

# Crisis Triage and Hand-off Process

Minnesota Department of Human Services  
Community Supports Administration  
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## Olmstead Plan Language

### Supports and Services section

*Action Three: Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis.*

*By August 1, 2014, a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.*

-Minnesota's Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 66.

### Introduction

Crisis is defined as a condition of instability or danger that constitutes a turning point in a person's life. Crises occur where people live and work, in big cities and wide-open spaces, when people are alone or in community, during office hours and in the dead of night. The requirements for reliability across all support systems, ensuring that there is early crisis planning and immediate crisis response, as well as the gravity of the consequences if the response is not provided, demands extraordinary levels of systems coordination, integration, and synthesis.

The overarching goal of crisis services is to provide timely and appropriate support to people who are experiencing significant instability in their lives or are facing eminent danger. The term "crisis" covers a range of situations, such as those prompted by the loss of a caregiver or a significant change in a medical or health condition, that compromise the ability of a person or that person's support system to manage their symptoms or behaviors to such an extent that there is potential for serious harm to the person or others.

A response that is activated only when physical safety of the person or others becomes an issue is compromised is often "too little, too late" or "no help at all" in addressing the root of the crisis."<sup>1</sup> Effective crisis services, therefore, constitute an interconnected network of supports before, during, and after a crisis episode, during which appropriate responses must also meaningfully address the issues underlying the crisis.

Minnesota currently offers crisis services to people with disabilities through different service systems—community-based mental health services, home and community-based services, and state operated facilities. These three systems have different definitions of and responses to "crises." These differences are part of the underlying issues that lead to gaps in the crisis response system.

<sup>1</sup> Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.

## Background Information

### *Current services*

A number of existing efforts and planned initiatives are underway to serve people in crisis, as shown in Appendix A. These efforts and initiatives relate to one or more of the recommendations of the Olmstead Planning Committee, and are best viewed as an interconnected group of tools and services. However, there are themes around which these efforts and initiatives can be grouped, as follows:

**Case Management:** Related services include Community Support Services Crisis Teams; Metro Crisis Coordination Program in the seven county Twin Cities metro area; adult mental health crisis response teams, who routinely see clients in rural hospital emergency departments or jails; and an array of children's mental health services. Crisis response teams are expected to develop regional collaborations with law enforcement, probation officers, schools, case management, and emergency departments for referrals and to know when and how to access crisis services. Case managers are encouraged to develop crisis/relapse prevention plans as part of the individual's Community Support Plans. Crisis plans become part of a person-centered plan that seeks to proactively address both positive as well as challenging behaviors in the community. With the recipient's consent, these plans are shared with the mental health crisis response teams. Adult protective services is a 24/7 county-based common entry point for reporting suspected maltreatment of a vulnerable adult screening for immediate need for protective services or law enforcement, and referral to lead agency to investigate the alleged maltreatment. Additionally, there is a 2015 legislative proposal for enhanced crisis wrap-around services for persons with Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), and Development Disability (DD) waiver services that had two or more behavioral-related hospitalizations in the previous calendar year.

**Mobile Wrap-around Service Crisis Response Teams Services:** The mental health services system includes mobile crisis response teams in 5979 counties and one tribe. ~~The State plans to expand services to an additional counties and tribes.~~

**Training for Community Capacity:** Mental health crisis teams provide community intervention with families and other affected persons; children's mental health services include families and guardians in service design and evaluation; Community Support Services provides training, mentoring, and coaching to clients and others, technical assistance to divert commitments and address crises; and the Minnesota Family Investment Program is developing short- and long-term crisis planning for families with children with mental illness.

**Short-term Residential Crisis Stabilization and Respite Capacity:** Crisis stabilization beds are available for short-term crisis services for adults; Minnesota Intensive Therapeutic Homes (MITH) Respite offers 30-day crisis return to forensic transitions to prevent revocation of provisional discharge; residential crisis stabilization facilities (licensed as either Intensive Residential Treatment Services or Adult Foster Care) provide structured living for adults who are fragile or are experiencing a crisis; the state-operated Life Bridge program provides housing and support during transitions; currently there are 16 crisis respite

beds (≤90 day stay) available statewide for persons with developmental disabilities. There is also in-home crisis respite service available for persons who are on the Developmental Disabilities waiver.

**Sustainable and Flexible Funding:** A number of services are paid through federal waivers. In addition, services are funded through third-party payer billing, grant funding, county funding, state funding, medical assistance, and the Medicaid State Plan.

**Technology-Assisted Consultations:** Telepresence is implemented in 18 southwestern counties for Assertive Community Treatment teams, emergency rooms, and psychiatrists for consult; mental health crisis teams are beginning to use telepresence to assist mental health practitioners; Community Support Services Crisis consultation and telepresence is under expansion in the Southern Cities Clinic; and the Phase II Telepresence Option is being planned.

**First Episode of ~~Mental Illness~~Psychosis:** A cross-divisional workgroup designed a proposal to strengthen the state's capacity to provide early identification and intensive intervention services for children and adults who have a first episode of ~~serious mental illness~~psychosis.

**Understandable and Accessible Information:** The MNhelp.info Network provides objective information to individuals to help them make decisions about services; culturally-specific grants are available to help with outreach to diverse communities. There are recommendations in place for reforming case management to make services more accessible and less duplicative.

**Help People Retain Housing:** The Crisis Housing Fund provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness while they receive mental health treatment.

**Provider Training:** Positive support strategies and guidelines on emergency use of manual restraints, and a legislative proposal to provide training between Community Support Services teams, Metro Crisis Coordination Program, and Assertive Community Treatment teams to enhance competency of treating individuals with complex comorbid conditions.

**Long-Term Monitoring:** Community Support Services Extended Supports provides long-term monitoring for up to 75 individuals with clinical complexity and intellectual disabilities.

