

Governor’s Task Force on Mental Health

POTENTIAL RECOMMENDATIONS FROM FORMULATION TEAMS draft as of 10/11/16

This document is a compendium of the recommendations developed by the five Formulation Teams of the Governor’s Task Force on Mental Health as of October 11, 2016. These recommendations were re-organized and revised to create an integrated set of recommendations for the Task Force meeting on October 17, 2016. This document is being provided so that Task Force members can get a sense of the “raw material” for the Draft Recommendations document they will review at the October 17th meeting.

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I. Continuum of Care Formulation Team

A. Define and Further Develop a Comprehensive Mental Health Continuum of Care

The Governor and Legislature should adopt a wide definition of the mental health continuum of care and make **availability and access** to mental health services and activities in the continuum its highest priority. To fulfill this priority, the following steps should be taken:

1. Assign responsibility for the following work to an existing body or establish a workgroup or other body to coordinate the work. Designing the continuum must balance unique local and regional circumstances with the need to establish statewide expectations for a comprehensive continuum of care. Thus the work must be designed to promote both flexibility and accountability to ensure availability and access. Responsibility for the following process should be accompanied by adequate funding, staffing, and time to complete it. (I don't get this one. We laid out a pretty robust continuum, it just isn't available throughout the state – I think we did this)
2. Develop a service/need matrix that systematically identifies:
 - a. The services and activities needed in each function of the continuum
 - b. The appropriate service levels for each service or activity (e.g., every person should be within 90 minutes of a mobile crisis team, or there should be one psychiatrist for every 10,000 people in a geographic area). Identify where services can be co-located (schools, colleges, clinics, etc.) to enhance access.
 - c. The categories of population that are most relevant for population-based mental healthcare planning, including categories of age, cultural background, ability/disability, etc.
 - d. The regions of the state around which service availability and access will be planned. This could be in conjunction with the re-design of the Adult Mental Health Initiatives, or coordinated with that work.
3. With all of the above dimensions laid out, coordinate with regional planning bodies to prepare "Continuum Maps" that outline what activities and services are available, where, and for whom, and identify what activities and services are still needed in each area for particular populations.
4. Policy planning and funding decisions—including state and county agency strategic plans—should be made with consideration of the Continuum Maps. The Governor and Legislature are urged to build stable funding for the activities and services outlined in the Continuum Maps. Investments should be considered in three buckets: short term priorities, infrastructure investments, and sustained investments for proven services. The Task Force recognizes that building funding for this continuum could take many years.
5. While each community will have somewhat unique priorities, Formulation Team members identified the following specific services, actions, and populations as priorities:
 - a. Increase access to the core services such as crisis, community supports (ACT, ARMHS, CTSS), residential and especially to early intervention efforts such as first-episode programs and early childhood mental health.
 - b. Ensure that specific populations' needs are addressed including providing reimbursement for assistance provided to someone with mental health symptoms who

has not yet received a diagnosis (such as those persons who are at-risk due to exposure to trauma); addressing the needs of the deaf, deaf blind, and hard of hearing community (this requires both language and cultural competence); and funding mother/baby programs and support child care for mothers needing to access mental health and/or substance use disorder treatment.

- c. Build capacity of children’s residential mental health services to serve specific populations and different levels of care such as crisis homes and psychiatric residential treatment facilities (PRTFs).
- d. Address shortage of adult inpatient hospital beds (covered in the Inpatient Bed Capacity Formulation Team) and address “flow” issues
- e. Address barriers that limit IRTS development (covered in the Inpatient Bed Capacity Formulation Team)
- f. Expand access to employment opportunities.

B. Strengthen Integration and Accountability in the Continuum to Improve Outcomes

6. Assign responsibility for centralized assessment, forecasting, and planning of the mental health continuum of care, with the Continuum Maps a one organizing tool. This will require funding and staffing.
 - a. Clarify state and county roles as mental health authorities in this process (discussed further in the Governance Formulation Team).
 - b. Assign state and local responsible parties and develop capacity to conduct ongoing tracking of the Continuum Maps.
 - c. Assign responsibility for coordination of quality assurance and metrics. Determine the most meaningful metrics required to assess the performance of the system (especially from the client’s point of view) and make strategic and operational changes based on those assessments.
 - d. Invest in the public/private data infrastructure necessary for ongoing tracking and quality assurance.
7. Define “safety net” services, assign responsibility for providing them, and implement accountability mechanisms to make sure that the responsibilities are fulfilled.
8. Fund a “Mental Health System Innovation Center” to identify and/or develop innovative solutions to challenges in the continuum of care and share promising models across the state so they can be customized and implemented in other communities.
9. Improve discharge planning following the recommendations in the RARE report. This should include expectations of specific coordination to support people moving from one level of service to another.
10. Implement more care management models, including CCBHCs and BHHs.
11. Develop mechanisms for better data sharing (while protecting privacy).
12. Support local collaboration to create joint planning and transition protocols among providers
13. Where possible, set expectations and measures for appropriate and timely transitions between services and/or between levels of care.

14. Continue to align and integration mental health services with substance use disorder treatment
15. Integrate mental well-being and health into primary care; for example, develop a mental health and well-being learning community for Health Care Home providers and their partners and fund implementation of best practices outlined in the learning community. Include mental health care in urgent care.
16. The Departments of Health and Corrections should work together to improve state prisons' visiting environments and policies to encourage and foster parent child relationships.
17. Support organizations to engage in trauma informed care organizational process, beginning with health care facilities.
18. Support utilization of trauma and resilience assessment tools and an effective implementation process in health care facilities. Coordinate implementation with efforts on the social determinants of Health.

C. Develop the Mental Health Workforce

Workforce challenges are, and will continue to be, the most daunting barrier to development of a robust continuum of care. The Governor and Legislature should continue to fund the recommendations of the Mental Health Workforce Report and assign specific responsibility for tracking progress on mental health workforce development.

19. Continue to fund the recommendations of the Mental Health Workforce Report.
20. Assign specific responsibility for tracking progress on mental health workforce development.
21. Extend mental health training for people most likely to be "first contacts" for possible mental health issues: law enforcement, EMTs, education staff, spiritual leaders, criminal justice, etc.

D. Optimize Parity

Parity—treating mental health services in the same way that physical healthcare services are treated—has not been achieved in either Minnesota law or in common practice. To build our mental health system private insurance must cover treatments and supports so that people with private insurance have access and so that the cost burden is not shifted to state government. The federal mental health parity law has not been implemented in Minnesota. The basic issues under parity are: a) the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage); b) cost-sharing requirements or treatment limitations; c) out-of-network coverage; d) medical necessity and treatment denials; e) coverage for new treatments; e) nonquantitative treatment (coverage of like services).The Governor and Legislature should push toward parity with the following basic steps:

22. Require private insurers to cover the model mental health benefit set.
23. Parity should be implemented in Minnesota statute and there should be allocated funding and accountability assigned to the state to review and ensure health plans are providing the coverage required to meet mental health parity, especially where federal implementation guidelines lack detail adequate to serve Minnesotans.

24. Require the Departments of Commerce and Health to review health plans to assess alignment with parity laws and establish a complaint mechanism to enforce parity laws including market conduct exams of insurers, evaluation of plan's network adequacy, and a robust method of collecting, public reporting (including insurer's information), and investigating complaints by consumers about coverage of mental health services and treatment. Any consumer complaints about coverage received should include a requirement for insurance providers to respond within an appropriate timeframe, as crisis situations require timely mental health treatment and services.

E. Strengthen Health Promotion and Prevention

Minnesota cannot achieve a sustainable mental health continuum of care unless we can build a robust health promotion and prevention function within the state. Focusing on treatment is important, but we can't treat our way out of the mental health challenges that Minnesotans are facing. We have to "move upstream" and support healthy practices that promote wellbeing and build protective factors against mental illness. This is our investment to reduce the disease burden and slow spending increases in healthcare. The Governor and Legislature should take the following steps:

1. Develop a statewide campaign to build understanding about what creates mental health and well-being, including communication and awareness about resilience, trauma, social determinants of health, positive psychology practices and anti-stigma. Target particular preparation to those who work directly with children and families (primary care, child care, schools, and local public health). Partner with existing efforts to implement and expand anti-stigma campaigns and include evidence based training models where feasible.
2. Increase public education about how to support people who are experiencing mental health challenges. Include information about where to go for help if needed and basic paths to accessing mental health services (based on the type of insurance one has).
3. Establish a network of local community initiatives to develop and implement community resilience plans aimed at improving mental health and well-being of residents. Local initiatives should focus on engaging and mobilizing residents, assessing local needs and resources, developing an action plan that includes multiple sectors, customizing models or policies in response to local needs and strengths, and evaluating progress. For example, a local initiative may focus on helping communities come together to address mental health risk and protective factors for adolescents.
4. Establish a statewide Community of Practice on resilience and well-being to facilitate and advance learning about community based and culturally specific strategies.
5. Integrate mental well-being and health strategies into primary care; develop mental health and well-being learning community and fund implementation of identified best-practices for Health Care Homes and community partners.
6. Develop infrastructure and implement mental well-being programs that are evidence based or promising, culturally responsive, multi-generational, and support individuals and families who are experiencing risk factors. Some examples include Living Life to the Full, and the Mother and Babies Program.

