

Chapter 6

Hospitals and Long-Term Care Facilities

"The ultimate goal is the provision of adequate hospital facilities for all of the people."⁵²⁴

Dr. Helen Knudsen, 1951

Note: The photo of Dr. Helen Knudsen is missing from this file, as the disk did not have sufficient memory for it.

Helen L. Knudsen, B.S. in Medical Technology M.D., M.P.H.

Director of Division of Hospital Services, 1948 to 1974

Minnesota Department of Health, 1944 to 1974

Hospitals, nursing homes and other health facilities in Minnesota underwent a transformation between 1949 and 1999. With the institution of regulations by the Health Department in the 1950s, standards were established and the quality of care received in all facilities was more closely monitored. Unable to meet the standards, houses converted to converted nursing homes and other small facilities began to disappear, replaced by larger, modern buildings. Overall, the number of hospital and nursing home beds began to increase. This was due in large part to the availability of federal Hill-Burton funding, administered by the department for more than 20 years. Payment through Medicare, Medicaid and insurance further encouraged growth of the industry, as well as improving quality of care. The 50-year period began with concern over a shortage of hospital and nursing home beds. By the 1970s concern was raised over the excess numbers.

Hill-Burton: Hospital Growth Begins

Very few hospitals were constructed between 1929 when the Depression started all through the mid-1940s, and communities needing hospitals did not have them.⁵²⁵

The stage was set for a post-war hospital building boom all through the mid-1940s, made possible in 1946 by the Hospital Survey and Construction Act, better known as the Hill-Burton Act. This created a five-year program in which \$75 million in matching grants would be provided annually to states to build hospitals in underserved areas.

⁵²⁴ Helen Knudsen, M.D., M.P.H., "Where the State Agency Fits In," *Modern Hospital*, April 1951, pp. 77-79.

⁵²⁵ *American Hospital Association News*, August 14, 1995.

The law also appropriated \$3 million for all states to inventory their health facilities. For the first time the nation would have a comprehensive picture of where the need for hospitals was most urgent and each state would have a planning process for meeting that need.⁵²⁶

The Hill-Burton program was extended later to provide grants for building nursing and each state would have a planning process for meeting that homes diagnostic centers and chronic disease hospitals.

The boom in hospital building and the transformation of health facilities throughout the nation began when the 79th Congress passed federal Public Law No. 725, the Hospital Survey and Construction Act in 1946. This law authorized an annual grant to states to assist in constructing and equipping needed hospitals and public health centers. Before a state could receive federal grants for construction purposes, it had to submit an overall state plan to the U. S. Public Health Service for approval. The initial plan for Minnesota was completed in early 1948 after a comprehensive study of existing facilities and a determination of present and future needs.

The first funds from this program were used to survey hospital needs, plan the location of facilities, and cover up to one-third of the construction costs of facilities in underserved areas.⁵²⁷ Funding for equipment was also offered. In return, hospitals had to make services available to all members of the community, and they were expected to provide charity care for a period of 20 years. Some hospitals have continued to provide charity care after the 20-year period ended.⁵²⁸

Sponsored by Sen. Lister Hill (D-AL) and Sen. Harold Burton (R-OH), the bill which began the changes to health care facilities, was signed into law by President Harry S. Truman August 13, 1946. Funds from this federal program were intended to give first priority to rural and minority populations currently without adequate hospital service. According to designs promoted by the Public Health Service, hospitals were to create a "human" setting. Sites were to be chosen to make sure every patient could receive sunlight in his/her room.⁵²⁹

The Health Department was the agency designated to plan and distribute Hill-Burton funds in Minnesota. Chapter 485, Laws of Minnesota 1947, charged that the Board of Health cooperate with the U. S. Public Health Service in the conduct of this program. For the first time, the board had a significant role in directing health care facilities and was in a powerful position to determine the location of hospitals throughout the state. The board made the final decisions as to which communities received federal Hill-Burton funding for designated facilities.

⁵²⁶ *American Hospital Association News*, July 20, 1998.

⁵²⁷ P.L. 725, 79th Congress, c. 958.

⁵²⁸ Jack Bess, "If You Build It...", *American Hospital Association News*, July 20, 1998, p. 7.

⁵²⁹ *Ibid.*

Between 1948 and 1974, Minnesota received \$80,942,230 in Hill-Burton grants.⁵³⁰ These funds were used to assist with the construction of health facilities in the state. The amount Minnesota received represented nearly 10 percent of the total estimated cost of health facility construction costs during that period.⁵³¹ The Hill-Burton funds also represented a large percentage of the Health Department's operations. In 1956 nearly 60 percent of the department's total revenue was from Hill-Burton funds.

The Hill-Burton Act of 1946 helped finance the construction of hospitals and public health centers, and in 1954 the law was amended to include nursing homes, chronic disease hospitals, diagnostic or treatment centers and rehabilitation centers.⁵³² In 1964, it was again amended to authorize grants for area-wide planning and consolidation of the chronic disease hospitals and nursing homes into one category – “long-term care.”⁵³³ A final amendment in 1970 established a new category, outpatient facilities, in lieu of diagnostic and treatment centers and offered loans, as well as grants.⁵³⁴

The hospitals and nursing homes in Minnesota in 1949 were quite different from what existed 50 years later, in 1999. In 1949 hospitals and nursing homes might be converted dwellings. The hospital in Cambridge, for example, had a large staircase on which patients were helped or carried up and down, as there was no elevator. In some hospitals the surgical and operating rooms were in the same area or the emergency rooms and the operating rooms shared a space. Many facilities did not have sprinkler systems to better protect the residents from fire. Change was needed.



First Hospital in Thief River Falls
Negative No. 0482-8 Location No. MP3.9
TR7.1 p1

Minnesota Historical Society· 345 Kellogg Blvd.
West, St. Paul, MN· 651.296.6126 [Copyright](#) ©
1999

Dr. Helen Knudsen

The person in charge of this important program was Dr. Helen Knudsen. She was pragmatic, organized, and determined to make certain the citizens of Minnesota had adequate access to hospital facilities. Her detailed reports from 1948 through 1974 chronicle the expansion and improvements of health care facilities in Minnesota.

⁵³⁰ MDH (health facilities division), *Minnesota Hospitals: 25th Annual Revision, 1973-74*, January 1974, pp. VIII, pp. 5-25.

⁵³¹ MDH (health facilities division), “Minnesota State Plan for Hospitals, Public Health Centers, and Related Medical Facilities” (news release), January 16, 1974.

⁵³² P.L. 482, “Medical Facilities Survey and Construction Act of 1954,” 83rd Congress, 2nd Session, C. 471).

⁵³³ P.L. 88-443, “The Hospital and Medical Facilities (Hill-Harris) Amendment of 1964.”

⁵³⁴ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, pp. VIII, pp. 5-25.

The Health Department almost missed the opportunity to have Dr. Knudsen lead the program. Nearing the end of her internship at the University of Minnesota Hospitals in 1944, she hoped for a career in internal medicine. She asked Dr. Cecil Watson, chief of medical service, about the possibility of a fellowship. He explained, "I've never taken a woman, and I wouldn't take anyone without a year in pathology first."⁵³⁵

It was Dr. Ruth Boynton, head of the student health service at the University of Minnesota and a member of the Board of Health, who suggested that Dr. Knudsen talk to Dr. Albert Chesley, secretary and executive officer of the board about an open position at the department. Dr. Knudsen met with Dr. Chesley in the library of the old Health Department building on the University campus. He offered her a position as head of the emergency maternity and infant care program. She accepted. Walking back to the University of Minnesota Hospitals, 10 minutes after her conversation with Dr. Chesley, she was paged by Dr. Watson. He now offered her a fellowship in internal medicine, without the prerequisite year in pathology. Fortunately for the Health Department and the hospital system in Minnesota, Dr. Knudsen replied, "I'm sorry, but I'm going into Public Health."⁵³⁶

Dr. Knudsen was also offered a fellowship in neuro-surgery by Dr. William Peyton. She turned this down, too, explaining, "Who would go to a woman for a brain tumor?" Dr. Peyton replied, "I need help, and I know you would work hard."⁵³⁷

Dr. Knudsen began work for the department on October 1, 1944. The program she ran provided maternity care and infant care up to age one year for families of the four lowest paid ranks in the armed forces. The job waiting for Dr. Knudsen was indeed challenging. Cases hadn't been processed and forms lay in huge piles on her desk. She discovered the \$75.00 fee limit for obstetrical care wasn't always observed. Finding extra charges by the Mayo Clinic, she met with the business manager and no further problems resulted.

In 1946, Dr. Knudsen took a leave from her work at the department to earn a master's degree in public health at the University of Minnesota, where Dr. Gaylord Anderson headed the program. Classmates of hers included Dr. A. B. Rosenfield and Dr. William Harrison, both employees of the department. Another classmate, in an earlier speech class, was Hubert H. Humphrey. For two quarters she sat two seats from him, and describes the experience as "frustrating." Graduating in 1947, Dr. Knudsen was appointed chief of the department's hospital services section on June 6, 1947.⁵³⁸ This was later named the health facilities division.

⁵³⁵ Conversation with Dr. Helen Knudsen, Minneapolis, Minnesota, March 10, 1999.

⁵³⁶ Ibid.

⁵³⁷ Ibid.

⁵³⁸ MDH, *Minnesota's Health*, Vol. 10, No. 1, January 1956, p. 4.