**Post-Discharge Psychiatric Consultation:** Consultation for individuals recently discharged from St. Peter Security Hospital, Anoka Metro Regional Center, and from community behavioral health hospitals where the discharge planning team determines that ongoing post discharge monitoring provided by psychiatrists and psychologists would be essential to successful community placement.

### *Crisis-related barriers to achieving integration*

Although there are a number of crisis-related services, there are a number of barriers that currently exist in access, available services, and follow-up for people in crisis. The examples below help to illustrate the issues that are not yet adequately addressed.

**Layering Effect:** People with co-occurring conditions, such as those with both mental illness and developmental disabilities, may be treated and stabilized in crisis but end up back in the system because of the complexity of treating the co-occurring conditions. Or, in times of crisis they may not be able to connect in a timely fashion with providers who have the necessary skills to support them, resulting in what may have been avoidable moves back to more restrictive settings. For example, at times the underlying mental health needs are not adequately addressed by providers of developmental disability services. Similarly, mental health providers may use talk-based therapies that are not well-targeted to the needs of people with developmental disabilities. If the mental health needs of people with developmental disabilities or brain injury are not met as they emerge, there can be further complications such as drug use, homelessness, and chronic physical disease. Another example is, when people are using services from different systems, there can be confusion about where to turn in a crisis. This can be particularly true for people who have recently transitioned from a more controlled setting to a more integrated setting.

**Housing for Persons with Behavioral Issues:** People with mental illnesses, dementia, developmental disabilities, or other disabilities who have experienced crisis may be admitted to ~~mental health institutions~~ psychiatric inpatient hospital units or other institutional settings without community options for re-establishing housing, or their options for future housing may be limited to sites far from their home communities when they can no longer stay in their former domiciles because of behavioral issues. There may be barriers to reestablishing housing, such as those found when subsidized housing sites screen out individuals with a history of violence or other behavioral issues.

**Lack of Experienced, Trained Staff:** Direct support workers may not have adequate training, experience, or assistance available to deal with crisis situations. When crisis situations arise, these staff may not be able to address the situation themselves, and also may not have access to someone in their organization with the appropriate skills. Providers may not be aware of the range of services that are available to help them with crisis incidents, and may not be knowledgeable about trauma-informed care, which can help providers identify the triggers of behavior that cause a life crisis.

**Crises outside the Home:** Crises may occur in the community, such as school, a day service program, or a vocation setting. Most interventions are focused on supporting the person in their home or residential setting.



## Measurable Outcomes

Following are measurable target outcomes that will result from Minnesota's efforts to improve the crisis system for people with disabilities. More information about the measurable outcomes is provided in Appendix C. Note: the goal below builds to 500 people.

*Getting Services*

2015

- 100 more people will receive ~~more appropriate triage~~ crisis response services: information and hand-off due to referral, phone consultation with the Minnesota Crisis Coordination Program, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,145 metro-wide)).
- Of these additional 100 people who will receive crisis response services, 50 people will need immediate face-to-face services and 50 people will receive information/referral or consultation. (Note: This is our baseline year. The numbers will be adjusted as needed.)
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 25 people who receive immediate face-to-face services will be able to remain in their own homes rather than be admitted to a hospital.

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2016

- 200 more people will receive more appropriate triage and hand-off due to consultation with the Minnesota Crisis Coordination Program. (7,245 metro-wide)
- Of the additional 200 people who will receive crisis response services (7,245 metro-wide) 100 people will receive information/referral or consultation. 100 people will receive immediate face-to-face services.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 50 people who receive immediate face-to-face services will be able to remain in their own homes than be admitted to a hospital.

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2017

- Of the additional 300 more people with who will receive more appropriate triage and hand-off due to consultation with the Minnesota Crisis Coordination Program, crisis response services (7,345 metro-wide)), 150 people will receive information/referral or consultation. 150 people will receive immediate face-to-face services.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 75 people who receive immediate face-to-face services will be able to remain in their own homes than be admitted to a hospital.

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2018

- Of the additional 400 more people who will receive more appropriate triage and hand-off due to consultation with the Minnesota Crisis Coordination Program, crisis response services (7,445 metro-wide)), 200 people will receive information/referral or consultation. 200 people will receive immediate face-to-face services.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.

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	<ul style="list-style-type: none"> <li>• <u>100 people who receive immediate face-to-face services will be able to remain in their own homes than be admitted to a hospital.</u></li> </ul>
2019	<ul style="list-style-type: none"> <li>• <u>Of the additional 500 more people who will receive more appropriate triage and hand-off due to the consultation with the Minnesota Crisis Coordination Program, a crisis response service, (7,545 metro-wide) 250 people will receive information/referral or consultation. 200 people will receive immediate face-to-face services.</u></li> <li>• <u>Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as safely possible give the traffic and weather.</u></li> <li>• <u>125 people who receive face-to-face services will be able to remain in their own homes instead being hospitalized.</u></li> </ul>

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## Process to Develop Strategic Approach

### *Community participation*

Community members, particularly those who use public services, their families, advocates, service providers, and community partners, such as counties and tribes, all play a critical role in helping shape how public services are designed and delivered.

Within the last couple of years, as the Olmstead Plan was written and implementation began, there have been numerous ways in which the public engaged in processes that contributed to the development of the framework described in this report. The following list highlights some of this work.