7. Build capacity to collect and analyze population health data regarding risk and protective factors associated with mental well-being and illness, such as the Minnesota Student Survey, Pregnancy Risk Assessment Monitoring System, and Behavior Risk Factor Survey.
8. Expand evidence based home visiting models to all high risk families.
9. Expand programs to reach all newborns for anticipatory guidance, access to culturally and linguistically appropriate developmental and social emotional screenings and referral, including the Follow-Along program.
10. Develop supports and education for parents of adolescents that are accessible, evidence based, and teach positive parenting skills.
11. Expand transition supports for new immigrant and their families.
12. Develop resources and learning communities for organizations to engage in trauma informed organizational development, beginning with health care facilities. Organizations may include: health care clinics, early childhood providers, juvenile justice programs, schools, and other sectors. Models for supporting organizational change typically involve a multi-year process and require time and resources to fully engage in this effort. This includes activities such as training and assessment of policies, environments, practices, and organization culture.
13. Support development and implementation of trauma and resilience assessment tools in health care facilities.

F. Ensure Access to Housing

The entire mental health continuum of care cannot keep Minnesotans mentally healthy if the underlying social determinants of health continue to create stress and trauma for individuals and families, especially from generation to generation. The availability of affordable, safe, stable housing is the most basic of these determinants. The Governor and Legislature should take the following steps to ensure that housing—including housing with supports for people with mental illnesses—is available to all individuals and families who need it.

25. Increase existing state investments in housing and support services serving people with mental illnesses, including Bridges, supportive housing and tenancy supports.
26. Support the 2017 policy and budget requests for housing and supports that are recommended by the Commissioners on the Interagency Council on Homelessness.
27. Request that DHS, Minnesota Housing, the State's Office to Prevent and End Homelessness, and the Olmstead Office work together to provide an analysis (modeling) of existing resources, strategies to leverage additional housing opportunities utilizing existing resources, and to identify the remaining gap of supportive housing opportunities needed to ensure all Minnesotans living with mental illnesses have access to affordable and stable housing and services.

II. Governance Formulation Team

The Governor and Legislature should establish a workgroup to be comprised of current Mental Health Task Force members, with additional key members *(see below) charged with developing

recommendations for an effective governance structure. Final recommendations are due October 1, 2018 with an interim progress report to the legislature February 1, 2018.

To that end, the work of the group will:

- Need adequate staffing resources, familiar with the work, to convene, conduct, and coordinate the activity of the workgroup and any sub-groups created to complete the work.
- Research other national and/or state models of governance for consideration.
- Design and Recommend a Governance structure that:
 - ✓ Defines the purpose and scope, roles and responsibilities of governing the mental health continuum of care
 - ✓ Has oversight of the mental health continuum of care.
 - ✓ Is inclusive of those who have direct involvement in the mental health continuum of care including those with lived experience.
 - ✓ Ensures there are clear lines of reporting to the applicable entities based on authority, funding and accountability that are streamlined for efficiency and reduction of duplication.
 - ✓ Recommends a pathway to effective partnership amongst the various partners to reach desired outcomes.
 - ✓ Is responsible for ensuring:
 - access local or regional capacity assessments, penetration rates compared to state and national benchmarks, best practices etc. to the Mental Health Continuum of Care
 - availability of basic set of mental health services and activities for all Minnesotans.
 - properly funded and implemented including the use of needs assessment, accurate average wait time for an available routine appointment, waiting list for services, and others
- Make recommendations that align regional boundaries (adult mental health initiative map, children's mental health collaborative maps, etc.) and accountability for services. The regions' population base is sufficient to support the full continuum of services.
- Redefine what the mental health Safety Net is and determine if it is an applicable term to be used in MN in the newly defined governance model.
 - And if so, incorporate the roles and responsibilities of the safety net into the governance model.
 - Utilize other current efforts related to the safety net system in MN (see 2015 recommendations from the Community Based Steering Committee) if this moves forward, and

- Collect and analyze data to assess the existing funding structures for mental health and develop recommendations for changes in funding that align with the proposed governance structure and the goals of health care reform.
- Collect, analyze and act on data for the purposes of:
 - Identification, development, implementation, funding, and evaluation of new services driven by local need
 - Aligning financial resources to support and fund this activity.
 - Continuous Quality Improvement:
 - a. Identify the current quality measures that are being collected.
 - b. Determine the outcomes, indicators to benchmark against and process measure to be collected, analyzed, reported and addressed.
 - c. Determine the quality improvement structure, methods and strategies used that includes genuine input from individuals and families impacted by mental illnesses.
 - d. Support adoption of Best Practices such as Integrating care across mental health, chemical dependency, prevention/early intervention (public health) and social services
 - e. Implement annual a quality improvement project.
- Recommend changes in legislative language to support the Governance Model that strengthens current language related to county and state partnership/roles and responsibilities.

Recommended additional membership to include: DHS Child and Adult Mental Health, Direct Care and Treatment, Disabilities Services, Alcohol and Drug Division, Department of Commerce, Department of Health, Public Health, Regional AMHI, Counties (geographic representation, including human services director), Managed Care Organization (including state funded and private market), Community Mental Health Providers, people with lived experience and families,

III. Cultural Lens Formulation Team

1. Our system should offer ‘cultural interpreters’ much as language interpreters are offered, or “cultural consultation.” These interpreters or consultants could be credentialed by the minority populations, cultural groups, and spiritual groups that they represent (much like Qualified Expert Witnesses in the Indian Child Welfare Act court cases are). These experts should be consulted in all extended Diagnostic Assessments for adults and children and where individuals are committed to the custody of a court system. Cultural consultation should be reimbursable. This could include a higher rate of reimbursement for providers who use cultural consultation in their treatment planning.
2. DHS will include a reimbursable part of mental health treatment specific to engagement and incorporating cultural meaning/understanding into diagnostic assessments, particularly done pre-diagnosis. This will include multiple sessions needed pre-diagnosis to establish a therapeutic relationship prior to a formal diagnostic assessment. This reimbursement rate should take into consideration the need to pay the mental health providers and the cultural professional.
3. DHS will support and implement trauma focused modalities that are culturally specific and responsive. Some examples are: Trauma Systems Therapy for Refugees (TST-R), American Indian adapted Trauma Focused- Cognitive Behavioral Therapy (TF-CBT), and Parent Child Interactive Therapy (PCIT) with Dr. Dee Bigfoot in Oklahoma. Currently, many evidence-based practices are expensive and providers pay in two ways – for the trainings themselves and follow-up certifications, and in lost revenue due to being in training. In order to continue to uphold the highest standards of treatment, we must create a means for providers and agencies to be able to afford to get and maintain training.
4. “Practice-based evidence”—evidence based on everyday clinical practices—should also be recognized as an important basis for deciding what services and models to follow, especially with cultural communities.⁴¹ As clinicians work with the many culturally diverse patients they encounter, cultural perspectives are exchanged and negotiated.
5. Look at our state rules, statutes, and processes and the Centers for Medicare and Medicaid Services (CMS, the federal agency that enforces Medicaid nationally) rules for where we could be more flexible than we have been in the past. The focus is to reduce barriers and increase access. The diagnostic assessments that have been written into Rule 47 (the outpatient mental health rule) have created additional barriers to services and are particularly pronounced in culturally diverse communities where there already exists many other systemic barriers.
6. Restructure how the state administers Medicaid dollars. Create a seamless, integrated payment mechanism for a system of care that is not based on what can be paid for, but on what the consumer/family needs. Allow mental health agencies to afford to be able provide treatment and ancillary services needed in order to increase the wellbeing of the person. As such, while

¹ Includes 1) recognizing problems in daily practice that produce dissention between recommended and actual care, 2) examining whether treatments with proven efficacy are actually useful and sustainable in the context of real life, and 3) examining how structural and organizational factors may be shaped.

our state is currently in the planning stages of applying to become a demonstration state for the Certified Community Behavioral Health Clinics, we must examine how to support this type of model with or without federal demonstration dollars.