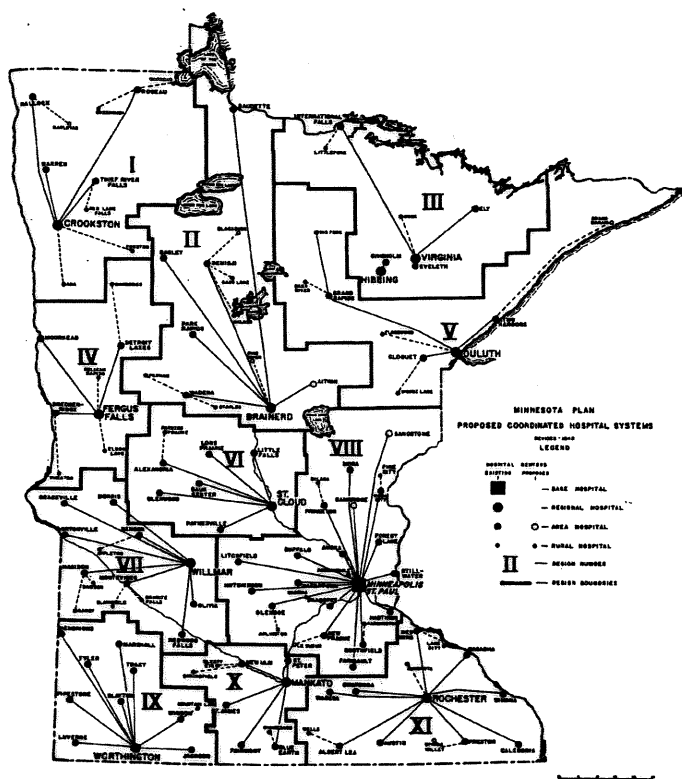
Hill-Burton: State Hospital Plan

The road map for Dr. Knudsen's actions was contained in the hospital plan that was created with the input of a state advisory council on hospital construction appointed by the governor. Dr. Viktor Wilson, chief of the department's special services section, was the first chair of the committee. Later, Mr. Ray Amberg, superintendent of the University hospitals, was chair for many years. Mr. Glen Taylor, executive secretary of the Minnesota Hospital Association, was a member, and other members included representatives of hospitals, medicine, dentistry, nursing, pharmacy, architecture, labor and farm groups, plus governmental agencies.

The objective of the state hospital plan was to develop a uniform distribution of general hospitals reasonably available to the population and capable of rendering qualified service. To obtain quality service, consideration was given to hospital sizes consistent with efficient and economical operation. In areas of sparse population, it was found necessary to compromise on the hospital size to obtain reasonable availability of service. The actual determinants involved were hospital location, service areas, and sizes of institutions.

The first Minnesota plan for hospitals and public health centers, approved by the Surgeon General of the U.S. Public Health Service on March 5, 1948, was based on a comprehensive study that defined what facilities existed in Minnesota and what was needed.⁵³⁹ ⁵⁴⁰ The plan identified priorities for selecting a particular community, targeting communities with the greatest needs.

Gov. Youngdahl announced the hospital plan for the state in 1948. According to the plan, everyone in Minnesota would live within approximately 20 miles of a hospital. The plan called for regional hospitals in 11 locations: Crookston, Hibbing-Virginia, Duluth, Fergus Falls, Brainerd, St. Cloud, Willmar, Mankato, Worthington and Rochester. Regional hospitals would receive the highest priority. The University of Minnesota Hospitals in Minneapolis, equipped to handle all types of patients, would serve as the base hospital for the state.



⁵³⁹ MDH, *Minnesota Hospitals 1973-74*, January 1974.

⁵⁴⁰ MDH, *Minnesota's Health*, Vol. II, No. 6, June 1948, p. 2.

Originally, up to one-third of the construction costs of a hospital were financed with federal funds.⁵⁴¹ This limit was increased to 45 percent in 1950.

Hill-Burton: Selecting Sites

Determining which communities received funds was politically challenging, as usually each community wanted its own hospital. In order to be eligible, a project must have a high priority rating.⁵⁴² Communities had to demonstrate they had the financial ability to complete and operate the facility. The hospital must be owned and operated by public or non-profit corporations or associations, and there had to be assurance that the facilities would be open to provide medical services to anyone in the community.⁵⁴³

The advisory council⁵⁴⁴ reviewed each situation and made recommendations to the Board of Health as to which projects should receive funding. The advisory council usually scheduled its meetings just before board met. Given the political nature of the decisions, the board had to keep the governor and Legislature informed as to the basis for its decisions. Dr. Chesley commented on this at one board meeting:

"You have a change of administration and there are going to be questions raised about 'My Home Town.' If the Governor knows this is a stated policy and we have adhered to it through two administrations, it won't do any harm."⁵⁴⁵

Dr. Albert Chesley, 1955

Despite the board's efforts to focus on need, some persons felt its decisions were political. At one board meeting, Dr. Litman said, "...there seems to be some underlying rumors that if there had been better representation on the Board of Health they might have had better consideration by the Board."⁵⁴⁶

Applicants for projects were ranked by number. At one board meeting, members discussed the ranking of one hospital. Dr. Barr said, "We have had two telephone calls from the Governor to ask that we give consideration to the request of this hospital. My frank opinion is that the man in charge is a promoter..."⁵⁴⁷

Representatives of communities whose projects had not been funded sometimes complained. When, in 1957, the City of Minneapolis requested an additional allotment and was turned down by the board, Minneapolis Mayor Peterson wrote U.S. Sen. Edward J. Thye. Sen. Thye contacted the U.S. Public Health Service, which informed

⁵⁴¹ MDH, *Minnesota's Health*, Vol. II, No. 2, February 1948, p. 2.

⁵⁴² MDH, *Minnesota's Health*, Vol. III, No. 8, August 1949, p. 3.

⁵⁴³ MDH, *Minnesota's Health*, Vol. 9, No. 3, March 1955, pp. 1-2.

⁵⁴⁴ The Health Facility Advisory Council was established in 1951 as the Health Facility Advisory Board (Minnesota Laws 1951 c304 s9). The law was changed in 1975 (Minnesota Laws 1975 c 234). The Council was abolished in 1983 (Minnesota Laws 1983 c260 s 68).

⁵⁴⁵ BOH, *Minutes*, January 10, 1955, MHS, p. 16.

⁵⁴⁶ BOH, *Minutes*, May 26, 1959, MHS, p. 123.

⁵⁴⁷ BOH, *Minutes*, August 1, 1950, MHS, pp. 359-367.

Sen. Thye it was a decision to be made by state and local authorities. Sen. Thye supported the board as the key decision maker.⁵⁴⁸

Sometimes communities were dissatisfied when a neighboring community received funding for a facility and they didn't. A lively session was held at one board meeting when community representatives advocated funding for a hospital in St. James and challenged the funding of a nearby community:

St. James Community Representative: "How large a hospital is being planned at Long Prairie?"

Dr. Barr: "Thirty beds."

St. James Community Representative: "If that area is so poor, how can those people be able to go to that hospital?"

Dr. Barr: "No matter how poor you are, you have a right to good hospital care."⁵⁴⁹

A few health facilities were selected as recipients of Hill-Burton funding due to special reasons. A general hospital in Big Fork was justified by the distance people had to travel. Fairview-Southdale Hospital was recommended for Hill-Burton funding on the basis of its unique character as a satellite in a rapidly growing suburban area in conjunction with a well-developed downtown hospital and the potential for study in several areas relating to the conservation of personnel and economies in operation.⁵⁵⁰ The Olmsted Community Memorial Hospital in Rochester was justified because of the high demand for hospital beds in Rochester due to the large number of people from outside Minnesota who came to the Mayo Clinic.

A representative from the Health Department always attended the bid openings in communities. In the early years Dr. Knudsen made sure she attended each one, traveling around the state, sometimes on bus. Bid openings were also attended by Dr. Knudsen's assistants, Mr. Elmer Slagle and Mr. Eugene Koepp. Mr. Slagle, assistant director of the hospital services section, was a long-serving employee of the department. He began working for the department in 1930 in the Duluth district office as a sanitary engineer.⁵⁵¹ Mr. Koepp, auditor for the division, was praised for his excellent management skills.

The first hospital in the state to be completed with the help of Hill-Burton funds was a 20-bed community hospital in Greenbush, opening on February 1, 1950.⁵⁵² The first public health center financed with Hill-Burton funds was the Rochester Public Health Center, completed in 1950. In addition to providing space for offices, laboratory and clinic facilities of the Rochester-Olmsted County health unit, and city welfare offices, it housed the department's district office.⁵⁵³

⁵⁴⁸ BOH, *Minutes*, October 9, 1957, MHS, p. 228.

⁵⁴⁹ BOH, *Minutes*, September 23, 1954, MHS, p. 35.

⁵⁵⁰ BOH, *Minutes*, July 9, 1963, MHS, p. 428.

⁵⁵¹ MDH, *Minnesota's Health*, Vol. 20, No. 1, January 1966, p. 4.

⁵⁵² MDH, *Minnesota's Health*, Vol. IV, No. 2, February 1950.

⁵⁵³ MDH, *Minnesota's Health*, Vol. III, No. 8, August 1949.

When a hospital, financed with the help of Hill-Burton funds, was dedicated, persons from the Health Department were invited. Dr. Knudsen attended three of these dedications with Sen. Hubert Humphrey, the fellow student in her speech class at the University of Minnesota.

Community Challenges: One Hospital per Community

The hospital plan called for only one hospital per community. If a community wanted to use Hill-Burton funds, it sometimes had to determine which of two institutions it would support. A Catholic and a Lutheran hospital in Crookston joined together, as did two hospitals in Mankato and two hospitals in Fergus Falls, for example.

Not all communities, however, readily agreed to join together, and this could lead to disharmony within the community. An example of this type of challenge faced by Dr. Knudsen and others was the situation in Tracy, Minnesota.

