 - Plummer	-2.4%	-8.8%	-3.8%	1.2%
56750 - Red Lake Falls	-0.8%	-7.0%	-2.0%	3.0%
SSA Total	**-1.6%**	**-7.8%**	**-2.8%**	**2.2%**
Total Service Area	**0.3%**	**-3.9%**	**1.1%**	**6.1%**

In terms of psychiatric utilization rates, there are varying percentages across the state, but one fact is for sure: in Northwest Minnesota, the rates of admission are 44% lower than across the state. We have not broken out our own admissions, or admissions across the state for that matter, by age or any other demographic factor. Given the specificity of our request to psychiatric services, it is our assumption that it is not pertinent. Here is a comparison by county to the state average.

Statistic	BELTRAMI	CLEARWATER	KITTSON	LAKE OF THE WOODS	MAHNOMEN	MARSHALL	PENNINGTON	POLK	RED LAKE	ROSEAU	Minnesota
Admissions	189	23	15	10	27	39	139	120	25	74	35,745
TRF Market Share	35.4%	34.8%	40.0%	60.0%	55.6%	64.1%	89.9%	38.3%	84.0%	68.9%	
Population	44,442	8,695	4,552	4,045	5,413	9,439	13,930	31,600	4,089	15,629	5,303,925
Incidence	0.43%	0.26%	0.33%	0.25%	0.50%	0.41%	1.00%	0.38%	0.61%	0.47%	0.67%

Proposed Primary Market Service Area	
Total Population	141,834
Current Incidence	0.47%
State Average	0.67%
Potential Increase % age	44%

As you can see, utilization rates vary widely by access to services. If we could expand our capacity, some of these counties would have increased access to these services, and utilization could increase in a place that kept the residents closer to home, and closer to their existing support structures. We have included corresponding "turn-away" data, logged by our own staff over the course of the same time period, to justify that there is need that isn't being met in these counties. We turned away 393 admissions over the course of the year, and 347 of those were for no other reason than we did not have capacity. It may be worthwhile to note at this point that we always try to keep one seclusion room available in case of emergencies, a policy we would likely carry forward with us. This is the reason that our average occupancy rate has hovered between 80% and 90%, but we've turned away so many patients. See the table below for detail.

Reason for "Turnaway" County	At Capacity	At Capacity (Holding 1 Bed)	Inappropriate Programming	Patient Acuity	Other	Grand Total
Beltrami	56	45	9	3		113
Clearwater	9	6				15
Kittson	3					3
Lake of the Woods	4	1				5
Mahnomen	8	1	1	2		12
Marshall	5	1				6
Pennington	11		1			12
Polk	21		4	3		28
Roseau	14			2		16
Total for Primary Market Area	131	54	15	10	0	210
All Other Counties	72	90	11	8	2	183
Grand Total	**203**	**144**	**26**	**18**	**2**	**393**

So now that we've looked at the data representative of the current state, the question becomes this: How do we project our need going forward? We don't have 100% market share, and for good reason. Many situations are too medically complicated for us to handle. Some are not appropriate patients for us to take because of existing support systems for patients. The methodology for what we may reasonably expect could be constructed a number of ways, but we've gone with potential increase percentage amongst our primary market area counties based on the state average rate of incidence, and then also our "secondary market" potential based on "turn-aways" we've recorded from referral sources elsewhere. We've illustrated three potential scenarios below. Given the demonstrated support and need for access from a number of counties and other referral agencies, we believe reality will fall somewhere close to, if not exceeding, the numbers represented in scenario 3.

	Scenario 1	Scenario 2	Scenario 3
Current Admissions	471	471	471
Admissions from Primary Market	370	370	370
Current Days	2918	2918	2918
Average Length of Stay	6.20	6.20	6.20
Primary Market Area Variance to State Avg Admissions	22%	44%	66%
Additional Admissions from Primary Market Area	81.4	162.8	244.2
Turnaways from "Secondary Market" (Everywhere else)	162	162	162
Realistic Admission Capture Percentage from these turnaways	50%	75%	100%
Additional Admissions from Secondary Market Area	81	121.5	162
Total Admissions Projected	633.4	755.3	877.2
Projected Days	3,924.1	4,679.3	5,434.5
Projected Actual Beds Needed	11	13	15

One variable we've left constant in this equation is average length of stay. It is difficult to say where this number will move in the future. It did drop from around 7.5 to 6.2 over a couple of years from 2010 to 2012, but has since leveled off. This was due to a shift in the mix of patients towards more being admitted on 72 hour holds and then released. This trend may actually turn, however, as the 72 hour holds are more frequently turning into longer stays based on need for additional services, and coordination with counties and patients' families and other support groups. In summary, we left it constant because it's unclear which direction it is currently trending, and anecdotal evidence can be offered in both directions.