- The Department of Human Services conducted numerous focus groups with people who use services, such as those organized through the National Alliance on Mental Illness Minnesota in planning the Minnesota Behavioral Health Homes.
- People who use mental health services and their families meet (typically) monthly to discuss adult mental health initiatives.
- The State Advisory Council on Mental Health consists of stakeholders representing all facets of the mental health system. The Local Advisory Workgroup, a subset of the Council, is made up of individuals with a lived experience of a mental illness, family members, and a county provider. The Subcommittee on Children's Mental Health provides recommendations to the Council. It is comprised of parents, people who presently or formerly used adolescent mental health services, and other stakeholders.
- Certified Peer Specialists quarterly networking
- Offenders with Mental Illness Workgroup
- Mental Health Improvement Workgroup
- ADAD Tribal and Citizen Advisory Council
- Community First Services and Supports and Money Follows the Person Implementation Council
- State Quality Council
- Traumatic Brain Injury Advisory Committee
- Autism Spectrum Disorder Advisory Council

- Home and Community Based Services Settings Rule forums
- Autism public meetings and other input opportunities
- Tribal listening session on people with brain injury and releases from correctional facilities
- Gaps analysis surveys and focus groups
- Olmstead Plan development process, including Olmstead Plan Committee, public meetings, and public comment period

### *State work groups*

State-led work groups contributed to the development of the plan presented here and included people from a broad array of perspectives, including from the following:

- Adult mental health
- Children's mental health
- Disability services
- State-operated services
- County crisis services
- Youth services
- Minnesota Department of Health
- Minnesota Department of Education

In addition to participation in work groups, community subject matter experts contributed feedback and advice.

### **Strategic Approach to Crisis System**

Minnesota is undertaking transformative systems change to achieve the goal of having people with disabilities living in the most integrated settings, being fully engaged in the community of their choice, and pursuing their own life goals and interests. This transformation will take years to fully realize, and our wide-reaching, cross-sector approach needs to be strategic to be feasible and successful. The crisis triage and hand-off concept, which is the focus of this report, fits within a broader strategic approach to crisis response and intervention. And, in turn, the crisis strategic approach interlocks with other key strategic focuses, such as building a person-centered culture, effective transitions, increased access to housing, and competitive employment. The barriers identified in the earlier section are addressed in various ways across these strategic focuses as well as in the crisis area.

The three-pronged approach to improving crisis response and intervention services includes: 1) improving crisis triage and hand-off; 2) use of positive supports and person-centered planning; and 3) mental health services system reform.

### *Crisis triage and hand-off*

The intent of the statewide crisis triage and hand-off system is to efficiently get people to the best service for them in times of crisis, and to ensure that the hand-off between providers is effective. To do this, the state must develop a statewide, integrated, crisis information, intake, referral, and assessment network model. The intent is to have a centralized point of entry, that people in crisis contact in a crisis, regardless of their diagnosis or what type of services they provide (e.g., community-based mental health services, state-operated services, waiver services).

This is envisioned as a single statewide phone number. The people staffing the phone/portal will provide an immediate response to requests for crisis services statewide with appropriate triage and coordination among crisis services. They will be skilled in crisis assessment and determine both the urgency of the need intervention, and the most appropriate provider for that intervention. They will be well-versed in the services that are available across the state and who they serve.

The access, intake, and processes for service delivery determination and authorization will be seamless to the person. Having a single point of entry, staffed by skilled providers, will decrease confusion, duplication of effort and gaps, resulting in callers getting to the right service in a timely manner. This is crucial as timely, appropriate intervention is the best way to stabilize crisis situations.

In addition to getting the person to necessary services, the intent of the centralized triage system is to ensure that crisis services are delivered in the least restrictive setting possible.

Another key feature of the centralized system is that the triage providers will follow-up with the callers to see if the person actually connected with and received the appropriate service in a timely manner. If there are problems identified, the triage system can work to resolve them, if that is possible, or, at a minimum, record the system failure.

One of the benefits of a centralized system will be the opportunity to track meaningful data that will be used to help us measure the success of the system, identify gaps, and continuously improve the state triage system.

For example, the system will be designed to track data, such as:

- Response times
- Crisis resolutions
  - Resolutions that result in the person remaining in their home, returning home from a medical facility, i.e. ER/urgent care, etc.
- Outcome comparisons by access route, geographic location, population, etc.
- Crisis interventions initiated in psychiatric hospitals, other hospitals and other facilities despite the individual not meeting requirements for those levels of care

While the current system is fragmented, it does have strengths upon which the model can be built. The state will strategically develop this network in phases, using the opportunities and strengths that are available.

Developments in technology in recent years are a great boon to this kind of effort.<sup>2</sup> Some parts of the crisis response system are already beginning to make use of tele-presence technology.<sup>3</sup> Another existing strength is that Minnesota already has pieces of a 'centralized' system for crisis response. Specifically, within the Twin Cities metropolitan area, mental health services are already using a central point of access and triage ~~model~~protocols.

The first phase of developing a statewide triage system is currently underway and expected to last through June 2015. This work centers on defining the roles and responsibilities within the state-operated services and county and provider system of waiver services. These two systems are administered by the Department of Human Services Direct Care and Treatment Administration and the Disability Services Division of the Community Supports Administration, respectively. They support many people with co-occurring conditions, people who are moving from segregated settings to more integrated settings and people who are at high risk of experiencing crises and returning to segregated settings.

Building upon the first phase, also in 2015, the second phase will involve building the statewide triage and hand-off system. This work will center on adding mental health services that are administered through the Adult and Children's Mental Health Divisions of the Community Supports Administration into the project. This phase will include planning and initial implementation. Implementation will begin with realigning currently available resources and continue as resources and opportunities become available.

Also in 2015, there is proposed legislation to build a single statewide number for all mental health crisis services. If this is enacted, it will provide a significant platform upon which to build the single triage system for all disability-related crises (i.e., mental health and/or behavior-related crises).

### *Positive supports and person-centered planning*

Promoting statewide use of positive supports is one of the three-prongs of Minnesota's crisis strategy. The term *positive supports* refers to practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social and mental health into

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<sup>2</sup> For example, Minnesota operates technologically integrated systems (i.e., MNhelp.info Network and its Senior Linkage Line, Disability Linkage Line, and Veterans Linkage Line) that support people, help them navigate complex service systems, connect policy and service professionals in 'real time', follow-up with them, and track/measure the effectiveness in achieving meaningful outcomes for people.