There were two hospital facilities in Tracy, the Tracy Hospital and the Clinic Hospital. The board was prepared to approve Hill-Burton funding for the Tracy Hospital, if it would operate as a hospital for the whole community. The Tracy Hospital was owned and operated by 84-year-old Dr. W. H. Valentine. Years earlier, in 1927, two other physicians, Dr. W. G. Workman and Dr. Hoidale, had formed an institution in Tracy known as the Clinic Hospital. The Clinic Hospital had been ordered by the state fire marshal to provide a sprinkler system and complete other changes by April 1, 1959. They felt this was an unwise expenditure, as the facility was quite inadequate in other respects.⁵⁵⁵ Wanting to continue to work in Tracy, Dr. Workman and Dr. Hoidale met with Dr. Valentine and

Method of Determining Priorities

Priorities were developed to aid in the equitable distribution of Hill-Burton funds for construction and modernization of eligible health care facilities. Priority was based upon an evaluation of bed need for each category of health care facility in each area based on these factors:

- A factor of utilization experience was expressed in terms of the current area use rate (total patient days per 1,000 area population per year)
- An occupancy factor was utilized 85% for general hospital beds and 95% for long-term care beds
- Population estimates and projections were made for each area. Adjustments were made based on anticipated change in use rate, opening or closing of a hospital, new industry, changes in availability of physicians' services and utilization patterns derived from patient origin studies.
- Separate priorities for new construction and modernization were developed for each category of facility in each area. The priorities were developed through the survey made of each facility as required by the Hill-Harris amendment to the Hill-Burton Act in 1964.
- Special priorities were given to those communities with two hospitals that merged under one management, operating as one facility.⁵⁵⁴

⁵⁵⁴ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. III-1 and 2.

⁵⁵⁵ BOH, *Minutes*, October 8, 1963, MHS, pp. 539-541.

agreed that if an addition were built onto the Tracy Hospital, Workman and Hoidale would work there. Dr. Workman and Dr. Hoidale instituted a community fund drive. A total of \$118,000 was collected – not enough to cover the lowest bid of \$142,723. The funds were returned to the donors. Without a unified community effort, the board moved that the hospital did not meet its definition of an acceptable community hospital in terms of the master hospital plan of the state and funding was not approved.^{556 557}

Workman and Hoidale then proposed building a new hospital in Tracy and requested \$330,000, 55 percent of the total cost of the hospital, from Hill-Burton funds. A total of \$600,000 was needed, and they planned to raise the remaining \$270,000 through a bond issue. A vote was scheduled June 9, 1959.⁵⁵⁸ The bond issue passed, but there was a question of legality. Still trying to support a community hospital, the department approached Dr. Valentine and asked if he would serve all physicians, establishing a new board for the hospital. He declined.

The bonds were to go up for sale in the fall, but there was an injunction against the sale of local hospital bonds. Dr. Knudsen had to appear in district court in Jackson, on September 24, 1959, relative to the injunction. The plaintiff was required by the court to post bond in the amount of the Hill-Burton share (\$283,090) on the grounds of damage to the community. The bond wasn't posted by the due date. Tracy again advertised the sale of its bonds.⁵⁵⁹

Dr. Valentine was not satisfied with the course of events and requested a meeting with the Board of Health on January 12, 1960. He was given 20 minutes. He explained why he could not work with the other facility. The following interchange took place between board members and Dr. Valentine:

Dr. Edgar Huenekens: "...I am getting close to your age, too. I, too, remember Dr. Bracken and all the others as well as you do. I would say to you that accepting as 100% correct what you said, you still are in the wrong because I think you are interfering with the health of your community by your attitude. Accepting everything you have said as right, I still think your final conclusion is wrong because you are standing in the way of the health of the community. I would like to say this to you. As I say, I am a man almost your age and I might have taken the same attitude you have taken in what has happened, but I still say it is wrong if you look at it from the broadest sense of helping your community."

Dr. W. H. Valentine: "Just what is your basis, may I ask you, of your conclusion that the service rendered at the Tracy Hospital at the present time is detrimental to human beings or insufficient?"

Dr. Frank Krusen: "I didn't hear him make such a statement, Doctor."

Valentine: "Well, you thought I was all wrong in asking to keep the Tracy Hospital open. I beg your pardon if I am incorrect."

Krusen: "I don't think he made such a statement as that, either."

⁵⁵⁶ Letter from Dr. W. H. Valentine to Dr. Frank Krusen, Board of Health president, May 14, 1959, MHS, pp. 135-138.

⁵⁵⁷ BOH, *Minutes*, February 24, 1959, MHS, pp. 38-39.

⁵⁵⁸ Letter from Dr. W. H. Valentine to Dr. Frank Krusen, Board of Health president, May 14, 1959, MHS, pp. 135-138.

⁵⁵⁹ BOH, *Minutes*, November 10, 1959, MHS, p. 249.

Valentine: "What was the statement, then, please?"

Huenekens: "When I said I thought your attitude was interfering with the health of your community, it has nothing to do with your hospital. What I mean is that Tracy and any other community needs a community hospital where every doctor can practice, and no matter what differences of opinion exist between you and Dr. Workman, the fact that you can't work in the same hospital is interfering with the health of the community."

Krusen: "We now have consumed 40 minutes, Doctor. We want you to know that you have been given more than the time promised you. You have spoken, I know, from the bottom of your heart with regard to your own feelings. We hope that you understand that the Board is sympathetic with you and in your interests. We hope you understand that the Board has definite obligations to the people of the State as a whole. We can't be involved directly in local jurisdictional problems which would be to the detriment of the health of the people of the State as a whole. We are eager to serve the people of the State to the best of our ability. We will, I assure you, give careful consideration to what you have just said. I want to be certain that you feel you have had a chance to say everything that you want to say to the Board and if you have any final statement now we will be glad to receive it."⁵⁶⁰

During the next three years, department representatives continued to work with the Tracy community, trying to resolve the inadequacies of the hospital. The hospital had many deficiencies and had some unusual features. When Dr. Knudsen examined one patient's chart, she read the diagnosis as "lazy." The "patient" was using the hospital as a hotel, paying for room and board.⁵⁶¹

By January 1963 the issue of what to do with Tracy Hospital had still not been resolved. At the board meeting, members considered the two hospitals in Tracy and wondered if they should close one. Dr. Swenson recommended the closing of Tracy Hospital since one hospital, adequately staffed, was the best thing for the health of the people of Tracy. Dr. Barr responded:

I think the question is, should we lower the boom on the Tracy Hospital and close it out except as a nursing home? Or should we indicate that we are very reticent but that we will give a limited license for a hospital provided certain steps are taken, as discussed when the Department representatives were at Tracy, so that this can and will be converted to a nursing home by the end of 1963.⁵⁶²

Following the meeting Dr. Valentine expressed interest in converting the facility to a nursing home.

Hill-Burton: Challenges for the Department

Administering the Hill-Burton program and managing the health services division was challenging. Dr. Knudsen arrived early and worked late. She had to deal with divisiveness within communities, politics, funding changes by the federal government, competition among health facilities, failure of projects to meet deadlines, increased

⁵⁶⁰ BOH, *Minutes*, January 12, 1960, MHS, pp. 13-14.

⁵⁶¹ Conversation with Dr. Helen Knudsen, March 1999.

⁵⁶² BOH, *Minutes*, January 12, 1960, MHS, pp. 13-14.

costs of projects, and more. One organization advertised the availability of Hill-Burton funds as part of their \$500,000 fund drive for a new 50-bed hospital, even though the board had not yet approved them for funding. The board was not pleased with this approach to fund raising, but eventually approved funding for this new hospital.⁵⁶³

Sometimes communities did not meet deadlines, causing difficulties for the Board of Health. Two Harbors did not meet its deadline, and it was extended. The extension was not met. The board felt the community needed the funds to improve services but were concerned about giving Two Harbors special treatment through another extension. It was discussed at a March 17, 1955, board meeting:

Bosch: "Extend the deadline. But will we be placed in any embarrassment with Cloquet and other commitments of the Board?"

Knudsen: "It will be a hot situation, I suppose."

Dr. W. W. White: "Essentially you are changing your order."⁵⁶⁴

After considerable discussion, the board agreed to extend the deadline one more time.

Another difficulty more common in the early years of Hill-Burton was the marked discrepancy between the estimated and actual costs of projects. This was caused by inadequate planning in the preliminary stages, decisions to upgrade the work after the initial plan had been approved, unrealistic cost estimates by the architects, and the inclusion of items that were deluxe. Substantial portions of the subsequent fiscal allotment had to be used in order to complete projects in process. This delayed new projects, disrupted community plans and slowed down the overall expansion of hospitals in the state. The state advisory council discussed the issue in 1955. It made a recommendation, approved by the board on November 1, 1955, establishing a policy which limited the board's financial responsibility: "Any increase in Federal funds between Part 1 and Part 4 of the Application will be limited to five (5) per cent of the original estimate, with the costs over and above this amount assumed wholly by the applicant."⁵⁶⁵

While unplanned expenditures delayed the expansion of health facilities in the state, quick actions by the department brought additional funds to the state and expedited the growth of facilities. On January 3, 1958, the regional office in Kansas City phoned the department requesting immediate information on how much Hill-Burton Part C and Part G funds Minnesota could use. The request was to go to Washington for the Subcommittee of the House Appropriations Committee. The department responded immediately, sending an eight-page report to Washington, D. C., by airmail.⁵⁶⁶ Due to the department's quick reaction, additional funding was obtained.

⁵⁶³ BOH, *Minutes*, December 5, 1955, MHS, p. 378.

⁵⁶⁴ BOH, *Minutes*, March 17, 1955, MHS, p. 71.

⁵⁶⁵ BOH, *Minutes*, attachment: letter (6/18/57) from Dr. Robert Barr to Rep. Edward J. Thye, October 9, 1957, MHS, pp. 230-232.

⁵⁶⁶ BOH, *Minutes*, January 7, 1958, MHS, p. 13.