7. Invest in prevention and early childhood mental health. Many of the communities suffering the greatest inequities are not high utilizers of mental health services; however, they often enter the mental health system through other systems (child protection, special education, corrections, etc.). We must start the continuum much earlier than what our current system allows and view prevention and early childhood mental health as an important part of our continuum of services, and therefore as part of the benefit set for people with both private and public health insurance.
8. Train and implement one of the various types of feedback-informed treatments which involves creating an intentional process of engagement, feedback, and reparation in therapeutic relationships. Receiving feedback from clients has shown boost to the effectiveness of therapy, increasing client's wellbeing, and decreasing symptoms, dropout rates and no-shows. In order to create a "culture of feedback" and receive such feedback, the therapist has to present an environment that is supportive of honest feedback.²
9. With the understanding that greater healing occurs when individuals believe in the treatment and find connection with their healer, figure out how we can incorporate cultural healers, cultural brokers, and elders into existing service structures. In addition, examine current provider standards, such as ones for certified peer specialists, peer recovery specialists, family peer specialists and mental health practitioners for barriers that may be preventing the expansion and diversification of the workforce and make the changes needed in order to support this. This opportunity should allow for spiritual groups, minorities groups, and other systems to have input into setting their own credentialing standards for this process. This process could be created similar to eminence credentialing in teaching standards.
10. Develop support mechanisms for providers from cultural communities who share histories with consumers and thus sometimes experience "secondary trauma" as they provide services to their clients. These support mechanisms should be developed in consultation with these healers themselves.
11. Public funds will be used to create a demonstration grant to gather evidence that could lead to more sustainable funding options. Perhaps a Return on Investment (ROI) study could also accompany it.
12. Establish a group of people from multiple cultural backgrounds to explore how culture fits with our understanding of mental wellbeing and mental illness. With this background, the group could develop expanded definitions of wellbeing, mental health, and mental illnesses that would be more responsive to individuals' cultural backgrounds and self-understandings.

² Research shows clients who provide feedback about their treatment showed about twice as much improvement as clients who didn't provide feedback and in fewer sessions (Reese ET. Al, 2009).

13. We recommend the creation of a feed-back loop where DHS and other government systems can receive feedback on changes in services and policies from providers and consumers, with a focus on ensuring that diverse communities are represented, and that there is a shared system of accountability for providers and government agencies to take action on the reduction of systemic barriers for diverse communities. This system should allow for criticism of services as well as feedback on what practices are being effective and meaningful for consumer and providers. Clinical expertise of providers must be a part of all of these conversations. We must not forget that providers at different levels already have requirements for training, supervision, or experience (depending on education, work class, etc.) and while we need to continue to refine a system to increase the effectiveness of services, we cannot create a system that becomes so over controlling and bureaucratic that it takes away individual clinical expertise.
14. Assign responsibility for defining and supporting cultural-responsive mental health services and activities and clarify what agencies, organizations, providers, and consumer groups should be involved. The parties identified should paint a vision for a transformed mental health system that could be culturally-responsive and person-centered and that could reduce disparities. Lay out the range of roles for people in such a transformed system. Suggest concrete steps that could be taken to move toward this visions (e.g., by funding cultural healers through formal mechanisms like Medicaid reimbursement).

IV. Crisis Response Formulation Team

A. Use of Telehealth

Crisis providers are already using telehealth services to expand their reach, and mitigate workforce shortages and long travel times. The following are potential strategies for building on this.

Build out common network and protocols

Minnesota could adopt a unified network for telehealth services relating to mental health crisis. This would include expansion of the DHS hosted network, identifying a model for other emergency responders to bring a connection out into the field through tablet or other device, as well as protocols for timelines and responsibilities each partner has in crisis telehealth. This will build on prior work in several areas. Northwestern Mental Health Center has invested significant effort into developing protocols and workflows to support the deployment of telehealth connections between the crisis team and small hospitals in the area.³

DHS and AMHI Region 3 (Northeast MN) have partnered to pilot the deployment of a common standard and network for telehealth connections. Hospitals, schools, and clinics all can gain access to the DHS network which allows for fast and easy connections. One of the core principles that the group has affirmed is that telehealth services should adapt to the needs of individuals, not be limited to fixed locations.

³ Reitmeier, S. Chief Executive Officer, Northwestern Mental Health. Correspondence. 9/9/16.

Some examples of use: One member of a crisis team can stay in contact with a child in crisis at a school, while another travels to meet them in person. A psychiatrist from HDC, the community mental health center, can provide a diagnostic assessment and start an individual at the Carlton County Jail on medication without any transportation time or cost.⁴ MN.IT provides helpdesk to support for all users.

Objectives: Expand a single, interoperable network standard for telehealth and identify sustainable allocation for those infrastructure costs. Establish best practices for the workflows used to implement telehealth for crisis situations.

Timeline: *Incoming information from Roger Root, MN.IT.*

Resources: Variable. Identification of best practices for use and deployment would require relatively few resources. Building out broadband connectivity and the infrastructure could be far more ambitious.

Incoming information from Roger Root, MN.IT.

Partners: MDH Office of Rural Health has experience managing grants for capital expenditures rural health systems would otherwise be unable to afford. MN.IT has managed the expansion of the DHS hosted telehealth network to mental health providers in Region Three. Further stakeholder work would require broader representation: more hospital systems, crisis teams, other telehealth implementers. Establishing a statewide conference or community of practice could help develop and spread best practices.

Reserve Capacity for Crisis Response via Telehealth

Minnesota should establish a common pool of telehealth resources for urgent mental health needs. An RFP process would identify a provider to function as a reserve, available when local resources are not able to respond quickly.

If a person calls in to a crisis team during a busy time, a shortage of available responders might mean that they are told that the team cannot respond in a timely fashion. Instead, callers could be presented with options: a timeframe for mobile response, or directions to a site where they could access the telehealth team. Potential local sites could be clinics offering physical urgent care, a hospital without dedicated psychiatric resources, or fire station/paramedic base. The local site would need to be able to provide some level of support: paramedic or triage nurse, and the ability to call for further resources when required. A framework for responsibilities, reimbursement to the local site, and other funding considerations would need to be developed.

Drawing from a larger pool of potential callers, a more predictable staffing model could be developed for this reserve. Depending on the needs and staffing models of existing teams, they could potentially chose to cover calls from other areas during times when they have additional capacity.

⁴ Lee, D. Director of Public Health & Human Services, Carlton County. "Vidyo Telepresence System Live Demonstration- State Advisory Council and Children's Subcommittee." 10/6/16.

Objectives: Decrease the number of instances where a potential recipient is told that crisis services are unavailable because all staff are already committed to calls. Utilization data from telehealth team would drive further development of the mobile teams.

Timeline: Would require funding, the development of a new team, and the identification of appropriate sites to host the connections in the community. Due to the workforce issues around the state, the location would probably need to be in an area not currently identified as a shortage area: either Metro or southeast MN. It would take approximately 3-6 months post signing of contract to get staff hired, get the equipment up and running and get staff trained in crisis response and in using the telehealth equipment. Host sites may take longer to develop, and host sites will need to train/collaborate with the telehealth crisis providers to work out logistics and team protocols.

Resources: An initial target would be 13 to 15 staff. This would allow 3-4 providers to be available at a time for 3 shifts per day to provide assessments via telehealth.

Staff Costs (Professionals and practitioners available to provide telehealth services)	\$364,000
Administration staff costs	\$24,000
Other Administration/overhead	\$61,000
Total Team Cost:	\$550,000

To develop a new remote site in areas that do not already have the capability, costs for equipment and overhead might be around \$33,000/year based on prior expansions. The staffing needs at those locations could vary based on what services were already present.

Some of these timeframes could be accelerated if teams with existing telehealth capacity were able to contract for portions of this coverage. In some cases it might be more cost effective or expedient to pay for additional capacity in an already existing team.

Partners: 911 responding agencies, counties, existing mobile crisis teams, host site locations, DHS. Implementing hospitals would need buy in from internal stakeholders, especially at the remote sites: physicians, nurses.