<sup>3</sup> Community Support Services (CSS) Crisis Teams, Southern Cities Clinic use telepresence and 18 counties in southwestern Minnesota also telepresence for consultation between Assertive Community Treatment (ACT) teams, emergency rooms, and psychiatrists.

consideration. Positive supports include strategies that teach people productive ways to deal with stress. These supports are essential to eliminate the use of prohibited procedures, avoid emergency use of manual restraints, and prevent physical harm to the individual and others.

The use of positive supports has been proven to be effective in preventing problem behavior and helping a person gain new skills or alternative behaviors to participate effectively in community life. Problem behavior can trigger a crisis situation; the use of positive supports, therefore, is a strategy for avoiding crises.

Person-centered planning is the foundation for positive support practices. Pro-active person-centered planning and assessment anticipates, prevents, and/or responds in a timely way to potential or actual crisis situations, in a way that promotes maintaining individuals in the community, particularly for people with co-occurring conditions.

In September 2015, the Minnesota Departments of Human Services and Education produced a report entitled *Minnesota's Statewide Plan: Building Effective Systems for Implementing Positive Practices and Supports*. The report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined, and meaningful lives in their home communities. The plan described in the report will be successful by a) designing and implementing technical assistance that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners and community members. The report represents a first step in the state-wide planning process. The plan itself will continue to be refined and updated as it is implemented.

The plan identifies six implementation goals: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding pre-service and aligning in-service training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A graphic illustration of the logic model for the plan appears in Attachment B.

### *Mental health system reform*

Minnesota's mental health infrastructure is insufficient with many gaps, poor measurement, and insufficient service availability. Gaps in the system can mean that opportunities for early intervention are missed and crisis situations arise. Gaps in the system can mean that when there is a crisis situation the intervention takes place in a more restrictive setting than is necessary. Sometimes people in crisis go into a segregated setting and, once there, encounter barriers to moving back into integrated settings.

Minnesota has a package of mental health reforms before the Legislature in 2015 that address several of the gaps listed on page 3 in this report. More information about these reforms is in Appendix C.

#### **Prevention and early intervention**

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.
- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.
- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.
- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all mental health crisis services.
- Improve consistency and quality of crisis services.
- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.
- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

#### **Reform and enhance Minnesota's mental health treatment system**

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.
- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.
- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

#### **Expand capacity to care for children and adults with complex needs**

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.
- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.
- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.

- Create a public psychiatry track in the University of Minnesota's residency program.

**Promote and support recovery**

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.
- Enhance the quality of current Assertive Community Treatment services.
- Expand high quality Assertive Community Treatment services across Minnesota.
- Develop a Forensic Assertive Community Treatment Team to serve people involved with the criminal justice system.
- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.



**Appendix A: Environmental Scan of Current Efforts and Initiatives related to  
Crisis Services**

**Appendix 1 - DHS - Crisis Services:  
Current Efforts and Initiatives by OPC Number**

#	OPC Recommendation	Current Efforts	Initiatives
8-32	Recommendations for Community-Based Services and Supports		
14-27	Recommendations for Medicaid State Plan Services (p. 25)		
19	<p><b>Enhance care management/care coordination at the point when individuals experience contact with law enforcement, psychiatric hospitalization, or emergency room visits related to actions that present a risk of harm to themselves or others.</b> These services will be available where the consumer lives, strengthening the capacity of the system to serve individuals with clinical complexities in their home community.</p>	<p><b>Community Support Services (CSS) Crisis Teams</b>  <b>Legislative proposal</b> for enhanced crisis wrap-around services for persons with CADI, BI, and DD waiver services who have had 2 or more behavioral-related hospitalizations in the previous calendar year.  <b>Adult Mental Health:</b> Crisis response teams in rural areas routinely see people in hospital ERs and jails.  <b>Adult Protective Services:</b>  Eligibility is based on meeting the statutory definition as a vulnerable adult who is maltreated. This service is not based on financial eligibility or MA status. The Common Entry Point in each county operates 24/7 to receive reports from voluntary and mandated reporters of the maltreatment, including self-neglect, of vulnerable adults. The CEP evaluates reports for immediate risk and provides necessary referrals. Counties offer emergency protective social services to vulnerable adults. CEP reports are forwarded to the agency responsible for investigation of the alleged maltreatment; the county, DHS licensing, MDH. Counties make decisions on investigation and protective services based on the county's prioritization guidelines. DHS provides training to mandated reporters and the general public regarding the Vulnerable Adult Maltreatment Reporting Statute; duties of the CEP and lead investigative agencies. DHS maintains data regarding</p>	