Sometimes communities resisted plans for a new or improved hospital or the closing of one. In these cases, Dr. Barr, Dr. Knudsen and others from the department visited the communities to explain the state plan and its purpose. For example, when Hastings was unable to raise matching funds, Dr. Knudsen spoke at an area wide meeting, explaining the need. When there was resistance to closing the hospital in Milaca, department representatives went to the Milaca to try and encourage local participation. Sometimes representatives from the U.S. Public Health Service accompanied department members.

Dr. Knudsen also had to deal with communities that operated outside of the state plan. In 1960, there was increasing concern about the number of hospital beds that were being planned in small communities when the state had surveyed the area and found it too small for a hospital. The Minnesota Medical Association sent a letter to each physician in the state asking them to inform the Department of Health if they were aware of any plans for a hospital in their area that had not been discussed with qualified hospital authorities. The last sentence of the letter read: "Such action on your part is the duty of a good citizen and a conscientious physician and may help to avoid unnecessary and wasteful expenditures of much time and a great deal of money."⁵⁶⁷

While the Hill-Burton program encouraged only those hospitals that were most needed, there were many more hospitals built without Hill-Burton funds and, consequently, not affected by the program's priorities and guidelines. In 1963, there was concern with the lack of community-wide planning and resultant overbuilding of hospital beds in the big cities. Referring to the cost of extra beds and expressing concern that there was no assurance Minnesota would continue to have a first-class medical plant, Thomas P. Cook, executive secretary of the Hennepin County Medical Society and a respected spokesman for area doctors, said: "All this is one of the biggest problems we've had in a long time."⁵⁶⁸

Nursing Homes and Long-Term Care

In 1949, 20 of Minnesota's 87 counties did not have a single nursing home, and 57 counties did not have a home for the aged. Nearly all homes had waiting lists.⁵⁶⁹ There were few places for patients to go, if a home closed.

By 1955 there was an estimated shortage of 2,000 nursing home beds in Minnesota.⁵⁷⁰ Dr. Helen Knudsen was receiving calls from distraught children who couldn't find space for their aging and infirm parents. To respond to the need, women began setting up a few beds in their homes. A home could have up to two beds for unrelated persons without requiring a license.⁵⁷¹

⁵⁶⁷ BOH, *Minutes*, May 24, 1960, MHS, pp. 90-91.

⁵⁶⁸ *Minneapolis Morning Tribune*, "Report on Our Hospitals," February 25 to March 2, 1963, p. 1-4.

⁵⁶⁹ MDH, *Minnesota's Health*, Vol. III, No. 3, March 1949, p. 4.

⁵⁷⁰ BOH, *Minutes*, March 17, 1955, p. 81.

⁵⁷¹ Conversation with Dr. Helen Knudsen, March 1999.

The board received requests from facilities to add additional beds. Hesitant to approve such requests, there didn't seem to be another solution. Dr. Robert Barr commented on the difficult position in which they found themselves: "The only thing we can do is blink at our standards in most instances. Pressure is on more and more to fill them up. There is no place to put them..."⁵⁷²

In 1957, the department's hospital services division estimated that 17,798 nursing homes and homes for the aged beds were needed in Minnesota. This was 4,854 less than the state had.⁵⁷³

An intense interest in nursing home construction started in the 1950s, no doubt generated by the availability of funds through Hill-Burton when federal legislation made this change in 1954. While most nursing homes in the 1940s were converted houses, this began to change in the 1950s. It wasn't until 1958, however, that the construction of new homes exceeded the conversion of buildings.⁵⁷⁴ Dr. Knudsen estimated that there would soon be an abundance of beds in Minneapolis where empty beds were already appearing in new homes, as well as old converted homes.

Between 1950 and 1963, the number of licensed nursing homes and boarding care homes increased from 284 to 580. The number of beds increased from 7,951 to 22,562.⁵⁷⁵ There were fewer and fewer reports of shortages of nursing home beds. In 1962, empty beds were beginning to appear in older nursing homes and even in some new ones in areas where there had been substantial construction.

By 1963, the state began expressing concern about the overbuilding of nursing homes in particular areas. The board recognized that privately owned homes would probably suffer, as they would not be completely occupied and it would be difficult financially to make it. The Federal Housing Authority required certification of need for nursing home construction, and the Health Department was responsible for determining whether or not there was a need. In 1962 Dr. Barr felt the approval of building plans should go with a warning:

We feel that while we can give a certification of the need, we must include a warning as well. Even though we say there is a real need for so many beds here, we must add to this that the owner is going to face some real tight competition in the future. We should tell these people that most of the beds in Minnesota are nonprofit, that they have to build good beds or else they are in trouble, and that the poor beds are going by the wayside, so they know what they are facing. We will continue to encourage the nonprofit homes of high quality.⁵⁷⁶ We are going down the middle of the line and are going to tell the people the facts.⁵⁷⁷

The concept of long-term care, a facility for patients with chronic debilitating disease, took hold during the 1940s and 1950s. In 1944 hospitals were classified as general hospitals or specialized hospitals. At that time, large chronic or convalescent homes

⁵⁷² BOH, *Minutes*, March 17, 1955, p. 84.

⁵⁷³ BOH, *Minutes*, July 30, 1957, MHS, p. 145.

⁵⁷⁴ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 82.

⁵⁷⁵ MDH, *Minnesota's Health*, Vol. 17, No. 9, November 1963, p. 3.

⁵⁷⁶ BOH, *Minutes*, April 9, 1962, MHS, p. 111.

⁵⁷⁷ *Ibid.*, p. 112.

that did not fit into the home-for-the-aged category were classified as chronic or convalescent hospitals. In 1947, when hospital administrators were required to be registered, it became necessary to define hospitals and classify institutions. Five of the large nursing homes became chronic disease hospitals and two became other specialized hospitals."

Dr. Barr was a strong supporter of long-term care facilities for those who needed rehabilitative care. In 1950 he said:

Most people think that a chronic disease hospital is a place to put old seniles. Its primary purpose is to put someone in there who has a chronic disease over a long period of time for physical and occupational therapy to rehabilitate that person. But that should be operated at less cost than are the general hospitals.⁵⁷⁸

Dr. Barr, always a supporter of care for the elderly and disabled, advocated for long-term care facilities again at a 1956 board meeting:

Acute hospitals do not have facilities for rehabilitation. Where a man loses a leg they keep him in a general hospital until the thing is completely healed and then send him home. If that individual as quickly as possible, is transferred to a hospital which has facilities for physiotherapy, you have got him rehabilitated using that artificial extremity as soon as possible. That is only one example. That is the thinking in connection with chronic hospitals. There is some question whether they should be built in a small community. If there is no trained individual to take charge of the physiotherapy work then you are simply supporting another bed and accomplishing nothing. Actually that bed is no different in a chronic hospital than if it is in an acute hospital. If you can do something there about rehabilitating him rapidly, then you are doing something. The latter group should be classified as a nursing home and have them near where they could have acute hospital facilities care.⁵⁷⁹

Hill-Burton: Its Effects in Minnesota

The types, locations and sizes of hospitals and other health facilities in Minnesota changed and evolved during the 1950s and 1960s. The list of facilities that received federal Hill-Burton funding and the year funds were awarded is given in Appendix E. Between 1950 and 1973 a total of 120 general hospitals, seven public health centers, four mental centers, five chronic disease units, three chronic psychiatric, nine psychiatric units, seven rehabilitation centers, four diagnostic and treatment centers, six mental retardation facilities and 45 nursing homes received some federal funding through the Hill-Burton program. Awards ranged from \$23,625 to \$2,000,000. This funding was helping to create more efficient and effective health care facilities for the people of Minnesota.

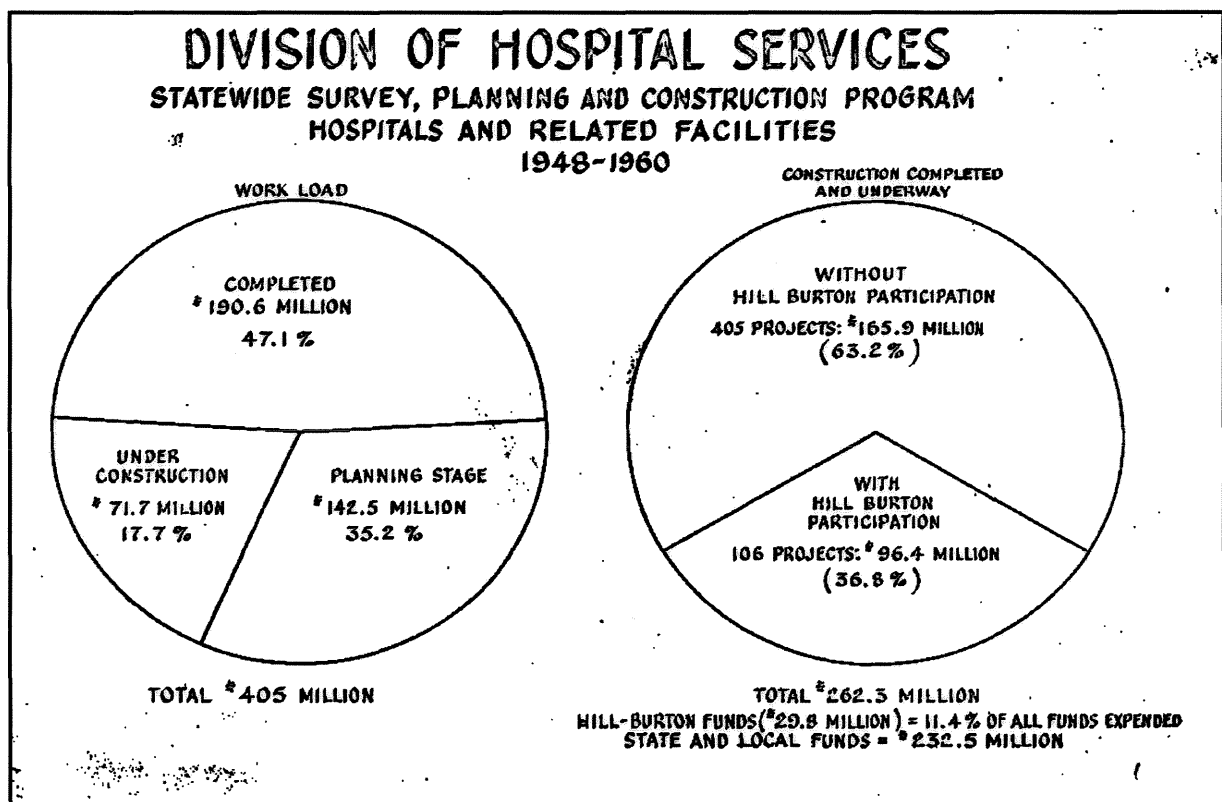
While modern community hospitals increased, small hospitals such as maternity home hospitals began to disappear. Maternity home hospitals once served a large portion of maternity cases in the state. Some of them used the kitchen table for the birth and, when overcrowded, a new mother and baby might stay in a storage room. With the transition of the facilities in the 1950s, these homes began closing. One of the last to

⁵⁷⁸ BOH, *Minutes*, February 14, 1950.

