

# Governor's Task Force on Mental Health

## TASK FORCE MEETING SUMMARY

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**Monday, September 26, 2016**

**8:30 a.m. – 5:00 p.m.**

**Cambridge Medical Center**

**701 S. Dellwood Street, Cambridge, MN**

**Governor's Task Force on Mental Health- Members Present:** Commissioner Emily Piper, Melissa Balitz, Brantley Johnson, Kim Stokes, Crystal Weckert, Sue Abderholden, Shauna Reitmeir, Pahoua Yang, Dr. Paul Goering, Dr. Bruce Sutor, Sara Suerth, Deputy Commissioner Jeanne Ayers (for Commissioner Ed Ehlinger), Commissioner Tom Roy, Cathy ten Broek, Roberta Opheim, Representative Roz Peterson, Representative Clark Johnson and Senator Tony Lourey, Commissioner Jim McDonough, Chief Rodney Seurer, Liliana Torres Nordahl, Hon. Jamie Anderson, Daron Korte (for Brenda Cassellius).

**Governor's Task Force on Mental Health Members absent:** Senator Julie Rosen

**Governor's Task Force on Mental Health Staff Present:** Susan Koch and Mariah Levison

**8:35 a.m. Welcome**

- Commissioner Piper welcomed the Task Force members and guests to the Governor's Task Force on Mental Health meeting.
- Commissioner Piper called the Governor's Task Force on Mental Health meeting to order at 8:30a.m.
- Commissioner Piper introduced the president of Cambridge Medical Center, Gary Shaw so he can give a brief welcome.

**8:45 a.m. Overview of Today's Meeting**

- Summary of fourth meeting on Task Force website: Commissioner Piper informed the Task Force members that the meeting summary for September 12<sup>th</sup>, 2016 is posted on the Task Force website at: <https://mn.gov/dhs/mental-health-tf/>. For questions about the meeting summaries, contact Sue Koch at [Sue.Koch@state.mn.us](mailto:Sue.Koch@state.mn.us)

**8:50 a.m. Cultural Lens Transformation: Formulation Team Presentation and Discussion**

- Presenters: Carol LaBine and Angie Hirsch presented on the current Minnesota efforts to address culturally appropriate and responsive service concerns:
  - Department of Human Services (DHS) Cultural and Ethnic Minority Infrastructure grants. These grants fund culturally specific organizations to grow mental health practitioners and professionals.

- DHS revised Rule 47, the outpatient mental health services rule, to ensure providers are mindful of cultural influences when conducting diagnostic assessments and clinical supervision.
  - DHS has funded tribal providers to attend culturally-adapted, evidence-based practices trainings in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and Parent Child Interactive Therapy (PIC).
  - DHS is completing a mental health services rate assessment study.
  - The Minnesota Department of Health (MDH) partnered with Somali American Parent Association on dialogue about mental health attitudes, perceptions, and gaps in services for the Somali community members and services providers.
  - MDH provides supportive training with Somali Imams and mental health and wellbeing.
  - DHS supported conversations about race and historical trauma.
  - MDH's Office of Rural and Primary Care offers options for loan forgiveness and repayment programs to mental health care students and residents.
  - MDH has goals for the Minnesota Suicide Prevention Plan.
  - MDH is piloting mental health assessments for new immigrants.
  - Minnesota is evaluating if community-led Accountable Communities for Health (ACH) models result in improvements in quality, cost, and experience of care, including for people of diverse backgrounds.
- The Cultural Lens Transformation Team presented a document that lays out the problems/opportunities and possible solutions for using a cultural lens to improve services and supports and reduce mental health disparities in five categories.
    - Medical Model Vs. Culturally-based healing
    - Supporting and Growing Culturally Specific Providers
    - Our mental health system needs to be more trauma- informed
    - Evidence Based Practices, Practice Based Evidence and Promising Practices
    - Roles and funding of state, tribe, county, providers and communities
  - The Formulation Team Posed these questions to the Task Force
    - Are there particular recommendations that you'd like to add or remove?
    - Is the system ready to embrace these ideas? What do you see as the major barriers to our recommendations?
    - Given all of the barriers that you have identified, which areas or particular recommendations would you advise us to focus on first?
  - Question and Comments from Task Force members
    - What would be reimbursable under public funded programs?