**Appendix 1- DHS - Crisis Services:  
Current Efforts and Initiatives by OPC Number**

#	OPC Recommendation	Current Efforts	Initiatives
		maltreatment reports and investigation outcomes to promote public policy of safety for vulnerable adults. <b>Children Mental Health:</b> Improved access & coordination of services to include establishing working relationships with law enforcement & probation offices and ERs within regions of service to know when and how to access crisis services.	
20	<b>Include mobile wrap-around service response teams</b> located across the state for proactive response to maintain living arrangements. The time for the crisis response should be as soon as possible with a maximum time of three hours from the time of request.  <i>The State must build a better more coordinated statewide crisis system that serves all disabilities. OPC 10/15/12</i>	<b>Mental Health:</b> Mobile teams in 59 counties and 1 tribe. There is a Legislative request for funding to create 4 more teams that would serve 16 counties and 2 tribes. Response time goal is 30 minutes to one hour from call or as soon as is safely possible considering weather conditions. While the main goal is not to maintain living arrangements, it is to help the person cope with the crisis to avoid hospitalization or other more restrictive settings.	<b>Possible expansion of MH crisis response services</b> to cover more of the state. (In state plan and supplemented by state appropriation.) Cynthia Godin.
21	<b>Crisis services will provide families, caregivers, and staff at community-based facilities and homes with state of the art training</b> encompassing person-centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking. Training, mentoring and coaching as methodologies will result in increased community capacity to support individuals in their community.	<b>Mental Health:</b> Crisis teams work with families, significant others, property owners, etc. if the person having the crisis allows it. This is billed as Community Intervention. Releases must be signed. <b>Children's Mental Health:</b> Inclusion of parents, guardians, and family members in service design and evaluation of delivery in a strength based manner, viewing them as allies in the service deliver process. <b>CSS:</b> Provides training mentoring and coaching client-specific and general – Average 11 training sessions per month delivered to an average of 128 participants per month	<b>MFP</b> Developing short-and long-term crisis planning for families with child w/MI CCA+/Karen Peed
22	<b>The crisis services will include short term respite capacity</b> for planned respite. The services will also include crisis/short term bed capacity with the ability to provide assessment, evaluation, treatment and stabilization services that will avoid the inappropriate use of more restrictive settings, institutions, psychiatric hospitals, or jails. The crisis/short term treatment bed capacity could also support individuals transitioning to new living arrangements.	<b>Crisis stabilization beds</b> for short-term crisis services. Includes assessment and stabilization. <b>Minnesota Intensive Therapeutic Homes (MITH) Respite</b> offers 30-day crisis return to Forensic Transitions to prevent revocation of provisional discharge. <b>Adult Mental Health:</b> Residential Crisis Stabilization facilities provide structured living for individuals who are experiencing a crisis, have been	<b>New Cambridge MSOCS "transition homes"</b> <del>planned</del> <b>implemented.</b> - SOS/Doug Seiler SOS/Forensics/Carol Olson  A <b>survey of providers</b> that offer one or more caregiver support service to caregivers of people across the lifespan will be completed in March 2013. The survey seeks to gauge, from the providers' perspective, the current capacity of caregiver support

**Appendix 1 - DHS - Crisis Services:  
Current Efforts and Initiatives by OPC Number**

#	OPC Recommendation	Current Efforts	Initiatives
		<p>assessed, had a successful crisis intervention but remain fragile due to symptoms or do not have a strong support system. Residential Crisis Stabilization facilities can also act as step down programs for people leaving hospitals.</p> <p><b>Children's MH Crisis Response Services:</b> The goal is to have the child experiencing the crisis remain in their own home with family or where they have a natural strong support system within the community, or a setting less restrictive, than a hospital or institutional setting. Crisis response services provided by residential facility to a recipient of that facility is not covered as crisis response service.</p>	<p>services, including respite, across the lifespan. Kari Benson/CCA</p>
23	<p><b>Funding for these regional crisis services</b> needs to be sustainable and provide for flexibility in service delivery.</p> <p><i><b>The state should continue to create a common waiver service menu</b> so that people using waived services can get access to the complete array of services... OPC 10/15/12</i></p>	<p><b>CADI waiver</b> (caregiver living expense; family training and counseling; transportation services, Independent Living skills training, prevocational services, supported employment)</p> <p><b>DD waiver</b> (caregiver training and education; caregiver living expense; family training and counseling, case management, Consumer training and education, DT&amp;H, supported employment, ACT classes, crisis respite; transportation services)</p> <p><b>MH Crisis Response Services</b> assist individuals facing a mental health crisis in any setting - teaches coping skills; symptom management techniques; crisis teams assist in arranging for other services.</p> <p><b>MH Crisis Response Services:</b> Funding is a combination of MHCP, DHS grant funding, third party payers (commercial insurers) and county levy funding. Grant funding is used for administrative costs (data reporting, etc), on-call costs, and to provide direct services to those who are not insured or underinsured. The rates for crisis response services are very low for the work that is done. Most people served are not on waivers.</p> <p><b>Children's MH Crisis Response Services:</b> Providers are required to bill third party payers for</p>	