B. Pre-service CIT as required training for law enforcement

Minnesota should implement 40 hours of pre-service CIT training for all officers through the Law Enforcement Academy. In service officers would get 4-8 hours of refresher training every 3 years. Because of the high cost of taking in service officers off patrol for 40 hours, pre-service training is the best approach as Minnesota seeks 100% CIT training for law enforcement. In addition, courses would be

made available for Fire/EMS responders and 911 dispatch staff. Formulation group members expressed interest in integrating training on trauma, including sexual assault.⁵

New officers may be more receptive to training, but each agency will need veteran officers or leadership who are trained and invested in the CIT model. Changes in policy may be needed to realize best outcomes, including clarifying who is the lead officer at a scene involving a mental health crisis.⁶ Trainees should also get information about coping skills and resources for themselves, so that they are better equipped to handle the stresses of responding to crisis situations.

Parallel to this, educators may need more resources and training to help support positive crisis interventions. Minnesota has about 55,000 teachers licensed, with 2400 new teachers in a year.⁷ Foundational training, such as mental health first aid, is about \$80/trainee.

Objectives: Increase community and officer safety when responding to mental health related calls by providing CIT training to law enforcement pre-service, and to Fire/EMS responders and 911 dispatchers.

Timeline: Training could be started relatively quickly. However, a focus on pre-service training would mean a lag time before a critical mass of officers would have the training. Current practice has been to restrict the 40 hour course to in-service officers since they have additional context for the training. The Task Force will need to consider this tension.

Resources: Contracts for CIT training have typically been \$650 for a 40 hour training with actors, which is recognized as the highest quality training. 30 people can be trained in a cohort. Minnesota has approximately 650 officers entering service each year, and about 11,000 in service.

Training Type	Persons being trained	Cost per seat	Total per year
Pre-service 40 hour course	800-1300 peace officer candidates, Fire/EMS/911 dispatch personnel in training	\$650 (training cost only, no salary or travel)	\$500,000-\$850,000
4 or 8 Hour refresher, 3 year cycle	3666 currently serving peace officers	\$415 -\$760 (includes salary and travel)	\$1,200,000 to \$2,800,000

⁵ Sara Suerth recommended “Understanding Trauma” as presented by Central Minnesota Sexual Assault Center.

⁶ Dupont, R., Cochran, M. S., & Pillsbury, S. (2007, September). Crisis Intervention Team Core Elements. Retrieved October 2016, from University of Memphis CIT Center, http://www.cit.memphis.edu/information_files/CoreElements.pdf

⁷ Schools, districts and teachers at a glance. Retrieved October 11, 2016, from Minnesota Education Statistics Summary, <http://w20.education.state.mn.us/MDEAnalytics/Summary.jsp>

Partners: Law enforcement agencies, schools, cities, counties, Fire/EMS services, MnSCU, CIT training organizations, individuals with lived experience, DHS, DPS.

C. Additional resources where people already seek help

Co-location of Community Mental Health Center staff in Critical Access Hospitals

Minnesota should prioritize the co-location of outpatient mental health services delivered by Community Mental Health Centers into Critical Access Hospitals (CAH). CAH's are 25 bed or smaller hospitals and are eligible for cost-based payment for Medicare/Medicaid. They must be a certain distance from the next available hospital, and most provide primary care and outpatient services in attached or satellite clinics. The underlying value is the recognized need to maintain some level of access to treatment, even in less densely populated areas. Residents of these areas are used to going to the hospital for regular outpatient services, as providers see a mix of clinic and hospital patients throughout the day. Sometimes, it may be the only primary care provider located nearby. Both providers and clients benefit from ease of accessing multiple kinds of care from a single site. Better care of mutual clients, and opportunities for joint system engagement. In crisis situations, mental health staff are on site and can offer consultation. In some CAHs, hospital staff also comprise the local Crisis Intervention Team.

Objectives: Significantly increase access in rural communities to mental health care located in Critical Access Hospitals. As a secondary benefit, those providers would be better able to offer consultation or services on an as needed basis to patients presenting through the emergency department.

Timeline: Prior projects have taken about one year to implement.⁸

Resources: Workforce is and will continue to be a significant barrier. Recommendations in the Workforce Report may assist in this process, including development of more rural-focused programs and clinical training through the University and MnSCU systems. Additional funds for targeted student loan forgiveness could also be used. Co-location can reduce capital/overhead expense for the Community Mental Health Center, and can help drive additional patient volume to the local hospital and clinic.

Partners: This proposal would require significant partnership and buy in between hospitals/health systems and Rule 29 Community Mental Health Centers. DHS and MDH would have roles in supporting and monitoring this work.

Urgent Care for Mental Health: Integrated Crisis, Psychiatry, and Chemical Health

Minnesota should develop more Urgent Care for Mental Health settings, combining detox (and/or withdrawal management), crisis response team, and urgent access to psychiatry (medication). This model does not have a locked or secure unit, and operates below the inpatient level of care. Data from the East Metro Crisis Alliance shows promising outcomes for individuals who access crisis stabilization. Individuals who infrequently access care saw gains in their connection to ongoing outpatient services. Both low and high frequency service recipients had fewer visits to the Emergency Department as well as

⁸ Reitmeier, S. Chief Executive Officer, Northwestern Mental Health. Correspondence. 10/3/16.

inpatient hospitalizations. For patients receiving urgent or gap psychiatry, 1/3rd would have otherwise presented in an emergency department.

This model is focused on Medicaid and other publically funded care. Clinic networks and healthcare systems that focus on individuals with private insurance are more likely to offer reserve appointments in general purpose clinic during daytime hours than a more narrowly focused standalone.⁹ The governance group may wish to consider what barriers may exist for such models to adapt for greater integration with health plans and clinic networks.

In 2011-2012, the East Metro Crisis Alliance commissioned a study by Wilder Research to understand the costs and results for the Urgent Care for Adult Mental Health program.¹⁰

- Emergency department utilization decreased significantly post-crisis stabilization for all patients, including “high-frequency” patients.
- Use of outpatient mental health services increased significantly for low-frequency patients following stabilization; no statistically significant change in utilization was observed for high-frequency patients.
- All-cause inpatient hospitalization decreased significantly for all patients, including high-frequency patients. In addition, significant decreases in mental health-related admissions were observed for patients as well.
- A cost-benefit analysis found that for every one dollar spent on Crisis Stabilization services, there is a savings of \$2.00 - 3.00 in hospitalization costs.

Additional data suggests a higher diversion rate (did not need to use Emergency Room or in-patient) among clients who saw a psychiatric provider (able to prescribe medication when appropriate.) In addition, the Urgent Care could connect people with medication assistance programs.¹¹ As teams reach 24/7 mobile coverage, Minnesota could commit to integrated psychiatry within crisis response as the next benchmark for service.

Objectives: Provide rapid access to psychiatry, crisis stabilization, and urgent chemical healthcare, in a less intensive setting than an inpatient unit.

Timeline: The Urgent Care for Adult Mental Health in St. Paul took about three years from idea to opening. A similar project might proceed somewhat faster based on lessons learned, but construction alone took 20 months.

⁹ M. Trangle. Senior Medical Director for Behavioral Health, HealthPartners. Interview. 9/20/16.

¹⁰ Bennett, A. L., & Diaz, J. (2013, May). The Impact of Community-Based Mental Health Crisis Stabilization. Retrieved October 3, 2016, from Wilder Research, <http://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/The%20Impact%20of%20Community-Based%20Mental%20Health%20Crisis%20Stabilization,%20Brief.pdf>

¹¹ M. Trangle.

Resources: This model may be better suited to a broader range of communities than dedicated psychiatric emergency rooms. Some population center is needed to sustain the volume, but it is not as resource intensive as an in-patient unit. The building cost \$9M, and ongoing operations break out as:

- Crisis (includes 24/7 phone services, crisis assessment, crisis stabilization): \$3.2 Million
- Detox: \$3.6 Million
- Chemical Health Placement and assessment unit: \$800,000

These costs were in-line with prior spending in each of these areas when they were not physically collocated. As the project continues, Ramsey County has experienced significant operational improvements and efficiencies. Staff are now being cross trained between programs and better able to respond to ebbs and flows in the needs of the programs. More coordinated and integrated care is being provided, and the collaboration has advanced their ability to achieve a recovery focused model of care.¹²

Partners: Counties, Health Plans, DHS, Hospitals, Community Mental Health Centers. Workforce would remain a key issue, additional funds could expand the psychiatry residencies offered at the University of Minnesota.

D. Intersections with Criminal Justice

Mental Health/Law Enforcement Co-responder Models

Minnesota should pilot models for embedded mental health providers within law enforcement.

While national models are available, some questions will need to be answered as we map those ideas to Minnesota's service spectrum. One major concern will be the availability of a qualified workforce. Nationally, models for co-responders have emphasized having a master's level provider as the embedded person. They have a more significant clinical background, are better equipped to accurately assess risk, and have a licensing board to whom they are also accountable.¹³ Members of the group affirmed this as an important principle.