⁵⁷⁹ BOH, *Minutes*, October 3, 1956, MHS, p. 191.

close was the Moehl Maternity Home in Morristown, Minnesota. The owner and operator was 87 years old when she decided to end her services.⁵⁸⁰

Many changes were taking place in the area of mental health hospitals. While the Department of Public Welfare had authority for the state mental hospitals in Anoka, Fergus Falls, Moose Lake, and Rochester, the Health Department had authority for areas within hospitals. Representatives from the Department of Health and the Department of Public Welfare were uncertain as to whether or not a mental health center should be in a hospital.⁵⁸¹ To help with these decisions and plan the construction of mental health centers and institutions for the mentally retarded, the Minnesota Mental Health Planning Council was organized in 1963. From 35 to 49 agencies representing interests in mental health served on this council.⁵⁸²



Though a lot of facilities had been added through Hill-Burton, the number of hospital beds in the state was still reported as insufficient in 1962. An estimated 5,500 additional general hospital beds and 12,690 long-term care beds were needed within the next eight years.⁵⁸³

⁵⁸⁰ BOH, *Minutes*, August 11, 1959, MHS, p. 237.

⁵⁸¹ BOH, *Minutes*, April 24, 1961, MHS, p. 107.

⁵⁸² BOH, *Minutes*, July 9, 1963, MHS, p. 433.

⁵⁸³ BOH, *New Dimensions for Minnesota*, p. 31.

Improving Service Delivery

In addition to facilitating assistance with funding for construction, the department offered technical support to health facilities, particularly small rural ones with fewer employees. Some of the initiatives offered by the department included:

- The first annual homes for the aged Institute was held March of 1949. It was jointly sponsored by Health and Social Welfare. At the first institute, the nursing home of the future was described. It was emphasized that it should be for the benefit of the resident, and the one-story building was advocated.
- In 1950 the department sponsored five classes for University hospital staff on the rehabilitative care of cardiac, diabetic, cancer and physically handicapped patients. Indicative of the interest, on the night of the worst blizzard in years, 48 people still showed up for classes.
- In 1951 the first annual nursing homes institute was held, jointly sponsored by the Health, Social Welfare and the Minnesota Nursing Home Association. In the 1950s the topics of the Institutes shifted from patient care to administration.
- In 1951 department staff provided assistance to nursing homes in Rice County and the St. Cloud area in setting up classes patterned after the nursing home institute.
- In 1954, the department coordinated with the Minnesota Dietetic Association, the Minnesota Hospital Association, the University of Minnesota and the Minnesota Medical Association to offer training for hospitals with no regular dietician. The first workshop on diets, menu planning, food buying, cost control, hygiene, sanitation and safe working conditions for dietary service personnel was offered in Fergus Falls on March 26 and 27, 1954.⁵⁸⁴
- The department was one of the sponsors of a demonstration for hospital personnel on how to evacuate patients in the event of fire or another catastrophe. The demonstration was held at Coffey Hall on the University's St. Paul campus on April 29, 1954.⁵⁸⁵

In addition to the above, the department published a newsletter on hospital licensure, helped the Minnesota Nursing Homes Association prepare a handbook of procedures for nursing home personnel, developed a booklet for supervisory nurses, prepared forms that could be used for record keeping, prepared displays on the floor plans of nursing homes and nursing home care for exhibition throughout the state, supported the volunteer visitor program, and conducted surveys and studies on nursing homes.

⁵⁸⁴ MDH, *Minnesota's Health*, Vol. 8, No. 3, March 1954, p. 4.

⁵⁸⁵ MDH, *Minnesota's Health*, Vol. 8, No. 4, April 1954, p. 3.

The department received two federal grants that were also used to strengthen the health delivery system in the state. In 1956 the department received a three-year grant from the U.S. Public Health Service. Funds were used to investigate quality of care within five hospital service areas – nursing anesthesia, dietetics, medical technology (including blood banking), medical records and physical therapy. Recommendations for improvements were made as to recruitment of personnel, refresher training, in-service training and extension courses in postgraduate fields.⁵⁸⁶

Another federal grant supported the improvement of care through better coordination and planning of services. A demonstration project for planning health care resources began in 1962. Using funds from the U.S. Public Health Service, the department promoted area wide planning and assisted local communities in developing planning councils. The first planning councils were located in Fergus Falls and St. Cloud.⁵⁸⁷

Regulation of Health Facilities: Standards and Licensing

In addition to expansion of facilities and technical support, another development that changed Minnesota's health delivery system was the increased monitoring of patient care through regulation. In the 1940s and 1950s the board was especially concerned with the condition of nursing and boarding care homes in Minnesota.

The first comprehensive health facility licensing law in the nation was enacted by the Minnesota Legislature in 1941.⁵⁸⁸ Amended in 1943 and 1945, this law required the Health Department to license hospitals and other institutions, including maternity hospitals that provided hospitalization or chronic or convalescent care for aged or infirm persons. In 1951 the definition was broadened to include personal or custodial care, and in 1952 homes were classified as nursing homes or boarding care homes.⁵⁸⁹ The Board of Health was responsible for issuing an annual license to institutions, and this must be accompanied by clearance by the state fire marshal.

While the board was charged with ensuring the safety of health facilities by issuing licenses, in 1949 it had no regulations. When the board denied a license to the Kenwood Rest Home because it felt it was detrimental to the welfare of patients staying there, the difficulty of operating without regulations was noted. Jerry Brower, head of departmental administration, said:

⁵⁸⁶ Robert Barr, M.D.; Helen L. Knudsen, M.D.; William Harrison, M.D.; and Bernard Wolcyn, Ph.D. "Program for Improving Patient Care Services: What Minnesota Found in a Three-Year Study, *Hospitals*, Vol. 37, October 16, 1963, pp. 81-94, 149.

⁵⁸⁷ Robert Barr, M.D.; Donald Van Hulzen, and Helen L. Knudsen, M.D. "Establishing Functional Relationships Among Health Care Facilities," *Hospitals*, Vol. 39, June 1, 1965, pp. 45-51.

⁵⁸⁸ Laws 1941, Ch. 549 (Minn. Statutes 1957 Sections 144.50 to 144.58, inc.)

⁵⁸⁹ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 81.

“ . . .our case has been made necessarily weak by the fact we have no regulations as such. Those that we have are standards. That is one of our first orders of business to see that they are adopted as regulations.”⁵⁹⁰

Jerry Brower, 1949

The board proposed regulations of homes for chronic or convalescent patients in 1949. Three proposed requirements provoked considerable discussion. The controversial regulations called for an increase in space for each patient, the availability of a recreation room, and a drastic change in the supervising nurse requirement, among other requirements. Dr. Robert Barr stated that if these homes were to be called nursing homes, the person in charge should be a licensed practical nurse or a registered nurse.

The regulations were adopted by the board on December 16, 1949, and submitted to the attorney general on December 20, 1949. The attorney general held an informal conference on January 10, 1950, and questioned the authority of the Board of Health, under the Hospital Licensing Law, Section 144.50, to adopt regulations for all phases of the operation of homes for chronic and convalescent care patients. The attorney general decided that Section 144.56 did not adequately define the area regulated by the board. The board withdrew its proposed regulations but made them available as guidelines.⁵⁹¹ Legally, however, health facilities were not held to the requirements.

Amendments to the M. S. 144.56 in 1951 made it possible for the board to promulgate regulations for nursing homes. The regulations prepared two years earlier were reorganized, restated and strengthened. A public hearing was held November 7, 1951, and the first regulations for hospitals, nursing and board care homes became effective February 1952.⁵⁹²

These early regulations established requirements for medical attendance, nursing and other personnel, patient areas, as well as furnishings and equipment for care.⁵⁹³ Two of the biggest concerns with nursing homes and boarding care homes were fire safety and overcrowding. Nursing homes were required to install sprinkler systems. The board set minimum space standards of 60 square feet of useable floor area per bed, with beds at least three feet apart.⁵⁹⁴ This was later increased to 80 square feet. Space requirements proposed for all health facilities were challenged. In a February 1953 Star and Tribune article, overcrowded hospitals were cited as the cause of tuberculosis cases and deaths. An interchange between Dr. Robert Barr, always a proponent for better patient care, and state Rep. Claude Allen was reported:

Allen: “Does a patient actually need 70 square feet?”

⁵⁹⁰ BOH, *Minutes*, January 20, 1949.

⁵⁹¹ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 39.

⁵⁹² BOH, *Minutes*, January 10, 1955, MHS, pp. 47-68.