**Appendix 1 - DHS - Crisis Services**  
**Current Efforts and Initiatives by OPC Number**

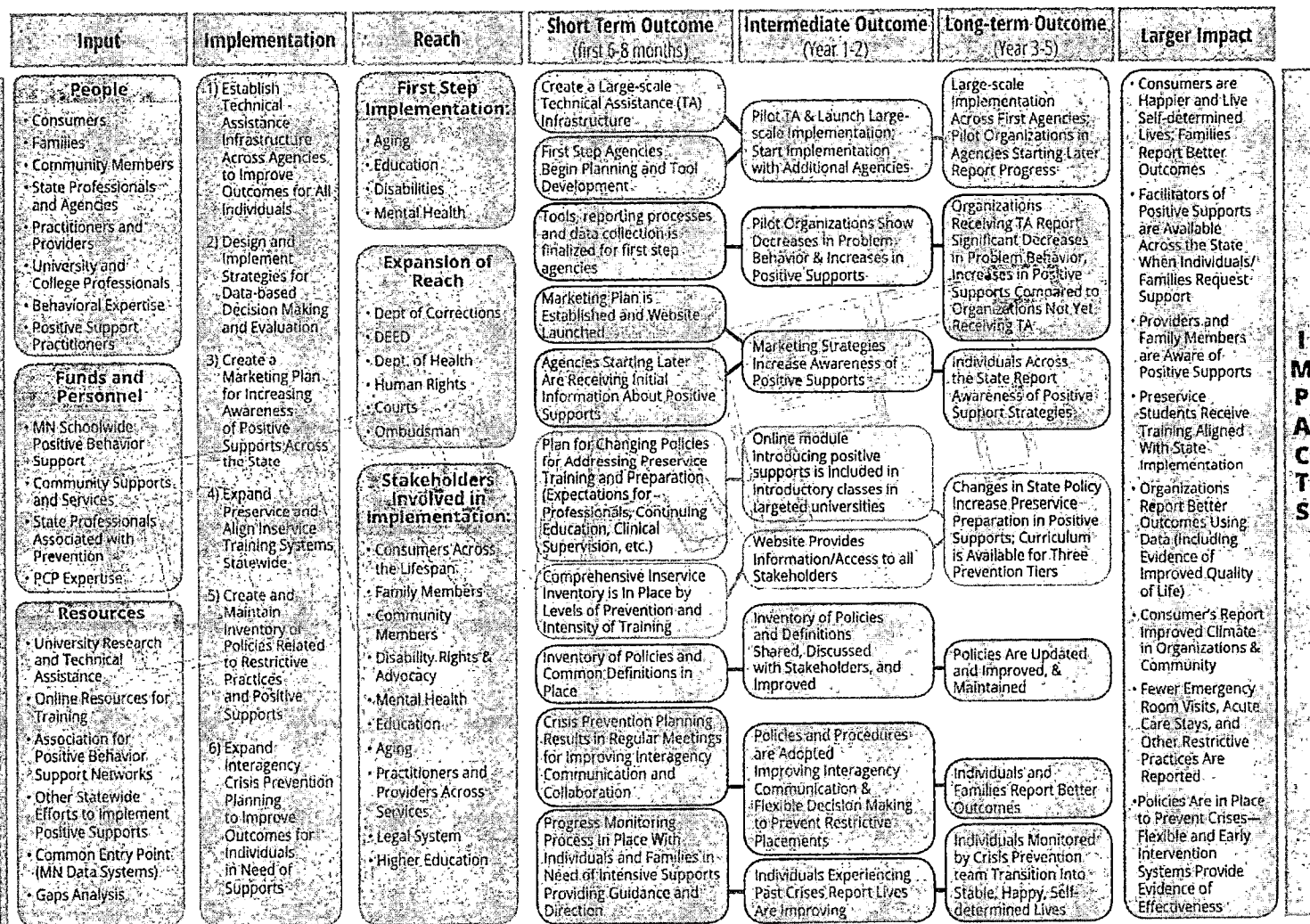
#	OPC Recommendation	Current Efforts	Initiatives
		<p>services and be certified as MA crisis providers. Grant funding is used for administrative costs, on-call costs, and to provide direct services to uninsured/underinsured children, adolescents and young adults.</p> <p><b>Brain Injury Waiver</b>  <b>Community Alternative Care Waiver</b>  <b>Alternative Care:</b> <i>State funded. Not Medical Assistance.</i> Age 65+. Must meet income and asset requirements and choose to receive community services. The program covers two basic types of services, including: trained caregivers, respite care, other services, home-delivered meals, adult day care, chore services and more.</p> <p><b>Elderly Waiver:</b> Those eligible for the EW program are 65 or older, eligible for Medical Assistance, and need nursing home level of care as determined by the Long-Term Care Consultation process. Covered services include visits by a skilled nurse, home health aide, homemaker, companion, personal care assistant, as well as home-delivered meals, adult day care, supplies and equipment, personal emergency response systems, caregiver assessment, home modifications, and certified community residential services.</p> <p><b>Medicaid State Plan Services</b></p>	
24	Expand <b>consultative</b> services and make them available state-wide through the use of <b>telepresence</b> .	<p><b>Telepresence</b> implemented in SW18 counties for ACT teams, ERs, and psychiatrists for consult.</p> <p><b>Mental Health Crisis</b> teams are beginning to use telepresence. Consultation with a mental health professional is required over phone when a mental health practitioner responds on-site.</p> <p><b>Southern Cities Clinic;</b> CSS Crisis consult; telepresence expansion. (Expansion of Telepresence could result in a capacity issue due to limited LIPs.)</p>	<b>Phase II Telepresence Option.</b> SOS/Pat Carlson

**Appendix 1 - DHS - Crisis Services:  
Current Efforts and Initiatives by OPC Number**

#	OPC Recommendation	Current Efforts	Initiatives
27	Develop comprehensive, <b>early identification and intensive intervention services</b> for children and adults who have a <b>first episode of serious mental illness</b> . Evaluate changing eligibility for services from SPMI to SMI thus enabling people experiencing mental illness to access more intensive community services at an earlier stage of the illness.	<b>Cross-divisional workgroup</b> regarding early ID and intensive intervention services for children and adults who have a first episode of serious mental illness. The workgroup researched best practices and developed 70 ideas for recommendations, of which 10 are recommended for DHS action.	DHS is developing a <b>behavioral health care home model</b> within the umbrella of the federal health home option, in an effort to better integrate care for individuals with mental illness.
30 - 31	Recommendations for Navigating the System (p. 27)		
31	The State should work toward making the service system easier to <b>understand and to access</b> .	<b>MNhelp.info Network</b> – provides objective information to individuals to help make decisions. <b>Culturally-specific grants</b> to help with outreach/access to diverse communities. <b>Mental Health:</b> Considering one number (possibly using current 211 system) to direct a person to the appropriate regional mental health crisis service. The number is easy to remember and some of the providers are currently contracting with 211 for triage services.	<b>Case Management Reform.</b> Pam Erkel/CCA.

