Full testimony of Bernadine Engeldorf, RN to the Behavioral Health Policy Division, 1/27/21

Good Morning

Thank you for providing me with this opportunity to share some of my experience with you. My name is Bernadine Engeldorf and I live in White Bear Township I am a registered nurse and for the last twenty plus years of my nursing career I have worked in the field of Mental Health and Addiction services. My primary place of employment has been at United Hospital. I only say that because I believe there is some relevance of my work location to this discussion. I also worked a number of years ago at the now closed Golden Valley Health Center, it was a free-standing Psychiatric facility providing multiple services for individuals with mental health / addiction that was closed shutting down significant services.

I'm testifying today as I am concerned about the potential reduction of mental health inpatient beds and services in the east metro by the planned closure of St. Joseph's Hospital that is now providing Mental Health and Addiction Services only.

The current climate of mental health care in Minnesota is in crisis. A recent study ranks Minnesota as one of the top states in providing care. With that statement acknowledged, as a nurse in the field I believe based on our lack of care, here in Minnesota this data demonstrates the true crisis the United States is experiencing. In fact, our neighbor, Wisconsin falls at the bottom thus noting significant lack of services. Obviously, we know that also impacts the access of Minnesota residents as those having difficulty in WI will seek care in Minnesota.

The lack of access and numbers of inpatient Mental Health beds / services in Minnesota is evident to front-line care providers. We not only face difficulty admitting individuals to inpatient beds, but we lack outpatient services. There are long waits that take up to four to six weeks to secure an appointment while symptoms may increase to a crisis level.

Most individuals enter the inpatient setting through the Emergency Department. Often this may be directly related to the lack of outpatient services and inability to access care. Social stigma, cultural variance and potentially lack of knowledge related to access most likely also impacts entrance through the hospital's Emergency Departments.

Our Emergency Departments are always busy. We know that at times they are extremely overwhelmed (especially now) and often individuals are waiting for several hours. Those individuals might have been able to be seen as an outpatient but either access is not available, or they wait due to lack of coverage for medical care.

Many of our Emergency Departments have specific units (limited number of beds) for those seeking mental health care. These units are specifically designed to provide assessment, referral, or actual treatment after medical cause is ruled out. Unfortunately,

often the mental health patient flows into the "regular ED" thus consuming beds that traditionally would only treat the "physical issues" of patients.

The nurses have a focus of both physical and mental health care. All ages are seeking care in these Mental Health Suites thus causing additional stress to care providers. In addition to all ages there are multiple diagnostics. The diagnosis / symptoms are varied including depression, positive suicidal ideation, altered thought process, potential homicidal ideation, hallucinations, opioid withdrawal, alcohol intoxication and withdrawal, and experience of domestic violence amongst a few. The ED Physician, Registered Nurse, Social worker, and assistants are often caring for these patients through multiple phases of care. The optimal level of care would be considered crisis stabilization, treatment, and discharge to the next level of care. Unfortunately, it is not unusual to be required to provide care longer in the ED setting than what is optimal for the individual.

The RN's are trained to care for mental health patients but caring for patients in crisis is different than ongoing development and execution of a treatment plan.
Hospitals are trying to deal with this crisis by establishing guidelines when an Advanced Practice Nurse or a Psychiatrist will actually see the patient when they are in the ED for longer than twenty-four hours sometimes days, or weeks.

I'd like to share some quotes from my colleagues in the ED:

"I feel so terrible we cannot provide the appropriate level of care. Patients on ED carts in a room with nothing but a TV". They are isolated from families often the isolation increases their symptoms!"

" with patients in crisis it is hard to provide the attention to those who are waiting to be admitted".

That is if there is a bed available in the hospital in which the individual that has arrived to seek care. Often there are NO beds, all are occupied with individuals needing care. Once someone is seen in the ED, they are assessed and deemed necessary to admit, usually due to danger to self or others, the hospital must find services for this individual. Then the process starts attempting to secure a bed, usually at the corporations' sister hospitals, if they have services. When that has been explored, if no beds are found the staff will seek care at other "nearby facilities". For example, United Hospital would seek beds at St Josephs, Regions or even HCMC. If NO beds within the metro the search goes outside of the metro to outstate facilities such as Mayo in Rochester, Essentia St Mary's or even Sanford in Sioux Falls, S.D.

The question ultimately focuses on "Why no beds" in the hospital's mental health department? Obviously, there are more individuals seeking care than actual "spots" or defined mental health / addiction service beds available. Our mental health units are specifically designed to care for these individuals experiencing a mental health diagnosis. People often ask, "Why can they not go somewhere else in the

hospital?" Medical / Surgical Units staff are not trained to care for potential needs of the mental health patient. While they can assist patients with MH issues they are not able to provide treatment and care but to simply make assessment and make referrals. There have been times that we have moved patients to units that are not MH units. When doing this, resources are taxed, the individual often requires one to one staffing due to the environment the patient is located. And often it is not safe for individual or staff.

Most nurses in mental health believe there is a financial impact to health care institutions that is not always acknowledged. Are mental health beds decreased in facilities due to lack of revenue? Often mental health beds are closed in our not-for-profit facilities due to lack of revenue. Many individuals with chronic mental health diagnosis do not have insurance coverage or they have Medicaid that is not as financially attractive. In recent years multiple private facilities have been built. Many of them are in suburbs thus usually in an income viable area. This issue should make us aware of continuing to maintain mental health / addiction services inpatient beds available to our communities of underserved populations, low income and homeless.

It is necessary for an ongoing evaluation of the status of our mental health / addiction services in Minnesota. This not only includes the number of inpatient services but outpatient as well. It seems so obvious to us (care providers) especially in the East Metro, that St. Josephs Mental Health/Addiction Services remain open. Currently in the East Metro Regions has 100 beds, United has 56, and St. Joe’s has 100. We cannot afford to lose beds with the increasing numbers of individuals seeking mental health care.