- There are different definitions for culturally specific providers. What's the next level of service--for a cultural provider that doesn't have licensure?
- Evidence based practice and practice based evidence: is there enough research out there or do we need to look at other research from other states?
- The culture of individual and community healing is disconnected within these recommendations and presentation. They need to be brought together.
- As we are formulizing these recommendations, let's keep the following levels in mind: the traditional clinical setting, innovative clinical models (community connectors), and total population-based model.
- Research the prevalence of trauma in MN: what is available for culturally specific and responsive programs and services?
- Are senior services included in the cultural lens discussion or excluded?
- Do we have the providers to fulfill these goals, given the workforce shortage the state is currently experiencing?
- Are there similar need in the health care environment for cultural providers?
- There could be two strategies: specific and granular cultural services vs. cultural competency for all providers.
- This could be a liability for medical facilities. What are we asking medical facilities to do with culturally specific services?
- Early childhood education is needed and needs to be implemented within these recommendations.
- As we address equity and cultural lens issues, make sure we are recommending that this is embedded throughout all the recommendations. Cultural lens should be the foundation to all the recommendations being formalized in the Task Force.
- This is too many recommendations from one formulation team; this can be overwhelming and possibility something that can't be accomplished.
- Consider the idea of cultural navigators- this may be more feasible.
- The disparities in MN are in education, housing, criminal justice, employment, health and mental health care, etc.
- There are issues with the current interpreter model because interpreters many times don't have a comprehensive understanding of mental health and may not be communicating to service recipients accurately.
- What are the cultural responsive models that are reimbursable in other states?
- We are missing the disparate use of seclusion and restraint as well as suspensions in the education system. How are we addressing these?
- Include a recommendation around completing multiple visits before finalizing the diagnostic assessment.
- I am concerned about using state funding to support individuals' religious beliefs and cultural practices; church and state are separate.

- We need to support culturally responsive early intervention services in schools.
- Community-based counseling aspects need to be implemented as a part of the cultural lens.
- It is hard to differentiate among health disparities, socioeconomic disparities, and other disparities.
- Where are the actionable items and recommendations? How do we administer this in the state? We need more actionable recommendations to guide legislators in making policy and funding decisions.
- In 2015, MN was the first state in the country to bring in providers trained in another countries in order to increase the workforce and to create a workforce that better reflects our communities.
- Person centeredness should be a focus within the cultural lens.
- I don't think there are too many recommendations. They can be used for creating and formalizing a work plan when the finalized recommendations go through.
- Is there a cultural resource book that has general information about the different cultures that are represented in the state?
- Implementing a funding stream for some cultural groups and not others might be slippery slope.
- We need to figure out how to use some of the resources we already have in order to bridge the gap.
- There are high needs in school settings for culturally responsive services and care.
- The system is fragmented and integration is needed.
- Accountability needs to be focused on the individual and the families as well; the state can't always be accountable for everyone.
- How can we increase Medical Assistance funding streams to bridge the gap in the mental health system for culturally appropriate services?
- Job of the formulation team is to come up with the list of recommendations but also to narrow the list down as we are moving forward so it's not overwhelming for the Task Force to go through long lists of recommendations.
- We need to get to a point where we are understanding the measures and understanding the communities' needs and the right way to approach the community and the individual.
- There are culture-related issues with the licensing boards and this is one of the barriers to expanding the workforce.
- It is a struggle to figure out who is the cultural expert and navigator in specific communities. How do we figure this out?
- There are concerns about religion being a part of culture and embedded in some cultures. This is an issue: how is do we separate these two things out?

**10: 10 a.m. Break**

- Commissioner Piper called the Task Force meeting back to order from break at 10:25 a.m.

**10:30 a.m. Continuum of Care Transformation: Formulation Team presentation**

**Presenters:** Kim Stokes, Cathy then Broek, Paul Goering, Sue Abderholden, Sue Koch

- The Continuum of Care Formulation team presented on the following:
  - Starting Point: People, Families, Communities (micro level)
  - Comprehensive continuum of care (macro level) would need to comprise these seven categories:
    - Health Promotion
    - Prevention
    - Early intervention
    - Basic clinical services
    - Inpatient and residential services
    - Community supports
    - Crisis services
  - Additionally, the continuum should focus on
    - Collaboration among services/activities in the continuum
    - State-wide collaboration and oversight functions such as governance and funding structure; centralized assessments; forecasting, and planning' quality assurance and metrics; workforce development
    - Collaboration with other sectors such as; substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and natural community supports
  - The presenters described the current mental health system in Minnesota
  - The presenters identified barriers to achieving a comprehensive continuum of care
    - Public Understanding of Mental Health and Mental Illness, and wide Continuum
    - Workforce
    - Rules/Oversight
    - Operational Challenges
    - Lack of community infrastructure/supports
  - The presenters proposed two high-level recommendations for defining and expanding the continuum of care.
    - Recommendation 1: The Governor and Legislature should adopt a wide definition of the Mental Health Continuum of Care (as described in

Section II and depicted in Figure 1 in the handout, which is available on the Task Force website).