Another element of the equation that we were not able to factor in was the capacity of the State Operated System, and their role in filling the capacity. The system, though, is typically coordinated through a centralized admissions process, and facilities are spread out throughout the state, and given priority based on critical nature of the admission rather than geographically, so one could presume that the missing admissions for each county would be relatively proportionate to the actual admissions captured by MHAs inpatient statistics. The most reasonable and convenient conclusion would then be that, though the base numbers may be off, the opportunity for the region to increase access to the point that the rate of incidence per capita would be consistent with the state average would still be 44%. Now, this may not be the case in practicality, but without the admissions information from the state operated facilities, it is impossible for us to determine conclusively that our assumption is materially incorrect.

If the average daily census was 15 versus the current 8, the staffing would change only for variable staffing of nursing and care techs. If the capacity was similar to existing volumes, FTEs would be at about 13 FTEs. If we had 25 bed licenses, and the average daily census was around 15, the FTEs for RN, LPN, and care techs would be about 21 FTEs. Granted, this is a significant difference, there would be minimal impact on surrounding facilities because of the specialty of the staff required.

Conclusion

So by our interpretation, the market and utilization data tells us that we could expect an average daily census of about 15 beds being utilized. Two key questions remain. First of all, why do we need 16 beds if we only have an average utilization of 15? Secondly, the crux of the market data relies on the state average of admissions being appropriate utilization; is it possible that statewide psychiatric beds are simply over-utilized, and there is really no need for more beds in to serve our region? We have considered each of these questions, and still feel 16 beds is appropriate, and that the need for additional access is real.

Given the variation in need at any given point in time, our contention is that even though we may average 15 patients per day, to have 16 beds available will ensure, without any real additional overhead cost because of the existing facility, that we have capacity to meet the access needs at all times. Additionally, we may seek to expand our facility's capacity to also serve diagnosed chemical dependency and psychiatric patients as we seek to develop more substance abuse programming, which will likely increase admissions. We'd rather have 16 bed licenses and not have to ask for more in the future, and assume that the Department of Health would prefer that as well.

When it comes to the fundamental question of whether or not the gap between admission rates is the result of a lack of access, or over-utilization elsewhere, we think the evidence is overwhelmingly in favor of the former rather than the latter. Nationally, we see stories about the lack of access to psychiatric care overwhelming emergency rooms. More locally, we've seen uniformed support for our additional capacity by referring agencies and competing hospitals alike for our project. Statewide, we've seen articles about the challenges for state-run agencies to keep up with the demand and the complexity of the cases. We are an organization that has the resources to meet the need. To deny our professional and technical staff the opportunity to fill that gap, given the capital already in place for this project, seems like an illogical decision.

Our motivation organizationally is always to serve people in the most cost effective manner possible. We realize that psychiatric inpatient services are basically the highest cost and highest acuity on the continuum of care for these patients. At the same time, it should be evident that we are not one dimensional in our approach to care for this population. For the primary market area that we've defined, we offer crisis response and community based rehabilitative services for the same type of patient in several of the counties. We feel that we are one of the more progressive organizations in terms of our integration of mental health services with primary care, as well as in terms of integrating a preventative approach to medical and mental health care. All that being said, we need to provide more access to this high acuity service to keep these patients close to home and still provide them adequate care. Again, we are in a unique position to provide that given our professional psychiatric staff and established service model, as well as our opportunity to utilize the bricks and mortar we have in place already.

Thank you for your time and consideration in this matter. If you should need access to any of the data repositories utilized to present the summary information in any of the tables presented here, or if you have further clarifying questions or comments, please do not hesitate to contact us at the contact information provided below.

Enclosures to Follow