## Appendix B: Positive Supports Implementation Plan Logic Model





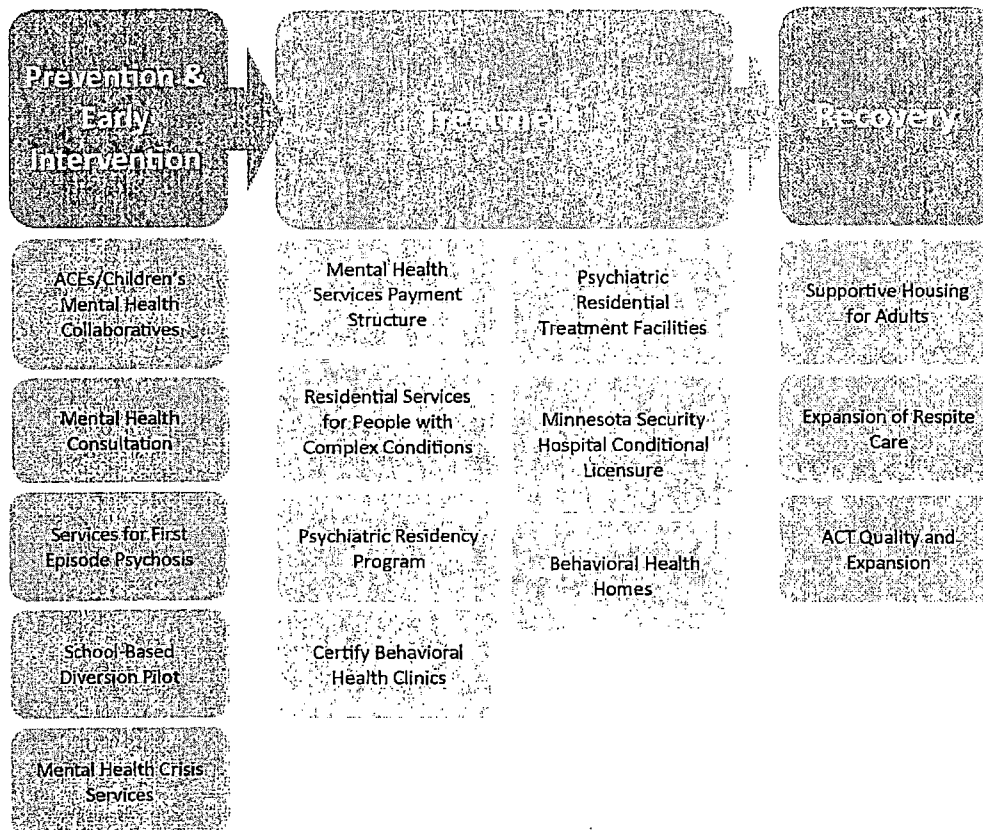
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# 2015 Mental Health Reform

The Problem	The Solution	The Impact
Minnesota's mental health infrastructure is insufficient with too many gaps in our measurement and information systems availability	Reform our mental health system to include: - Mental health prevention and wellness - Clinical service availability and quality - Community supports	More than 230,000 adults and 75,000 children with mental illness and their families will have the services available they need

## Building a continuum of mental health care for all Minnesotans



**Appendix C: Mental Health System Reform Proposals**



## **Current opportunities**

### **Problem:**

#### **Minnesota's Mental Health System is Fragile:**

- Residential services are in demand but capacity is shrinking. The Woodlands Center Intensive Mental Health Service (IRTS) closed earlier this year and others are in financially precarious positions.
- Community mental health services are vulnerable. Riverwood Community Mental Health Center, which served some 3,000 clients, closed suddenly in 2014.

### **Problem:**

#### **Existing Community Capacity Does Not Meet Needs:**

- Minnesota lacks community-based services for adults, especially those with the greatest needs. Anoka Metro Regional Treatment Center has a waiting list of over 75.
- Intensive children's services are not available in Minnesota. There are between 300-400 children each year with aggressive or self-injurious behaviors whose needs cannot be met.
- Prevention resources are limited. Focus has been on treatment and interventions, leaving prevention and early interventions behind.
- Minnesota has a severe mental health workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.
- Employment supports need to be expanded. People with serious mental illnesses in Minnesota have an 80 percent unemployment rate.

### **Problem:**

#### **Housing services are insufficient for those with multiple service needs**

- Over 50 percent of children and adults in Minnesota who are homeless live with a mental illness.
- Residential reimbursement rates are inadequate. The average monthly room and board costs for Intensive Residential Treatment Services (IRTS) and residential crisis providers are \$1,210 per client. The current monthly group residential housing rate is \$876 per client.
- Capital improvements are not covered in current rate structure.
- Lack of treatment services for the most acute children and adults. The system does not have adequate resources for the most aggressive clients.
- Some children's services are not available in Minnesota. We have between 300-400 children each year who would be best served in Psychiatric Residential Treatment Facilities
- There is a workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.



## **2015 Reform Initiatives**

### **Build a More Solid Foundation of Prevention and Early Intervention**

#### **Mental Health Consultation for Early Childhood Providers**

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.

#### **School-Based Diversion Pilot for Students w/Co-Occurring Disorders**

- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.

#### **Services and Supports for First Episode Psychosis**

- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.

#### **Mental Health Crisis Services**

- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all crisis services.
- Improve consistency and quality of crisis services

#### **Expansion of Respite Care**

- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.

#### **ACEs/Children's Mental Health & Family Services Collaboratives**

- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.



## **Reform and Enhance Minnesota's Mental Health Treatment System**

### **Stabilize and Reform Mental Health Services Payment Structure**

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.

### **Certify Behavioral Health Clinics**

- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.

### **Behavioral Health Homes**

- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

## **Expand Capacity to Care for Children and Adults with Complex Needs**

### **Establish Psychiatric Residential Treatment Facilities**

Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.

- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.

### **Residential Services for People with Complex Conditions**

- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.

### **Minnesota Security Hospital (MSH) Conditional Licensure**

- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.

### **Psychiatric Residency Program**

- Create a public psychiatry track in the University of Minnesota's residency program.

## **Promote and Support Recovery**

### **Supportive Housing for Adults with Serious Mental Illness**

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.