- Recommendation 2: The Governor and Legislature should consider improving availability and access to mental health services and activities in the continuum to be its highest priority.
- Question and Comments from Task Force members
  - Think about some balance in these recommendations.
  - Looking at the systems level and approaching the recommendations in that manner.
  - Nice balance with prioritizing (e.g. high level recommendations and more specific recommendations).
  - Integrating with community supports is necessary.
  - I appreciated the focus on prenatal and family mental health services.
  - An effective continuum relies on integration and not collaboration. Think about changing wording on recommendations that say “collaboration” to “integration”.
  - Safety and accountability: for people without strong family support or without strong family advocacy, how are we ensuring this?
  - This is a lot of recommendations. Who is going to take responsibility for implementing them? Definition of roles is currently an issue: how do we prioritize what are high level issues and what are low hanging fruits?
  - Having a more enduring path forward, we can take responsibility in the future.
  - More emphasis on the criminal justice system is needed.
  - Make sure that we are empowering the individuals and providers. Make sure we are also looking at the role of fathers in this as well, not just mothers.
  - I want to make sure that we are not focusing on “one size fits all” model when we are formulating recommendations.
  - Several privacy concerns have been brought up about the MN Student Survey.
  - Be a little more deliberate about how education ties in with these recommendations and how we are having these discussions.
  - I appreciate the inclusion of family education, especially family education for parents with adolescents.
  - Consider schools. Schools serve a large number of our children and youth. Especially for immigrant parents, schools are where they get resources and information.
  - Overall, these recommendations fall under two categories- parity and stigma.
  - We’ve built a system of health care but not mental health care. Now we are trying to integrate these systems.

- Stigma needs to really be tackled. Ongoing work on stigma reduction needs to continue and new work on reducing stigma needs to be created.

**11:15 a.m. Crisis Services: Formulation Team presentation and discussion**

**Presenters:** Carol LaBine, Sara Suerth and Mariah Levison

- Carol LaBine reviewed the Crisis Formulation Team background document that was shared by Ben Ashley- Wurtmann during the September 12<sup>th</sup>, 2016 meeting.
- “From Call to Call Response: Timeline for Services” scenarios were presented by Sara Suerth.
- “Crisis Timeline for Northwest Mental Health Center” was presented by Shauna Reitmeier. Shauna reviewed the following:
  - Mobil response and the community telehealth response
  - Staff on call for telehealth response
  - Credentialing all telehealth providers
  - Issue: latest legislation states that individuals need to be licensed to provide crisis services.
- Feedback from Task Force members
  - We need to have 40 hours of Mental Health training as a requirement for law enforcement.
  - Dispatchers aren’t currently receiving this 40 hour training and that is a concern.
  - I’m struggling with recommendations that are focused on who the payers are.
  - I have a question on the tele health: how does this work for crisis situations?
  - Feedback for moving forward: why are we letting people get this mental ill? Why aren’t we intervening earlier? We should focus on prevention and early intervention.
  - How do we support people in training and regionally based learning collaboratives? Training needs to be implemented.
  - Silos are breaking down in other communities as more collaboration occurs.
  - In order to know when the crisis is “done,” we need to talk to the individual utilizing/receiving the services. They can tell us more.
  - As we are looking at expanding telehealth services, we need to think about quality.
  - One thing missing in this discussion is the standards for crisis teams. How is this being addressed?
  - What happened before the individual ended up in jail or in the crisis? What happened a month before? We need to look at the root causes of some of these issues to tell us where intervention would have diverted the individual from being stuck in the system.

- Crisis Intervention Team (CIT) training should be 40 hours but there should also be continued education for police officers including trainings.
- Psych emergency rooms are a good idea but we need to be careful about doing this as a standalone service. Let's think about integrating this with existing emergency rooms to address co-occurring and dual diagnosis needs.
- Crisis Intervention Training also needs more trauma information implemented in it.
- Need to make sure that telehealth is meeting the individuals' needs and is not a "one size fits all" approach.
- Support crisis training for law enforcement but also strongly encourage that emergency room staff to have the same or similar training.
- To help schools with crisis interventions, are there options that we can expand on that don't involve law enforcement?
- I am thinking about how this will impact immigrant communities, communities of color and disenfranchised communities. These communities are usually afraid to call 911, and for immigrant communities there is a fear of deportation, lack of language and understanding of mental illness.
- What is law enforcement's connection with immigration services and why are we deporting people who are trying to connect to services and resources?
- How do we move on a path and recognize there are pieces that we are not going to be able to solve?
- Crisis Intervention Team (CIT) training is not a specialized training. How do we get it to be one and implement it into continuing education for law enforcement?
- We need to look at all payers; there needs to be parity in Minnesota.
- Where is that part the recommendation to the Governor that brings up that health plans need to be at the table and need to collaborate with state agencies in order to improve the mental health system in the state?
- How do we get upstream and look at housing, education, early intervention, prevention?