One of the key needs that a collaborative or co-responder model can meet is in informing police about the decision making process for assessment and intervention. Law enforcement officers frequently reference the experience of bringing an individual to the hospital, only to encounter them again in a short time period. Without a solid assessment of what (if anything) a hospital might reasonably provide to an individual, the officer's decisions tend to be made on the side of caution, bringing that person to the ER. This gap in expectations results in lost time, inferior outcomes, and significant costs. Minnesota should make a careful assessment of how to best provide for collaboration and communication that

¹² Conducy, A. Chemical and Adult Mental Health Manager, Ramsey County Community Human Services. Correspondence. 10/7/16.

¹³ Smith-Kea, N., Yarbrough, M., & Myers, S. (2016, September 28). Police-Mental Health Collaboration Programs: A Different Way of Policing. Retrieved October 04, 2016, from <https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/>

addresses that gap. The required workforce is in short supply across the state, with most areas being designated as Mental Health Professional Shortage Areas (MHPSA).¹⁴ The time that the embedded mental health professional spends in ride-alongs and engaged in other non-clinical work can help bridge healthcare and law enforcement cultures. However, many communities already struggle to hire and retain the workforce needed for clinical services.

The other major need addressed by different co-responder models is proactive outreach to individuals who come in frequent contact with crisis providers and law enforcement. Models in Texas and California emphasize this function. In most cases the mental health provider is leading the conversation, and the officer is there to build trust in the event law enforcement does have to respond to that person in the future. Health providers, such as case managers, seek a release of information that covers the mental health team on the law enforcement agency.¹⁵ Another related service can be follow up to communities or individuals affected by trauma and violence in the community, even if the original incident was not related to mental health. Minnesota should carefully consider how closely these roles should be tied to law enforcement. Case management and ACT teams should be accepting referrals for service from police. But it is not always clear where that service benefits from additional police involvement.

Some co-responder models are a standalone unit within a police department. The mental health provider is directly hired and is accountable to that agency. Others are a collaboration between mental health crisis services and law enforcement. These providers already have expertise in crisis assessment, intervention and stabilization. They cover distinct geographic regions, and have 24/7 access to a mental health professional, even if the assigned “embedded” clinician is not on duty.¹⁶ Because Minnesota already has a county based mental health crisis response infrastructure, this may be a better match. This may reduce the likelihood of co-responders becoming another service silo that is not connected with other resources. Minnesota could focus additional grant funding to support co-location of existing crisis teams with law enforcement, or to pay for time spent in ride-alongs or other collaboration.

With any of these models, racial disparities are a possible collateral consequence. Communities that have significant levels of mistrust towards police may be less likely to call for crisis services if they believe that they are connected to law enforcement. Another significant factor in long-term outcomes is the strength of the community services to which individuals are being redirected. Despite differences in various co-responder models, a common point is that a mental health provider assists law enforcement in making choices about disposition related to mental health. If the choices they have available are insufficient, the co-responder model will struggle.¹⁷

¹⁴ Health Resources and Services Administration.

https://datawarehouse.hrsa.gov/ExportedMaps/HPSAs/HGDWMapGallery_BHPR_HPSAs_MH.pdf

¹⁵ Smith-Kea, N., Yarbrough, M., & Myers, S.

¹⁶ Abbott, S. Advocates Jail Diversion Program: A Step by Step Toolkit. Page 4.

¹⁷ Helfgott, J.B., et al., A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program, *International Journal of Law and Psychiatry* (2015), <http://dx.doi.org/10.1016/j.ijlp.2015.08.038>

Objectives: Provide timely, on-scene assessment of an individual's needs and possibilities for diversion to community resources. Proactive outreach to individuals who come into frequent contact with hospitals, crisis services, and law enforcement.

Timeline: From planning to operation, co-responder programs have taken 1-2 years to develop. Workforce will be a significant challenge.

Resources: A mental health professional's salary/benefits might run from 90,000-104,000/year. Staffing levels might vary significantly based on population density.

Partners: Law enforcement, crisis teams, community mental health providers.

Expand Diversion Options for Juveniles in the Criminal Justice System

Minnesota should build on diversion programs to address the needs of children whose primary need is mental health treatment. When a juvenile has mental health needs and is involved in the criminal justice system, the existing tools don't always work to provide best outcomes. Using delinquency proceedings can mean significant collateral consequences for the child: self-identification as a delinquent, restricted access to therapeutic settings, family separation, and additional stress from an uncertain process.

A Child in Need of Protection (CHIPS) petition is framed for children whose needs include an unsafe home environment. The enforcement mechanisms are about actions the parents will take, not the child. A child with serious emotional disturbance may not be safe to return home, not because their family is neglectful or abusive: simply because their needs dictate a different setting. After 12 months, a CHIPS petition must be considered for permanency, which can lead to termination of parental rights. Children and families dealing with significant emotional disturbance need services, not separation.

Meanwhile, if a child is directed into Rule 20 proceedings, some parents may be less supportive of treatment because they wish to prevent the consequences of the criminal proceeding for their child. A child with significant needs might not be able to meet the standards for competency, and stay in limbo through Rule 20. Some of the best therapeutic settings a child might be placed into are not open to individuals with prior delinquency proceedings.¹⁸

Objectives: Provide high quality diversion options for youth with mental health needs and criminal justice involvement, following model developed in Stearns County. Identify services and supports needed to maximize safe and therapeutic outcomes for high needs children.

Timeline: Prior projects have taken 1-2 years to develop.

Resources: Significant realignment of current resources. Adding specialized mental health expertise into juvenile courts.

Partners: Law enforcement, child protection, residential programs for children, courts, community mental health providers, schools.

¹⁸ Mahoney, B. Family & Children Services Division Director, Stearns County. Interview. 10/6/16.

E. Improved Data Sharing and Collaboration

Continue to Build on RARE and e-Health Roadmap

Between 2011 and 2014, the Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association (MHA) and Stratis Health embarked on an initiative to reduce avoidable hospital readmissions: the Reducing Avoidable Readmissions Effectively (RARE) campaign. They focused on comprehensive discharge planning, medication management, patient and family engagement, transition care support, and transition communications. All of these are factors for individuals at risk of mental health crisis, or who have recently experienced one. The campaign enjoyed significant success, and is credited with preventing 7,975 readmissions for a total of 31,900 avoided bed days (all causes).

Staff turnover or a lack of identified ownership for these projects can undo progress. Minnesota can continue to improve by increasing the quality of resource databases, seeking longer staff retention in care planning roles, and reinforcing recovery and coping skills in discharge plans.¹⁹

As part of a State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and of Human Services in 2013 by the Center for Medicare & Medicaid Innovation (CMMI), stakeholders have created the Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services. The Roadmap process was structured, sequential, and integrated the diverse issues of priority settings, including mental health. The steering team, with 25 individuals, and the workgroups, with over 50 subject matter experts from the priority settings, met over 40 times from January 2015 to June 2016.²⁰

Minnesota will need to dedicate time and resources to implementing these findings to better use health information. This includes significant impacts on crisis situations. If healthcare and social service resources are not coordinating efforts, a breakdown in supports can easily trigger a crisis. A lack of understanding where else a person has sought help might mean missing the red flags that a person is at significant risk.

Uniform Storage and Access of Advance Directives/Crisis Plans

Some states have created a centralized registry of advance directives. Individuals complete their plans and store them through a secure online portal.²¹ They may print a wallet card with a bar code or store information on their phone that links their name and registry ID. In case of an emergency, a healthcare provider can access their documents with the individual's name and registry ID or date of birth. Minnesota could implement an option for individuals declare that they wish to have information disclosed to law enforcement in a crisis situation. While a registry does not necessarily mean the

¹⁹ Kemper, J. Health Care Consultant, Institute for Clinical Systems Improvement. Interview. 10/5/16.

²⁰ "Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services." Published June 6, 2016.

<http://www.health.state.mn.us/e-health/ehealthdocs/roadmap.pdf>

²¹ Models reviewed: Virginia, California, Idaho.

advance directive is integrated directly into the patient record, it does allow for the person to present at any healthcare provider and still have that information be accessible.

Objective: Provide a centralized location for Minnesotans to store their advance directive or crisis plan, and know that it will be accessible to the proper responders in an emergency.

Timeline: The Virginia registry took about three years from legislation to launch.

Resources: Various funding models exist for registries. Idaho charges \$10 to file a directive, Virginia has entered into a public/private partnership to cover the costs, and Arizona makes a general fund allocation of ~\$60,000/year.

Partners: MDHS, MDH, stakeholder community from prior work.

