

Governor's Task Force on Mental Health

CRISIS FORMULATION GROUP

Agenda and Formulation Document for 9/26

Staff contact: Benjamin.Ashley-Wurtmann@state.mn.us

Time	Topic	Presenter/Moderator
10m	Overview on revised background document, formulation document, and work plan for the formulation group.	Ben Ashley-Wurtmann
25m	From call to response: Timelines for service	Sara Suerth
40m	Check in with Task Force: Feedback on formulation document	Mariah Levinson

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.

Support common standards and protocols

Minnesota could adopt a common standard for telehealth services relating to mental health crisis. This could include compatibility of hardware/software, 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. Would build on work already being done (see background document, Northwestern Mental Health Center).

Objectives: Identify a framework for how Minnesota intends to use telehealth for crisis care, and speed adoption in additional regions of the state.

Timeline: Would require further stakeholder work and research, but policy items could be adopted relatively quickly, with time needed for providers to implement. Infrastructure investment would require more time.

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.

Partners: Investments in telehealth infrastructure could be directed to MDH Office of Rural Health to promote faster adoption. Further stakeholder work would require broader representation: more hospital systems, crisis teams, other telehealth implementers.

Common pool for Telehealth Resources

Minnesota could 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.

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. Existing mobile teams could refine focus on services in the community as a separate or collaborative response.

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: Metro and 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 people to be available at a time for 3 shifts per day to provide assessments via telehealth and one additional person per shift to take calls routed from other teams.

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.

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.

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. For additional details, see the background document: CentraCare.

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.

Partners: Hospital/Healthcare systems, MDH, DHS.

Pre-service CIT as required training for law enforcement,

Minnesota could implement 40 hours of pre-service CIT training for all officers through the Law Enforcement Academy. In service officers would get X hours of refresher training every Y 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.

Why this would work better than other options, key advantages or drawbacks for the task force to consider. Four to six sentences.

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.

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 currently 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 personnel in training	\$650 (training cost only, no salary or travel)	\$500,000-\$850,000
Pre-service 40 hour course	~650 Fire/EMS personnel in training	\$650 (training cost only, no salary or travel)	\$425,000
Early in service 40 hour course	650 officers per year, targeted for 2 nd year of services	\$3600 (includes salary and travel)	\$2,350,000
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

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

Additional resources where people already seek help

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

Minnesota could 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: Needs further development, will update for 10/17.

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

Minnesota could develop more collocated 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 inpatient hospitalizations. For patients receiving urgent or gap psychiatry, 2/3rds would have otherwise presented in an emergency department.

This model is focused on Medicaid and other publically funded care. Clinic networks and healthcare systems are more likely to offer reserve appointments in general purpose clinic during daytime hours than a more narrowly focused standalone. 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.

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

Timeline: Needs further development, will update for 10/17.

Resources: This model may be better suited to a broader range of communities. Some population center is needed to sustain the volume, but it is not as resource intensive as an in-patient unit.

Partners: Counties, Health Plans, DHS, Hospitals, Community Mental Health Centers.

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.) See background document for more details: HCMC APS.

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, will update for 10/17.

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. Based on prior numbers, we could expect each additional program to incur the following annual costs: ~\$1M to maintain the response infrastructure, and another ~\$750,000 for state share of Medical Assistance, with the remaining budget met by federal share or other insurance payment.

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.

Development of Children's Crisis Residential

Outline of current work, expected from Children's Team on 9/22.

Mental Health/Law Enforcement Co-responder Models

Will be written in advance of Oct. 17.

Improved Data Sharing and Collaboration

Will be written in advance of Oct. 17.

Uniform Crisis/Discharge Planning for Intensive Services

Improvements to interoperability of electronic medical records

Standard form for voluntary disclosure to law enforcement

Further Improvements to Crisis Standards

Will be written in advance of Oct. 17.

Inclusion of Psychiatry and Medication Access

Revised Service Standards for Residential Crisis/Intensive Residential Treatment Centers

Findings from "A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis" Greenfield, 2008.