**12:30 p.m. Lunch**

- Commissioner Piper asked the Task Force members to get lunch at 1:15p.m.

**1:15 p.m. Inpatient Psychiatric Bed Capacity and Levels of Care Transitions: Formulation Team presentation and discussion**

**Presenters:** Cathy ten Broek, Jen McNertney, Bruce Sutor

- Recommendations from the Inpatient Psychiatric Bed Capacity and Levels of Care Transitions Formulation Team were presented.

- Housing and supports
    - Looking at Medicaid reimbursement for housing with supports services
    - Strengthening housing and support services
  - Competency Restoration
  - Whatever it take grants funding needs to be expanded.
  - Civil Commitment: Dual commitment to commissioner and hospitals is being recommended.
  - Improve local coordination around crisis response
  - Expand options for parents and their children: This was suggested by the task force. However, the Formulation Team feels this should go the continuum of care group.
  - Private Insurance
  - Support Efforts to reform addiction treatment: Suggestions from formulation team is that task force support ongoing efforts to reform MN's addiction treatment
  - Adopt previous recommendations on discharge planning transition to community
    - Reducing Avoidable Readmissions Effectively (RARE)
    - Culturally- Sensitive discharge planning
    - involvement in discharge planning
  - Discussion of increasing Anoka Metro Regional Treatment Center Bed Capacity
- Long Term Considerations from the Formulation Team
    - Addressing financial disincentives to serving people with complex co-occurring conditions in community hospitals.
    - Assess the impact of the recent increase in the county share.
    - Study “Pipeline” issues and explore improvements to address gaps.
  - Questions and Comments from Task Force members
    - There is an issue with the original structure of the Regional Treatment Centers at St. Peter, which needs remodeling/restructuring. We will need a bonding bill to do this.
    - If we don't expand the physical footprint of the state hospitals, is there potential to expand the services?
    - County discharge planning: this is a struggle on the state level. There is a lack of clarity about county engagement and the state's role at keeping the counties accountable.
    - Everyone in the state should have the same access and services--in all 87 counties.

- Relationships between state and counties need to be maintained and conversations need to be continued.
- Focus on outcomes; what is the outcome we want for our state?
- School districts need quality residential treatment and care for children and youth. There is excitement about the Psychiatric Residential Treatment Facilities (PRTFs).
- We need to consider what's happening in greater MN with nursing homes and assisted living.
- How does this discussion fit in with the Olmstead plan? We are supposed to be integrating people in community, getting them the services they need in the most integrated setting.
- We have a county based system that leads to inequities. This may need to be looked at further.
- We need to refer to the gaps analysis work that has already been done.
- This issue needs a strong effort maybe outside the formulation teams and on a larger scale.
- An issue that has not been brought up is the staff shortage at St. Peter. The State Hospital has 2 staff per patient and other states average 3.5 staff per patient. These are huge difference and they need to be discussed.
- Regional partnerships are needed to provide quality and equitable services in communities that are outside of the metro area.
- I haven't heard in the recommendations anything about Assertive community Treatments (ACT) or Intensive Residential Treatment Services (IRTS).
- Let's be mindful that we are not formulating recommendations that are for one group but not for another. We need to makes sure that we are intentional and thinking about how these recommendations are solving the problem but an equitable way.
- More engagement is needed around medication and medication management.
- There is a difference between a Regional Treatment Center bed and a community bed. We need to keep this in mind when we are talking about the need for more beds.
- Expanding bed options for parents and their children needs to be focused on by this formulation as this is a bed capacity issue.
- We can't expand housing with support if there are no buildings for people to move into. Look into building more housing as there is already a housing shortage. This needs to be addressed first.