⁵⁹³ MDH, *Minnesota's Health*, Vol. VI, No. 7, July-August 1952.

⁵⁹⁴ BOH, *Minutes*, July 10, 1952.

Barr: "Certainly. A patient lives in that one room. And 70 square feet is small. None of the rest of us has bedrooms as small as 70 square feet – and we don't spend as much time there as a mental hospital patient."⁵⁹⁵

Representative Leonard Johnson cited two cases of large families in Minneapolis who lived in small quarters:

Johnson: "And they pay taxes. I guess if they want better living quarters, they ought to go to one of our State institutions."

Barr: "I don't see why their situation is any justification for pulling down State standards."⁵⁹⁶

The regulations, combined with educational programs, were geared to raise the standard for patients in all health facilities. Unfortunately, it was difficult for many of the homes to meet the new regulations.

At the December 18, 1953, board meeting Dr. Barr said: "If we apply present regulations to the nursing and boarding care homes in Minnesota we would have to close half of them. We have got to pick out one at a time until we have got them all up to reasonable standards."⁵⁹⁷

Licensure requirements were difficult for many homes that had been operating informally. They did not keep careful records, as described in a department report: "Some homes did not have even the age or address of a patient on file. It was necessary to search through many boxes of letters or slips of paper to obtain the most meager information."⁵⁹⁸

One regulation that was especially difficult for many homes, particularly the small ones, was the nursing supervision requirement. A survey in November 1952 found 97 of the 293 nursing and boarding care homes in the state did not have a qualified nurse. On the recommendation of the advisory board, the state allowed homes of less than 20 beds to employ a registered nurse or a practical nurse on a part-time basis to meet the requirements.⁵⁹⁹

Throughout the 1950s and 1960s, there was a shortage of personnel for health facilities, particularly in rural areas. A shortage of physicians in rural areas was discussed at the National Conference on Rural Health in Denver in 1952. Dr. Kenneth Kaisch of Philip, South Dakota, gave some hints on how to attract and keep a doctor in a small town: "To obtain a doctor, provide adequate hospital facilities and personnel, office space for a doctor to rent, the type of town in which a person would want to live. To keep a doctor, treat him as a human being: try working with him instead of against him." Mabel, in Fillmore County, and Kerkhoven, in Swift County, were two communities that took steps to attract doctors by constructing new clinics.⁶⁰⁰

⁵⁹⁵ *Minneapolis Tribune*, "TB Death Rate Blamed Overcrowded Hospitals," February 13, 1953.

⁵⁹⁶ *Ibid.*

⁵⁹⁷ BOH, *Minutes*, December 18, 1953.

⁵⁹⁸ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 63.

⁵⁹⁹ *Ibid.*, p. 41.

⁶⁰⁰ MDH, *Minnesota's Health*, Vol. VI, No. 4, April 1952, p. 2.

One gray area in nursing home regulation was fire safety. At its December 18, 1953, meeting, the board struggled with the decisions of approving or not approving the licenses of three hospitals in Hastings and one in Otter Tail County that it felt were fire hazards. The department's responsibility in the area of fire safety was not entirely clear. Hospitals were licensed based on U.S. Public Health Service standards. Although the department was authorized to develop standards and regulations, the standards for fire safety were not in regulation form.

Dr. Sweetser checked the state law to learn what options were open for the board:

Dr. Sweetser: "It says here, 'The state department of health is hereby authorized to issue licenses to operate hospitals, sanatoriums, rest homes, nursing homes, or other related institutions, which after inspection are found to comply with the provisions of sections 144.40 to 144.58 and any reasonable regulations adopted by the state department of health.' If they don't comply with those two sections of the law, they don't get a license whether they comply with the regulations or not. I was thinking that these two sections of the law might give us grounds for refusing the license, aside from any regulations."

Prof. Bosch: "It seems to me we have got a bad situation either way. For long-time correction, I think the Board of Health should institute or put into operation today the mechanism to adopt as a regulation that hospitals should be satisfactory from a fire protection standpoint and whether they are satisfactory should be determined by the Fire Marshall. To me it would seem that the safest thing to do would be to, on the first of the year, actually issue, but as of this day have the Board of Health adopt a resolution directing that there be a hearing on each one of these to show reason why their license should not be revoked because of the fire hazard."

Dr. Sweetser: "Because of conditions detrimental to the welfare of the patient."

Mr. Brower, Attorney for Health Department: "That requires a tremendous amount of definition."

Prof. Bosch: "I think that is the safest way out on this. First, start the mechanism, which takes practically 90 days. Secondly, take the necessary legal steps today to invite these people to show cause why their license should not be revoked. Give them thirty days' notice and give them the right of a hearing."

Dr. Behmler: "We certainly should adopt some regulations so we don't get into these things."

Dr. Barr: "Another thing we will have to do, we will have to have some policy on issuance of these things before the next meeting of the Board. All these things go through certain growing pains. You don't want to go out and slap them down."⁶⁰¹

After further discussion, the board decided to invite representatives of the hospitals in question to a meeting at the department to discuss the situation with them. Board member Herbert Bosch thought that was a good idea because "You can record the discussion and can get away from that local emotionalism, and people are used to going to the teepee of the Great White Father."⁶⁰²

⁶⁰¹ BOH, *Minutes*, December 18, 1953.

⁶⁰² Ibid.

In 1955 the department proposed additional hospital regulations, sent out the required notices, and mailed 400 or 500 copies to interested parties. The department received no negative responses, held the hearing, but when the regulations were approved, resistance from the community appeared. The board met with Mr. Glen Taylor of the Minnesota Hospital Association and with Mr. Mattson of the attorney general's office on March 17, 1955.⁶⁰³

Because of the resistance, Mr. Mattson felt a new hearing should be rescheduled and agreed to hold one in May. He felt that some of the regulations should be grandfathered for older hospitals. He pointed out the political pressure they were under:

Mattson: "...in view of the large number of persons representing hospitals, that are concerned with this, that the best way to handle this would be to call an additional hearing and give them an opportunity to come in and be heard. I think the manner in which the notice was given conforms to the statutes, however all these powers to make regulations are subject to the will of the legislature and the members who contacted me are very concerned about it. These regulations may be putting some of the small hospitals out of business. If you call an additional hearing and grant them an opportunity to be heard, I think it would be the only fair action you can take."⁶⁰⁴

The difficulty of implementing any changes in regulations was recognized:

Taylor: "I don't think you are going to have a law for minimum requirements without having certain complaints. We ran against the same thing under the Hill-Burton Law. Some of the hospitals began to be quite irritated to think we wouldn't accept their old hospital and build onto it or allow additions. It was interesting to me that after a few meetings, to have these people reverse themselves when they knew the facts. I think in some cases we certainly are not going to have 100 per cent. You are going to have complaints. I don't think there is any reason at all why we should not meet with these people and if possible, make changes, if we can do so without hurting the public. We realize that there could be some factors in them that aren't properly thought out. They could be worked over again without harm."⁶⁰⁵

While trying to ensure the well-being of the residents in Minnesota health care facilities, the board had to consider the power of the citizens and the Legislature:

Brower: "What I think is important is the attitude of the Legislature. They could by a very simple bill curb our rule-making powers."

Mattson: "I can say that the ones that contacted me were very concerned about the situation. One did state, feeling that these regulations were already in effect, 'We will have a law passed to take care of that.' I think it is a situation that should be taken into consideration."

Bosch: "I think it is a very important thing. I think legislators have always been concerned about this, and not only in connection with the State Department of Health."

Mattson: "They are very concerned about how much power the departments and Board have with regard to regulations. I think you have to consider not only the legal aspects, but give them a chance to come in."⁶⁰⁶

⁶⁰³ BOH, *Minutes*, January 10, 1955, MHS, pp. 58-68.

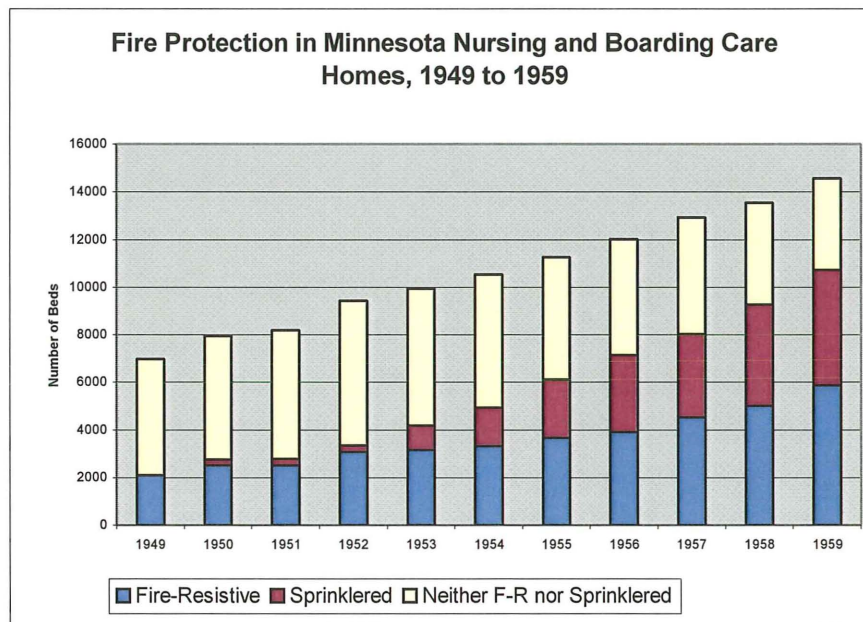
⁶⁰⁴ BOH, *Minutes*, March 17, 1955, MHS, p. 59.

⁶⁰⁵ Ibid., pp. 58-68.