F. Further Improvements to Community Services

Expand Forensic ACT Capacity

Minnesota should invest in specialized Forensic Assertive Community Treatment teams to meet the needs of individuals at risk of future/continued involvement in the justice system due to their mental health needs. This follows a recommendation in the 2016 Office of the Legislative Auditor report on mental health care in jails.²²

Assertive Community Treatment (ACT) is an evidence based service for people with severe mental illness (specifically schizophrenia and bipolar disorders) and is a multidisciplinary, team-based approach with a small staff to client ratio and 24/7 hour staff availability. ACT is a non-residential service, working with clients in the community, and provides all treatment, rehabilitation, and support needs from within the team (e.g., services not brokered out to other providers). ACT is sometimes described as a “hospital without walls”.

Forensic assertive community treatment (FACT) is an adaptation of the traditional model that is designed to help clients that have higher risk of repeated involvement with the criminal justice system or incarceration, than traditional ACT clients. This is a highly underserved population with complex challenges that require a high level of treatment, rehabilitation and services in order to more successfully re-integrate back into their communities. One FACT team is already operating, as a collaboration between the Department of Corrections, Department of Human Services, Ramsey County, and South Metro Human Services. Hennepin County is also starting a FACT team to work with clients who enter the county jail or are involved in the Mental Health Court.

Objectives: Provide high quality community based mental health services to individuals at high risk of future involvement in the criminal justice system. Reduce jail and hospital bed days among individuals served.

²² Alter, J. (2016, March 3). Mental Health Services in County Jails. 41. Retrieved October 11, 2016, from <http://www.auditor.leg.state.mn.us/ped/2016/mhjails.htm>

Timeline: Prior expansion has been done at about 1-2 teams per year. The staffing requirements to meet fidelity standards are rigorous, and it may be difficult to find qualified individuals any faster.

Resources: Prior ACT team expansion has required technical assistance and grant funding from DHS. The rate a team has is based on prior costs, and so the year in which they build up to a full case load can require additional funding. Adding 4 teams, each with the capacity to serve about 70 individuals in a year would cost approximately \$5M.

Partners: Counties, jails, Department of Corrections, DHS, community mental health providers.

Expand Pre-Crisis Services

Many individuals are frequently near a crisis state, and it may take them time to begin to find and accept resources for change. One way to augment clinical services and help individuals reach the next goal in their recovery is the use of Certified Peer Specialists (CPS). Mental Health Minnesota operates a “warmline,” which provides a safe, accessible resource for individuals working on their recovery. As the name implies, it is not intended as a “hotline” capable of responding to individuals who are feeling suicidal. It fills an important gap between outpatient care and crisis response.

The Minnesota Warmline is currently available statewide during evening hours (4pm – 10pm) Tuesday-Saturday, and provides support and stability for callers who need to connect with someone urgently. Individuals may call anonymously if they wish, and get the support they need to use their own resources and problem solving skills to address their immediate needs. Approximately half of the callers are experiencing significant stress or anxiety when they call, while the other half are reaching out to break isolation. Nearly 90% of callers report feeling calmer by the end of the call.

Warmline operators are CPS trained. The CPS model gives individuals who have experienced mental illness the framework for supporting others by modeling healthy behaviors, asking the individual to recall previous tools or strategies that have been successful, and offering hope that recovery is possible. Minnesota should support and promote warmline services as an adjunct to crisis services to help individuals avoid more intense needs.

Objectives: Provide one number access to moderate intensity peer services for all Minnesota residents.

Timeline: Hiring and training additional peers and additional clinical supervision may take 2-3 months after funding is allocated.

Resources: This program handles nearly 500 calls/month during its open hours (30 hours/week), with the number of calls increasing every month. The Warmline currently operates on a monthly budget of \$8,000. Goals for continued expansion would include adding expansion of hours (adding Mondays, 4-10 PM), increasing the number of operators available (minimum of three operators instead of the current two), and clinical supervision. An expanded program would require additional Certified Peer Specialists, and clinical supervision to support them (with an estimated need of \$170,000 in additional annual funding necessary for expanded service).

Partners: Counties, mobile crisis teams, health systems, certified peer specialists.

Support Inpatient Formulation Group on expanding capacity and discharge options

The crisis formulation group voices support for the recommendations forwarded by the inpatient group on IRTS expansion and permanent supportive housing. Many communities in Minnesota lack sufficient in-patient or residential capacity for individuals in crisis. These steps are needed to ensure the availability of the right services at the right time for individuals with acute needs.

G. Additional Recommendations

The following are models the group examined and potential areas for action that required more development.

Healthcare system based telehealth pools

Minnesota could support the development of telehealth resources for hospitals and urgent care settings that would be operated by the healthcare system for their affiliates. When a patient presented at a setting without dedicated resources for mental health, telehealth would be used to support the local ED in providing appropriate intervention and stabilization.

CentraCare is in process to establish telehealth for psychiatric consultation to the emergency rooms of the smaller hospitals in its system. Mental health staff would be based at St. Cloud. Hiring the needed workforce has been a challenge, especially to get 24/7 coverage. CentraCare participates in a regional planning effort, including law enforcement, county health and human services, and Central Minnesota Mental Health, the local community mental health center. They are exploring further improvements, including urgent care for mental health that would be co-located with physical urgent care.²³

Some key advantages to this model would be greater familiarity between host/remote staff than might be expected in a statewide system. A provider with a set territory can better learn local referral resources and collaborate better with other providers in the same health system. May be more workable in some systems than others based on how many remote sites would need coverage vs. the number of sites that already had psychiatric staff present. Drawbacks include variations in how closely hospital based services connect with county based services in some areas. Might increase regional disparities in the availability of services.

Objectives: Achieve a higher standard of care for patients who present in Emergency Departments where mental health providers are not available on-site.

Timeline: Primarily dependent on workforce considerations. Discussions between ED staff and mental health providers do take time to build trust, rapport, and clear delineation of responsibilities. ~6-12 month timeframe after funding is allocated.

Resources: Available workforce has been identified as a significant concern. Additional funding to target student loan forgiveness could be offered. Grant support for physical and IT infrastructure might be required.

²³ Hartford, D. Behavioral Health Section Director, CentraCare. Correspondence. 9/1/16.

Partners: Hospital/Healthcare systems, MDH, DHS. Implementing hospitals would need buy in from internal stakeholders, especially at the remote sites: physicians, nurses.

Development of Children's Crisis Residential

The 2015 Legislature gave instructions for the Department of Human Services (DHS) in consultation with stakeholders to develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. In June 2016, the Department of Human Services, Mental health division published an RFP to contract with a qualifying vendor to conduct a study on funding around this benefit. A vendor has been selected and the project is currently in the contracting phase.

The duties for the contract are to research and interpret best practices including researching other state's coverage for children's crisis residential services. Research will include state laws, literature search and other related research to inform policy and standards around treatment coverage such as funding, staffing, eligibility criteria and overall oversight. Research on funding models would include state Medicaid plan and private insurance, particularly on room and board to inform any research around this level of care, cost effectiveness, quality and outcomes. Conduct surveys and interview key stakeholders and providers to define problem, identify barriers and level of care needed. Facilitate and coordinate stakeholder meetings under the guidance of the children's mental health division. Identify topics for each meeting such as crisis models, target population, licensing and certification, authorization authority, review interviews and research. Submit final report of recommendation to the Department of Human Services by June, 30 2017 with a summary of research findings, meetings, interviews and other sources included.

Recommendations submitted to the department's mental health division will be used to inform establish children's mental health crisis residential services without requiring county authorization or child welfare as a new benefit with Center for Medicaid Services (CMS) approval.

The formulation group recommends that the Task Force adopt a rubric of values and functions to be used in this process, to judge how well potential solutions meet the needs expressed in taskforce meetings.

Psychiatric Emergency Rooms

Minnesota could support the development of more capacity in psychiatric emergency rooms. This model would support for higher levels of acuity than other centralized models. One key value would be preserving the focus on a mental health response to crisis (services are provided in a dedicated healthcare setting) but still support collaboration with law enforcement (shortened timeframe for transferring a patient to care, able to support individuals with recent assaultive behavior.)

Since 1971, HCMC has operated the Acute Psychiatric Services (APS) unit. Initially designed to handle walk-in clients and referrals from other parts of the hospital, APS has expanded services and operates a dedicated psychiatric emergency room with 14 rooms. The waiting room is recently remodeled, and is a more calming and de-escalating environment than a general ER. Walk in clients present with a variety of needs, particularly medication refills if they have lost access elsewhere or are not yet established with

another provider. HCMC has made the deliberate choice to use psychiatrists and other prescribing providers to perform the psychiatric evaluations, another common service. While this has costs, they see a lower rate of in-patient admission because they are able to address more potential concerns in the assessment process. Many individuals present with a “simple” evaluation, but their more complex needs emerge as they talk with the providers.