**2:20 p.m.**

**Governance Transformation: Formulation Team presentation and discussion**  
**Presenters:** Shauna Reitmeier, Nancy Houlton and Jana Nicolaison

- Nancy Houlton introduced the formulation team members and reviewed the history of governance in Minnesota’s mental health system.
- Shauna Reitmeier presented on the current overview funding structure and governance authority. She used School Based Mental Health Services as an example of how funds for one services can be fragmented.
- Shauna discussed the next steps for the Formulation Team and the Task Force on this topic.
- Documents from this Formulation Team are available on the Task Force website.
- The group posed these questions to the Task Force:
  - Given the current diverse funding streams and metal health parity requirement, what is the appropriate Governance structure and participating entities (Managed Care Organizations, counties, state, consumers, etc.) to effectively manage them mental health continuum of care?
  - Did the formulation team miss anything in the discussion/presentation?
- Question and comments from Task Force members
  - We need effectiveness and efficiency. The dollars in the funding come with conditions.
  - We need to have the right people at the table to have a long term discussion on the governance issues.
  - Other states have looked into other funding structures, like the “money follows the person” model. We could refer to these states’ experiences.
  - Money flow should be similar in all counties across the state. We should ensure local agencies will guide this in a standardized manner.
  - Let’s identify where the regional collaborations are working.
  - We should look at differences in treatment in different areas and regions.
  - Different payers= different outcomes data. We need to have all these things standardized.
  - There is complexity in the system; the more paper work, more likely that someone falls through the cracks. This is an ineffective way to set up a mental health system.
  - How do we determine the membership for governance for both funding and services? This is briefly discussed in the scope section but is missing within the recommendations.
  - Funding, service and governance is working better when it is organized by regions.
  - Is there research that shows that some elements of mental health treatment work better in the public realm vs. private?
  - Is there a way to ensure that we are still making investments in prevention and preventive strategies/opportunities?

**3:30 p.m.      Public Comment Period**

Commissioner Piper announced that this is the public comment period and called individuals that signed up for public comment to present to the Task Force members.

- Sandra Lewandowski. Intermediate School Districts 287, 916, 917. Ms. Lewandowski provided a handout (which is posted on the Task Force website in the comments received between 9/20/16 and 10/10/16, under the October 17<sup>th</sup> meeting webpage. She recommended that a school setting be established, “Setting 4.5,” for students with complex mental health and other needs. This would involve:
  - Dedicated access to critical services through partnerships
    - Dedicated School- Led Mental Health Funding
    - Dedicated hospital beds and teams for crisis placement
    - Access to short term crisis homes
  - Ensuring staff readiness and school accountability to meet the demands of new model
    - Staff and Program Development for School Partners
    - Program Development for the intermediates
    - Constructive Program Development Support
    - Program Accountability Study
  - Removing operational and funding barriers for intermediate districts
    - Intermediate Lease Aid
    - Partnership costs beyond per pupil funding are bore by the state
    - Recovering Cost through Non-Member Access Fee Open Enrolled Students
    - Students may qualify for services based on graduation incentives criteria (Minnesota Statute, section 124D.68.)
  
- Gary Shaw, Cambridge Medical Center President. Mr. Shaw gave an example of his experience at the Alaska Medical Center. This medical center implemented integrated and behavioral health care with success. Currently, Allina has a pilot clinic in Isanti County where there is an integrated behavior health care services. This clinic has also incorporates family rooms for improving healing and care. One problem is that setting up the integrated model is typically not funded, so community providers have to take the up-front risk to create. Without being encouraged to create and build a behavioral health system that is sustainable, providers and hospitals are not venturing off on their own to do this. We recommend and encourage that the Task Force consider Allina’s work on integrating services and creating and piloting their behavioral health system.

- Cambridge Medical Center doctor (name not included in sign-up sheet). The doctor discussed his experience providing service at the Cambridge Medical Center and to the Cambridge community. There is a lot of trauma, Post-Traumatic Stress Disorder, sexual abuse, emotional abuse, multiple generations of trauma, chemical dependency, substance abuse, and it's often a generational issue. Patients that have not received care or sought out care in past are seeking out care now. Allina does a good job with patients; they hear a lot of "glad I did this, why didn't I do this sooner?" from patients that receive behavioral health services. They do need more facilities to meet the needs and demand. People don't know about the services available to them and that has been a barrier to accessing the services sooner. There is a need for more chemical dependency and substance abuse services and treatments as they are seeing a lot of this in the Cambridge community and surrounding communities.

**4:00 p.m. Next Steps**

- Sue Koch reviewed the comments received from September 6<sup>th</sup>, 2016 to September 21<sup>st</sup>, 2016. This document is available on the Task Force Website and handouts were provided.
- Commissioner Piper announced that the next meeting will be in Rochester, MN on October 17<sup>th</sup>, 2016. Further meeting details are available on the Task Force website.
- Commissioner Piper announced that Formulation Teams will have time to work within their teams from 4:15 pm to 5:00 pm.

**4:00 p.m. Break**

**5:00 p.m. Adjourn**