⁶⁰⁶

The board adopted new health facility regulations on August 13, 1955. The new regulations clarified the difference between a chronic disease hospital and a nursing home. The distinction between these two was becoming more difficult to make but had ramifications in connection with payments by insurance companies and assistance programs. The new regulations clarified that a chronic disease hospital serves patients with chronic illness, excluding tuberculosis and mental illness.⁶⁰⁷

In 1957, Minnesota had 423 nursing homes and boarding care homes and 13,400 beds, many in converted houses. Of these, 4,685 were classified as unsuitable. That meant they were beds housed in buildings that were neither fire resistive nor sprinklered and did not conform to minimum nursing home requirements. Still, progress was being made. The number of unsuitable beds in 1957 was 44 less than the 4,729 unsuitable beds that existed in 1956.⁶⁰⁸



In 1957 the Legislature required the state fire marshal to adopt a fire safety code for hospitals and related institutions. The fire safety code for nursing homes and board care homes was approved by the attorney general and filed with the secretary of state on March 24, 1959.⁶⁰⁹

By 1958, when the shortage of nursing home beds wasn't as acute, Dr Robert Barr actively promoted that nursing homes should either meet standards or be closed. He cited some of the horrible examples that had occurred which gave nursing homes a bad name.⁶¹⁰

⁶⁰⁷ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 42.

⁶⁰⁸ BOH, *Minutes*, July 30, 1957, MHS, pp. 143-144.

⁶⁰⁹ MDH (health facilities division), *Minnesota Hospitals, 25th Annual Revision, 1973-74*, January 1974, p. 48.

⁶¹⁰ BOH, *Minutes*, May 22, 1958, MHS, p. 154.

The 1950s were times when the board was figuring out its role and responsibilities in licensure and regulation of health facilities. What belonged within the domain of the Health Department? What was the responsibility of another agency? Some states were transferring nursing home regulation to their social services (welfare) departments in the late 1950s. Dr. Helen Knudsen opposed this and felt it needed to remain in the health departments in order to maintain health standards. She suggested this issue as an agenda item for the Surgeon General's Conference, which she regularly attended.⁶¹¹ Responsibility for nursing home regulations in Minnesota was still in the Department of Health in 1999.

There was every indication that the department's role in regulation of health facilities would increase. In 1961 the possibility of Medicare, referred to as "old age insurance," was discussed at the board meeting.⁶¹² Four years later, the board learned it would be responsible for certification of Medicare facilities. Effective July 1, 1966, the department began certifying hospitals and on July 1, 1967, added nursing homes.

Nursing homes received increased public scrutiny through the 1960s and 1970s, with strong public activism to improve conditions.⁶¹³ As a result, the office of health facility complaints was established by the Legislature in 1976.⁶¹⁴ This office was formed to receive and respond to complaints on the conditions and treatment received in health facilities. Ernest Kramer was appointed its director in October 1976.⁶¹⁵

Regulation – Challenges to Enforce

Enforcement of health facility regulations was often challenging for the department. Nursing home regulations were especially difficult to enforce in the early years due to the shortage of beds. One example of the difficulty faced was demonstrated at the Samaritan Nursing Home in Minneapolis. State Sen. Ralph Mayhood, a nursing home operator, had gone three years without a license, as nursing home requirements were not met. The board decided he couldn't continue to flaunt its authority, and in January 1960 directed that a formal hearing be held to revoke the license.⁶¹⁶

The hearing was scheduled for May 30, 1960. One day before that date, Mr. Stenzel, from the attorney general's office, discussed a waiver in view of the fact the home would be sold within two months. The hearing was cancelled pending receipt of the signed agreement from Sen. Mayhood. Mr. Stenzel resigned from his position, and the agreement was not returned. The board agreed to send a letter to Sen. Mayhood, stating that the hearing would be held in 30 days unless the agreement was signed and returned.⁶¹⁷

⁶¹¹ BOH, *Minutes*, January 13, 1959, MHS, p. 10.

⁶¹² BOH, *Minutes*, January 31, 1961, MHS, p. 23.

⁶¹³ Note: Some of these cases are discussed in Chapter 9.

⁶¹⁴ Minnesota State Statutes, 144A.52.

⁶¹⁵ BOH, *Minutes*, October 14, 1976.

⁶¹⁶ BOH, *Minutes*, January 12, 1960, MHS, p. 19.

⁶¹⁷ BOH, *Minutes (appendices)*, May 24, 1960, MHS, p. 147.

The 60-day period to sell or discontinue the home expired on July 31, 1960. Possible new owners contacted the department on August 9, so the board did not move forward immediately on revoking the license.⁶¹⁸ The sale did not take place, so on September 13, 1960 the board ordered the home to complete the removal of all patients and to cease operations on or before October 14, 1960.⁶¹⁹ This was nearly four years after intervention was first initiated.

A problem with the board's efforts to regulate homes was the typical disparity in legal counsel. The state usually had bright but inexperienced new law school graduates from the attorney general's office. The nursing home owners often hired the top judicial officers in the state to defend them.

A number of obstacles stood in the way of the board's attempts to improve the care of the elderly in Minnesota. One example was a situation in Duluth. The board refused to grant one license to a care home on the basis of the owner's lack of cooperation over a period of several years. The board's decision was made November 10, 1959, and the attorney general's office was contacted for assistance several times the next few months. On April 19, 1960, the department learned a new attorney had been assigned to it and he would review the file. The new attorney called the department May 24, 1960, to report action was being considered. The department representative, the attorney general's office representative and the owner met on August 24, 1960, and the owner signed an agreement that she would meet the requirements necessary for licensure as a boarding care home. That fall a complaint of maltreatment was filed against the owner by one of the patients. The owner submitted plans for remodeling work, but the work was halted due to lack of finances. On December 5, 1961, a complaint was filed for operating a nursing home without a license. A six-member jury trial was held January 6, 1962.

One doctor was sworn in and testified relative to the condition of his patient in the home. The patient, a 62-year-old stroke patient, was paralyzed on one side and required complete bedside care. She had a retention catheter, needed help with feeding, had side rails and was lifted out of bed with a mechanical lift. She needed help with oral hygiene and received medications including a sulfa drug. The catheter required irrigation and was changed about once a week. Special care to the back and pressure areas was needed. The doctor testified that the patient required no treatment or care that required any special training or skill. When the judge asked about the catheter, the doctor testified that catheterization required no skill and an untrained person could administer and care for a catheter.

Another doctor testified that an 83-year-old patient needed no treatment or care that required any special skill or training. The patient was paralyzed on one side, unable to speak, incontinent and required complete bedside care. Following these testimonies,

⁶¹⁸ BOH, *Minutes*, September 13, 1960, MHS, p. 311.

⁶¹⁹ *Ibid.*, p. 73.

the defense attorney made a motion to dismiss the case, and the judge said he had no recourse but to dismiss it.⁶²⁰

Trying to uncover problems, department inspectors made unannounced visits to nursing homes and other facilities. Inspectors did not cover the same areas of the state; a facility could expect a different inspector each time.

When facilities did not meet standards necessary for licensure, it could take several years before it was closed down. An example is the Tracy Hospital. In 1963, the board failed to license the Tracy Hospital. It approved operation of the facility as a nursing home, but it wasn't certain whether it needed to hold a hearing on this action.⁶²¹ The board had the authority to reclassify institutions, but the law did provide that it hold a hearing when licensure was refused. In effect, the board was refusing to issue a hospital license. The board decided it could justify its actions on the basis that it was trying to upgrade the hospital care in the community and could not do this by continuing to divide hospitals.⁶²²

State Sen. Gordon Rosenmeier from Little Falls and State Sen. Leo J. Lauerman attended the October 8, 1963, board meeting to talk about the Tracy Hospital situation. Sen. Rosenmeier began:

State Senator Gordon Rosenmeier: "...In Tracy, and I am not familiar with Tracy, it is out of my area, traditionally there have been two hospitals. One had been a municipal hospital, the other a private one. The private one was established because of a need for it. I saw it last week. To me it's a very impressive substantial building. It looked to me well kept, well landscaped, cheerful, well ventilated and every room had an outside window; not a big building, but from the standpoint of the community it seemed to me quite suitable. I'm speaking to you as a layman, not as an expert. Sometime ago, apparently the need for a new municipal hospital was made known and this Department of Health saw fit to approve an application for Hill-Burton money and a hospital was built. I didn't go in to that hospital, I saw it from the outside. It seems to me a very impressive good looking building. ... Tracy Hospital has been operating and serving that community for several years. Its value today is probably a quarter of a million dollars. It has been privately endowed wholly. There is no tax money in it, it has no debts, it is operating at a profit, a small one but a profit, it has a small surplus, it is wholly a private non-profit organization. ... The hospital has been going for many years serving this community and until this year as far as we know there has been no complaint at all. There never was complaint, Mr. President, until the municipal hospital came into the picture. Up to this time the hospital not only has had no complaint from this Department but it had praise. Its administrator is a new one I understand, Mrs. Weinzetl, who is recognized by this Department as being an outstanding administrator. ... Now I want to emphasize this - at present the staff of this Department of Health, the staff of this board, has said that this board will not issue a license. That is this Board's staff. We are here because we think this Board is exercising discretion of its own. The complaints that are made today about this private hospital which has the virtue at least of standing on its own feet, have never been made before. They were never made until the municipal hospital developed a shortage of patients. Now if I seem cynical about this, it's because that's my observation that's my information. So today the people I represent, that Sen. Lauerman represents, are faced with the fact that there is a hospital serving a community doing a job, a hospital that 900 people are going to ask this Board to continue, faced with a loss of its property, its right to service the

⁶²⁰ BOH, *Minutes (attachment)*, January 16, 1962, MHS, pp. 87-89.

⁶²¹ BOH, *Minutes*, January 22, 1963, MHS, pp. 28-29.