APS is capable of handling high acuity: individuals with recent assaultive behavior related to a crisis or individuals with medical needs in addition to their mental health. The presence of security personnel on site and that a portion of the APS unit is secured means that law enforcement can expect a 7-9 minute turnaround when bringing an individual to APS. Rooms for acute clients are physically designed for safety.

Other collaborations help address related needs. HCMC staff push into the jail, to provide higher levels of treatment than could otherwise be delivered. While APS has a fairly high intake threshold for aggressive behaviors, some individuals are most appropriately housed in a corrections setting. APS also worked with nursing homes and other community settings to readmit individuals discharged to that setting but whose needs escalate. This is helping to build trust and create more discharge options, but significant needs remain. Backups in the in-patient unit tend to push back into APS, and then the Emergency Department, which can lead to patient boarding. Director Megen Coyne identifies increased collaboration as a key priority: HCMC and connected systems have both needs and resources all over. Building trust and communication among departments and programs makes it possible to harness the right resources at the right time to deliver the best outcomes to clients.²⁴

This model requires a significant patient volume and on-going operational funding, which likely restricts the model to urban areas. HCMC sees about 2/3rds of the cost recouped by billing, a shortfall of approximately \$1M per year. The value the psychiatric ER provides in assisting the ED and other areas of the hospital are significant, but not directly captured. Standalone “receiving centers” present much higher hurdles, including increased reliance on law enforcement if staff from other units are not available during code calls. The IMD exclusion is also a strong concern for a patient population with high rates of Medicaid eligibility. The experience of current providers also indicates that a key value of a psychiatric ER is being able to accept transfers from other units of the hospital, including the standard Emergency Department.

Objectives: Replicate and refine a model for people in crisis of moderate to high acuity, including aggressive behaviors, as an expansion of services in high-volume emergency rooms.

Timeline: Physical spaces which are conducive to recovery would need remodeling or building. Funding would need to be secured, and staff hired and trained. Needs more development.

Resources: Funding streams, particularly for costs that cannot be billed for, need to be identified. Eg: security personnel needed to ensure staff and patient safety. Depending on the persons served, some portion of the billed services would be to public health programs.

²⁴ Coyne, M. Senior Director, Department of Psychiatry, Hennepin County Medical Center. Correspondence. 9/29

Partners: Hospital/Healthcare systems would be needed as key partners, along with counties. MDH, DHS. Partnerships with law enforcement could be used to address security needs.

Zero Suicide Model

Linking physical and behavioral health to support young people with mental health challenges. Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.²⁵

1. Train- develop a competent, confident and caring workforce
2. Identify- Systematically identify and assess suicide risk among people receiving care.
3. Engage- Ensure every individual has a pathway to care that is both timely adequate to meet his or her needs. Include collaborative safety planning and means restriction.
4. Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
5. Zero suicide is a call to relentlessly pursue a reduction in suicide and improve the care for those who seek help.

Range Mental Health Wellstone Center²⁶

The RMHC Wellstone Center for Recovery is a community-based program designed to assist adults experiencing a mental health crisis or emergency. The program offers individualized services that meet the unique needs of those being served and is staffed around the clock by highly trained mental health practitioners and skilled nursing staff. Each resident has a private room. Most insurances, including Medicaid, is accepted.

The program utilizes evidence-based, recovery-oriented services including:

- Individualized Assessment and Treatment
- Psychiatry Medication Management
- Onsite Diagnostic Assessment
- Onsite Alcohol and Drug Assessments (Rule 25)
- Illness Management and Recovery
- Integrated Mental Health and Substance Abuse Program
- Family Psychoeducation
- Holistic Skills Training focusing on Prevention, Wellness and Self-Care
- Discharge Planning and Referrals to ongoing/follow-up services and resources

²⁵ Covington, D., & Hogan, M. (2015). What is Zero Suicide? Retrieved October 12, 2016, from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/zero_suicide_final6.pdf

²⁶ Range Mental Health Center Services. (n.d.). Retrieved October 12, 2016, from <http://rangementalhealth.org/services/>

Admission Criteria

- Experiencing a mental health crisis
- Minnesota resident
- Between ages 18 and 65
- Medically stable
- No imminent danger to self or others
- No substantial alcohol/chemical impairment
- Comply with a medical screening
- Bring a two-week supply of prescription medications in bottles

Admissions are taken 24 hours a day, 7 days a week, 365 days a year. The Mobile Crisis Team began in September of 2014 as an additional service out of the Wellstone Crisis Stabilization Center. The mobile crisis team serves adults and children, seven days a week. The mobile crisis team provides an on-site assessment at a common entry point in the community to persons experiencing a mental health crisis.

The geographic area served is Northeastern Minnesota. This area includes Northern St. Louis County, Koochiching County, Lake County, Cook County, and within the vicinity of the three tribes including but not limited to Bois Forte and Nett Lake.

Beltrami County Jail Diversion Program

Funded with \$2M in one time startup grants in 2015, Beltrami County is designing programs to address the mental health needs of individuals who come into contact with law enforcement. The county is required to show sustainability for the services and provide integrated care. This funding has supported the development of an Assertive Community Treatment (ACT) team, and the hiring of a project coordinator to represent the interests of Tribal Nations in the development of new services. This project may also include the development of Intensive Residential Treatment Services (IRTS).

Standards for Crisis Services and Providers

Minnesota made substantial investments in the startup and operation of Mobile Crisis in 2015, and is on track to have 24/7 mobile response throughout the state by January 1, 2018. As the increased allocations are becoming effective and teams are added or expanding, disparities in service models have become more apparent. This need was anticipated in the funding language from 2015, directing the Commissioner to “establish and implement state standards for crisis services” (§245.469 Subd 3.3).

Variations in how people access the service can discourage people from calling in, and create challenges for other responders, including law enforcement. DHS has been working on this area already, and has opened a stakeholder feedback process to take a very detailed look at these issues. Key issues under discussion include:

- Standardizing expectations and criteria for dispatching mobile crisis response
- Promoting better collaboration between rural hospitals and mobile crisis teams
- Realigning standards for who may authorize a transportation hold, so that more of this work is done by mental health providers

- Improving training for crisis teams, including broader offerings from DHS

Mobile Teams and Residential Stabilization Expansion

In 2015, Minnesota invested \$8.6 million for the next biennium into improved crisis services for children and adults. This includes a charge to revise and strengthen service standards, as detailed above.

Highlights include:

- Funding to establish “one number” access. As above, this will first be done as a pilot in the metro area. Currently available technology limits our ability to accurately reroute calls from both cell phones and landlines.
- Phone based consultation for teams serving individuals in crisis who also have co-occurring intellectual disabilities or traumatic brain injuries.
- Crisis services defined as “emergency service” for the purpose of private insurance coverage. Invokes parity requirements to cover to the same degree as emergency services covered for physical conditions.

Provides start-up funding to expand crisis residential services for adults and requires DHS to develop recommendations for children’s mental health crisis residential services models that don’t require county authorization or a child welfare placement

With this funding, DHS awarded \$500,000 for start-up costs to expand Adult Residential Crisis Stabilization (RCS) statewide. These grants provide funds for start-up costs for a 6 bed RCS program in Itasca County and three new IRTS programs which will include RCS beds in Sherburne, Scott and Hennepin counties. We expect that the addition of these 12 beds will be completed by July 1, 2017.

V. Inpatient Bed Capacity and Level-of-Care Transitions Formulation Team

The Formulation Team identified the following solutions for consideration by the Task Force because they could be implemented within one to two years. The Formulation Team does not see these as total solutions, but as strong first steps to take while the Governor and Legislature also undertake the more comprehensive planning and coordination needed to solve the inpatient bed capacity issue.

A. Establish an Ongoing Body to Coordinate and Oversee Work on Inpatient Bed Capacity

Given the time constraints of the Task Force process, the Formulation Team suggests the Task Force recommend establishing an ongoing body to coordinate and oversee work on inpatient hospital bed capacity for the state of Minnesota.