⁶²² *Ibid.*, p. 29.

community because the staff of this Department says that they won't have a license. . . . The said corporation was licensed to operate a hospital by the Minnesota State Board of Health and has been since its incorporation. The State Board of Health has refused to renew such license in the year 1963. Now may I say this, I don't know when the Board refused to renew this license. I ask you, Mr. Chairman, if it ever did?

Dr. Raymond Jackman: "Yes it did."

Rosenmeier: "Does the Statutes require a hearing? The Statutes do require a hearing before you can refuse it. Has your staff informed you of that?"

Jackman: "Informed me of what?"

Rosenmeier: "The fact that you must have hearing before you refuse to renew a license."

Jackman: "Oh, yes."

Rosenmeier: "You haven't had a hearing?"

Jackman: "No."

Rosenmeier: "So you refuse without a hearing?"

Jackman: "Yes."

Rosenmeier: "I think this is important, Sir. The statutes set down the limits of the requirements. I didn't assume that this Board had refused this license without a hearing but I now understand it has."

Jackman: "Senator, this has been going on for at least six years."

Rosenmeier: "It doesn't make any difference, Sir. The law sets out the scope of the authority of this Board. Now I am informed that you have refused a license already."

Jackman: "That's correct."

Rosenmeier: "Then is that decision irrevocable?"

Jackman: "No, not necessarily."

Rosenmeier: "All right."

Dr. Rosenmeier goes through each of the complaints made about Tracy Hospital and explains how they can be taken care of.

Swenson: "I think you were a little bit in error when you said this license had already been revoked. It has been suspended pending the hearing. This license can't be revoked until after the hearing but this is a preliminary action so a hearing can be held."

Rosenmeier: "I couldn't believe, Sir, that this Board could set itself up to refuse to issue a license. The complaint, signed by Dr. Barr, says that this Board has refused to issue a license. I'm sure you haven't done so."

Swenson: "Pending the hearing. It's a matter of semantics."

Rosenmeier: "It's not a matter of semantics. It's a matter of rights."

Anderson: "Sen. Rosenmeier, we can go back over these things a little later, but there has been work on this for several years. This is not new. The hospital has been appraised of these things time and time again. It is not an arbitrary action, we, all of a sudden, didn't decide this is it. I know that last year we had a special meeting down there, the State Hospital Association and all interested doctors. They all went down there and met with them. They have been working with them for years to get this resolved. We are not arbitrarily trying to put anyone out of business, we want them to stay in business, but as we build more hospitals in the State and raise our standards as we are supposed to do, it is necessary for the others to raise their standards."

Rosenmeier: "I would be the last one to say a hospital shouldn't meet your standards. It stands to reason, and I'm not here to argue that you should grant a license in the event that this hospital does not. But I am here to say this hospital and the people I represent are prepared to meet these standards. Now I cannot say anything about its reputation in the past."

Rosenmeier: "May I suggest to you, respectfully, you can't refuse to renew a license without a hearing, we are prepared to undertake all demands for a formal hearing plus judicial review too. It is our purpose in being here today to assure you that is not necessary. If you have reasonable requirements they will be met."

Huenekens: "I want to make the point that you are talking about the personnel on the Board. I've been on this Board for 9 years and while we may have the power to change things down there, no matter how we used that power, we never got anything. Now you offer some new evidence that we've never had before."

Rosenmeier: "Now I'm new at this, so is Sen. Lauerman. I have no reason to doubt that these people mean what they say. If I doubted it I wouldn't be here."

Swenson: "I have here a letter that was written to Dr. Valentine way back in 1957 when this Department conducted a survey of the Tracy Hospital during a visit to the hospital relative to proposed elevator installation. You see they have been told about these things and I think it is too bad that we have to hold a hearing or threaten not to renew a license in order to get these things done."

Mr. Hibbert Hill: "Is this a new board or how new is the board?"

Lauerman: "in the early days Dr. Valentine ruled it with an iron hand and now the whole community has elected a hospital voluntary committee and I have met with the committee and been assure that reasonable requirements will be met and I may add I don't know how long they have served but do think Billy Mitchell has been on it for a long time. He has a tremendous reputation with the Veterans Hospital. Billy Mitchell is the one who called me last night and I asked him if they would meet all requirements if granted a license and he said yes. When it comes to building the addition, however, that can't be done overnight and since it is a non-profit organization they have to raise the money for that addition but I am assure they can do that because they are out of debt."

Dreves: "I take it there is a need for the two kinds of hospitals or are there nursing home facilities in the area or are they available?"

Rosenmeier: "It is tradition to have two hospitals. I couldn't answer the question on nursing homes except the 'Board of the Hospital felt that it would cost just as much or maybe more to convert into nursing home than remodeling and the addition to the hospital. The main thing is that they do not want to convert it into a full time nursing home. They want a hospital. Because at one of the meetings they had down there one lady said she had eight babies in that hospital and if she was going to have anymore she would be able to have them in that hospital. The

people around there are very loyal to that hospital. They are willing to do everything necessary to qualify. Thank you very kindly."⁶²³

The board felt it should not get involved in the matter directly. It agreed to write a letter to the hospital outlining the action needed. The letter stated that Senators Rosenmeier and Lauerman promised that all reasonable corrective measures would be done. A schedule as to when those measures would be done was requested. A copy of the letter was sent to the two senators. The board decided any communication with the senators and the board of the Tracy Hospital would be made by registered mail with a return receipt requested.⁶²⁴

The board refused to grant licenses to several hospitals that didn't meet the requirements. One hospital that did not get a license was the hospital in Moose Lake. It closed voluntarily in January 1960 but later community members wanted to open it. The Moose Lake Hospital had had a confusing history, according to a community member. In September 1960, a Moose Lake delegation attended the board meeting to discuss the situation and appeal to the board to give the hospital a license to operate after remodeling:

Community representative: "We admit the hospital was not run the way a hospital should have been. Dr. M got in there from the very first beginning and at that time the shareholders, of course, they had a board of directors, and so forth, and they put Dr. M in there and then they forgot all about it. Everything died away completely. Nobody knew who the shareholders were. Dr. E at Willow River was one of the leaders, and Dr. B at Barnum was another. They are all dead. Most of the directors and the board members are dead and gone. So it was quite a job to get this straightened out again and get a board appointed, also the shareholders. Dr. M didn't care what happened to the hospital. He got the gravy out of it. That's about all he got. He didn't run it like a hospital should be run. He ran it just as cheap as possible. That's why we got to have a new roof. It should have been there quite a long time ago. He probably just patched it if it leaked too bad. So you see how the situation has been up there. It is really Dr. M's fault, in a way, because he let it go to the dogs."⁶²⁵

The board decided to write the Moose Lake community that it was of the opinion that a new hospital would be preferable to remodeling, but if they remodeled it and met all the requirements of the board, the board would have no option but to license it.

As the building was not operating as a hospital, requirements included that it be made of fire-restrictive construction according to the attorney general. Therefore, the Moose Lake Hospital building could not be licensed for use as a hospital.⁶²⁶ It was difficult and expensive to remodel a hospital and it usually was preferable to build new. The hospital in Red Wing remodeled a part of the existing structure, and afterwards wished they had built a brand new facility.⁶²⁷

⁶²³ BOH, *Minutes*, October 8, 1963, MHS, pp. 539-541.

⁶²⁴ *Ibid.*, pp. 480-494.

⁶²⁵ BOH, *Minutes*, September 13, 1960, MHS, pp. 321 to 324.

⁶²⁶ BOH, *Minutes*, December 19, 1960, MHS, p. 423.

⁶²⁷ Conversation with Dr. Helen Knudsen, March 1999.

Regulation: Health Facilities Personnel

M.S. 144.61 was passed in 1947 and charged the board with licensing hospital superintendents and administrators. To do this, it depended on the help of the Advisory Board of Hospital Superintendent Registration Law. The working relationship between this advisory group demonstrated a challenge that sometimes occurred when the board failed to accept the recommendation of an advisory group.

In 1956, the Advisory Board of Hospital Administration Registration Law decided not to recommend registration for a doctor who had applied to work as an administrator of a mental hospital in Minnesota. The doctor had been chief of neuropsychiatry at three different hospitals during the last six years.⁶²⁸ The law required that the applicant have "hospital administrative experience" defined as "two years of hospital experience in one or more duly established positions requiring a knowledge of hospital procedure and techniques, and the exercise of independent judgment, supervision of other personnel, program planning and formulation of policies." The advisory board did not feel the applicant met those requirements.⁶²⁹

The Board of Health decided not to accept the recommendation and registered the applicant. Following this, Dr. Krusen, board president, received a letter from Mr. Ray Amberg, administrator of University of Minnesota Hospitals and chairman of the government relations council of the Minnesota Hospital Association. He expressed his discontent. Excerpts from the letter, dated April 23, 1956, read:

This matter has caused considerable stir among the members of the Minnesota Hospital Association, and, as chairman of the Council on Government Relations, I will be compelled to bring it before the Council, but I wish to inform the Council that I have exhausted every effort in this matter before they take it up as a matter of business. My feeling is that the amenities that usually exist between advisory boards and boards of final disposition have not prevailed in this situation, and that the attitude of all advisory boards that have to work with the Department of Health will be prejudiced unfavorably by what has transpired.⁶³⁰

When the matter was discussed jointly, Dr. Krusen, board president, pointed out the role of the committee: "I would like to point out that according to democratic processes an advisory committee cannot be autonomous and that the parent organization must always have the final say as to what action is taken."⁶³¹

⁶²⁸ BOH, *Minutes*, April 19, 1956, MHS, p. 68.

⁶²⁹ Meeting of advisory board on hospital superintendent's registration law, April 5, 1956, MHS, p. 107.

⁶³⁰ Minnesota MHS, p. 130.

⁶³¹ Minnesota MHS, p. 192.