The Formulation Team understands that part of the difficulty of addressing inpatient bed capacity is the fact that the problem is so multi-faceted and that many stakeholders are involved, each with their own missions and goals, legal and administrative requirements, funding models, work processes, and

professional perspectives. An ongoing body of these stakeholders would provide the opportunity for a multi-faceted approach to the issue. The Formulation Team proposes future work include, but is not limited to, the following topics:

- Data collection efforts to better plan and coordinate services around the state, which feed into a larger data collection effort across the continuum of care.
- Use of data to determine what kinds of adult and children/adolescent inpatient services are needed and where.
- Use of data to determine what capacity of adult and children/adolescent inpatient services is needed and where.
- Discussion of Anoka Metro Regional Treatment Center and community hospitals in providing services, particularly for acute care for adults living with serious mental illnesses and complex co-occurring conditions, including symptoms of violence and aggression.
- Addressing the 48 hour law's unintended consequences, particularly for community hospitals and Anoka Metro Regional Treatment Center.
- Utilizing existing resources differently, such as encouraging critical access hospitals to create inpatient or crisis mental health services coupled with telepsychiatry and increased psychiatric training for hospital staff.
- Inpatient and intensive mental health treatment for families.
- Discussion of financial disincentives to serving people with complex co-occurring conditions.

B. Increase Intensive Residential Treatment Services and Require Private Insurance Coverage for Services

The Formulation Team suggests the Task Force recommend an increase in Intensive Residential Treatment Services, including exploring the development of IRTS that offer different levels of service intensity or are different sizes.

Private commercial insurance should be required to cover treatment in IRTS setting. This coverage is a matter of parity with physical rehabilitative services. Implementing this requirement will require work at the state and federal level, as well as with companies that self-insure and determine their own benefits.

Increasing IRTS capacity does not preclude the importance of increasing the capacity of other intensive community-based service such as Assertive Community Treatment (ACT) teams.

C. Strengthen Housing and Supports

The Formulation Team suggests the Task Force recommend expansion of evidence-based intervention housing models, such as permanent supportive housing.

In permanent supportive housing models, affordable housing is paired with or linked to services to assist individuals to remain in their homes. Providing housing with supports has been shown to create a level of stability that serves as a basis for recovery. In addition, bringing services to a person's home lessens the need for transportation and can help a person de-escalate who may be in crisis or cycling through

their illness. Supportive housing has been shown to decrease the need for hospitalizations and involvement with law enforcement.²⁷

The Formulation Team suggests support for Medicaid coverage for housing supports, also called individualized community living. Services provided under individualized supports will help people with disabilities, including mental illnesses, live independently in their own homes. Medicaid coverage will provide a stable and sustainable funding source to providers to offer these services.

D. Competency Restoration

The Formulation Team suggests the Task Force recommend expansion of community-based competency restoration services.

There are opportunities to expand community-based competency restoration that would open up beds at the Minnesota Security Hospital in St. Peter and at AMRTC, which would make those beds more available for others.

E. Civil Commitment

The Formulation Team suggests the Task Force recommend clarifying Minnesota's Civil Commitment Act to emphasize the ability for individuals to be committed to lesser-restrictive settings.

In addition, the Formulation Team suggests allowing an option of dual-commitments to hospitals and the Commissioner. This option gives hospitals the opportunity to discharge individuals without waiting for a remote provisional discharge from the state, thereby speeding up the discharge process from a hospital.

F. Improve Local Coordination around Crisis Response

The Formulation Team suggests the Task Force recommends strengthening crisis response services, as proposed by the Crisis Response Formulation Team.

Strengthening connections between mobile crisis teams and hospitals and law enforcement will assure individuals experiencing a crisis receive the right care, while relieving the pressure on hospitals and law enforcement to address acute crises with limited resources. There is also an opportunity for strengthening crisis teams to work with families, along with children and youth.

G. Expand Options for Parents and their Children

The Formulation Team suggests the Task Force recommend expanding options for families and children. Some hospital-based models to consider in future discussions include:

²⁷ For more information see <https://www.usich.gov/solutions/housing/supportive-housing>.

- Intensive mother-baby postpartum mental health treatment that allows mothers to receive mental health treatment while caring for their infants, such as Hennepin County Medical Center’s Mother Baby Partial Hospitalization, Intensive Outpatient, and Outpatient treatment programs.
- Inpatient mother-baby postpartum units, such as those in the United Kingdom, Australia, Canada, New Zealand, France, and Belgium.²⁸
- Services to allow parents to remain close to, or stay with, children who are hospitalized for mental health treatment.

Ensure the implementation of Psychiatric Residential Treatment Facilities (PRTFs) for children and adolescents who need intensive residential treatment. This option also allows for residential treatment without requiring families to go through out of home placement for their children. Implementation of PRTFs will be even more important if Minnesota loses federal funding for current children’s residential treatment services.²⁹

As stated above, strengthen crisis response for families and kids. Effective mobile and respite crisis services can prevent unnecessary hospitalizations and emergency department visits.

H. Support Efforts to Reform Addiction Treatment

The Formulation Team suggests the Task Force support efforts to reform Minnesota’s addiction treatment system.

A current reform effort will move Minnesota’s substance use disorder (SUD) treatment system from an acute, episodic-based system to a modern, client-centered, and equitable model of care with an emphasis on care for a chronic disease. It will establish a streamlined, client-centered process for accessing SUD services; expand the continuum of care to include withdrawal management, peer recovery support and care coordination services and allow SUD treatment to be delivered outside of a licensed setting. These changes are necessary to advance the integration of SUD services with the rest of the behavioral health care and physical health care system.

²⁸ Nicole Vlieghe, Sara Casalin, Patrick Luyten, Ria Docx, Marijs Lenaerts, Eileen Tang, Stefan Kempe (2013) Hospitalization-Based Treatment for Postpartum Depressed Mothers and Their Babies: Rationale, Principles, and Preliminary Follow-Up Data, *Psychiatry: Interpersonal and Biological Processes*, 76:2, 150-268. Maeve Kenny, Susan Conroy, Carmine M. Pariante, Gertrude Seneviratne (2013) Mother-Infant Interaction in Mother and Baby Unit Patients: Before and After Treatment, *Journal of Psychiatric Research*, 47, 1192-1198. N.M.-C Glangeaud-Freudenthal, A.-L. Sutter, A.-C. Thieulin, V. Dagens-Lafont, M.-A. Zimmerman, A. Debourg, B. Massari, O. Cazas, R. Cammas, C. Rainelli, F. Poinso, M. Maron, S. Nezelof, P.-Y. Ancel, B. Khoshnood (2011) Inpatient Mother and Child Postpartum Psychiatric Care: Factors Associated with Improvement in Maternal Mental Health, *European Psychiatry*, 26, 2215-223.

²⁹ CMS has expressed concerns that Minnesota’s children’s residential treatment settings are Institutes of Mental Disease, or IMDs, and therefore ineligible for federal reimbursement.

Waiting for an available addiction treatment setting has been cited as one reason why individuals become stuck in inpatient hospital unit after they no longer need hospital level care. According to the MHA/Wilder study, 11 percent of potentially avoidable days were due to a lack of availability of addiction treatment settings.³⁰

I. Adopt Previous Recommendations on Discharge Planning

There are a number of recommendations the Formulation Team suggests the Task Force adopt regarding discharge planning.

- Expand the Transitions to Community Initiative to include individuals in community hospitals who are on the AMRTC waiting list.
- Adopt recommendations of the Reducing Avoidable Readmissions Effectively (RARE) campaign on transitions of care for individuals leaving inpatient mental health treatment, particularly those on effective medication management and engagement in medication treatment.
- Develop and expand culturally-sensitive and culturally-relevant discharge planning.
- Increase county involvement in discharge planning for individuals admitted to an inpatient setting. Counties should be involved in discharge planning upon an individual's admission. County liaisons to AMRTC have successfully assisted discharges for individuals from their counties back into the community.

J. For Longer-term Consideration

1. Assess the Impact of the Recent Increase in the County Share

The Formulation Team suggests assessing Minnesota's recent increase in the amounts that counties pay to the state for patients at AMRTC and the CBHHS who no longer meet criteria for a hospital level of care.

- Has the increase driven a decrease in non-acute bed days while maintaining or improving stability in the community?
- Re-investing those dollars into community services is one option for strengthening the community-based mental health system. Currently, counties pay 100 percent of costs for residents who are in a state hospital without meeting that level of care. All of the funds collected go into the state's General Fund, not back to the counties or DHS to invest in additional community services.

2. Study "Pipeline" Issues and Explore Improvements to Address Gaps

The Formulation Team suggests the Task Force recommend study of gaps in services that lead individuals to be admitted to hospitals in a mental health crisis from residential settings and nursing homes, and why they are unable to return to their previous living situation or treatment setting at discharge.

³⁰ *Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot, 1.*