### **Assertive Community Treatment (ACT) Quality and Expansion**

- Enhance the quality of current ACT services.



Minnesota Department of Human Services

- Expand high quality ACT services across Minnesota.
- Develop a Forensic ACT Team to serve people involved with the criminal justice system.

**Increase Flexibility for Transitions to Community Initiative**

- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

## Olmstead Plan Measurable Goal Worksheet

Updated 2/24/2015

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Olmstead Plan Action Item Code:

SS 31

Description of Action Item:

By August 1, 2014, a coordinated triage and "hand-off" process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation.

Report will be delivered to the Olmstead Subcabinet.

Agency/Agency Lead:

DHS/Lorraine Pierce

Population Statement

**1. What is the total number of people with disabilities included in this action item? (i.e., the total number of people who could benefit from the action item)**

500 additional people who receive Home and Community Based Services (HCBS) and have not previously used mobile crisis services will benefit from a crisis response in a pilot of the seven county metropolitan area. This pilot will include the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. For our purposes here, crisis response will include the following categories: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention.

**a. What is the source and date of that number?**

People that need crisis services in the seven county Twin Cities metropolitan area are part of the pilot. The number of people is based on capacity of the crisis phone lines and response teams. The triage process will target interventions to meet individual assessed needs.

**b. What population subgroups are in this group? (Ex: disability type, age range, segregated vs non-segregated, geographic area, etc.)**

Individuals deemed disabled, in all age ranges, including those using HCBS services. Many of those who visit the emergency department for behavioral and mental health issues have diagnoses of intellectual and cognitive disabilities, brain injuries, and mental illnesses or are experiencing situational stresses that lead to anxiety, depression, or behavioral issues. The focus of this pilot will be on preventing hospitalization for those experiencing these sorts of crises (individuals remain in the community).

**c. How is this number relevant to this part of the plan?**

Providing an appropriate crisis response, including triage and referral/hand-off, will allow more people to stay in their own homes. The Governor's budget supports consultation between the mental health crisis phone lines and providers experienced in working with intellectual and cognitive disabilities, and brain injuries. Consultation with Metropolitan Crisis Coordination Program (MCCP), a program experienced in providing services to people with brain injuries and intellectual disabilities, will allow the mobile crisis teams to provide services that match the needs of people in this population group. MCCP serves the Twin Cities metropolitan area. This consultation will be another tool in the mobile crisis providers toolbox of services.

**d. Explain how this number may change over time because of demographics—birth rate, incidence, prevalence, death rate or changes due to age (graduation from high school or deaths).**

As additional positive support strategies are used in the day-to-day lives of people with disabilities, it is expected the numbers will decrease. The timing and amount of decrease is currently unknown.

**e. Are there duplications in the numbers? Report one person only once if possible. (Ex: Does 50**

**Appendix D: Measurable Goals Worksheet**



## **Olmstead Plan Measurable Goal Worksheet**

Updated 2/24/2015

Emergency Room visits mean that one person visited the ER 50 times or does it mean that 50 people visited the ER once?

By 2019, 500 (unduplicated) people on HCBS experiencing a crisis will receive crisis triage services which could include the following: information/referral, consultation and hand-off, face-to-face services within 24 hours of calling, or immediate face-to-face services. This low number is based on the assumption that the majority of the people who use HCBS services will have sufficient preventive services in place to intervene prior to a crisis occurring.

### **Current Status or Baseline**

Of the total number of people included in this action item, how many people currently meet the goal of this action item? (i.e., the number of people who already experience the benefit the action item will provide). In fiscal year 2014 (FY14), mobile mental health crisis providers delivered services to **12,283 people statewide** (3,079 children and 9,204 adults). Within the same time period (FY14), **7,045 people** (1,632 children and 5,413 adults) received mobile crisis services in the Twin Cities seven county metropolitan area. *Note: recipients of crisis services do not have to be deemed disabled; it is open to all individuals.*

The current expectation for mobile face-to-face response is 30 minutes or as soon as traffic and weather conditions allow. Individuals can also ask that a responder meet with them at a specific time which may be later than 30 minutes from the call.

Data from the past five years shows that 85 percent of people receiving face-to-face crisis response services for mental health issues remain in their homes and avoid hospitalization.

#### **a. Explain how this number was reached:**

Mobile mental health crisis service providers are required to report data to DHS. Included in the reported data elements: number of people served, interventions performed, and the results of the intervention.

#### **b. Explain any weaknesses or limitations with this number:**

This number (7,045) is based on the number of people reported to have received mobile mental health crisis services in FY14 utilizing current capacity. The population that is being targeted in this action item is broader and includes persons with diagnoses of intellectual and cognitive disabilities, and brain injuries. They, by definition, are involved with some support services. As noted earlier, the assumption here is that a lower number of crises will occur in this population due to the presence of those services.

#### **c. Explain plans to address these weaknesses/limitations:**

The reporting system will be expanded to identify persons serviced with diagnoses of intellectual disabilities, cognitive disabilities, and brain injuries; the number of information and referral calls; the number of consultations with MCCC and other resources; and the response time for immediate face-to-face interventions.

### **Goal: Change in Baseline over time**

**2. How many more people will benefit from the action item? (Enter numbers here. If you enter a percentage goal then you must also enter a number) Note: the goal below builds to 500 people between 2015-2019.**

#### **a. In 2015?**

- 100 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,145 metro-wide).

## Olmstead Plan Measurable Goal Worksheet

Updated 2/24/2015

<b>Goal – Change in Baseline over time</b>
<ul style="list-style-type: none"> <li>• <u>Of these additional 100 people who will receive crisis response services, 50 people will need immediate face-to-face services and 50 people will receive information/referral or consultation. (Note: this is our baseline year. The number will be adjusted as needed.)</u></li> <li>• <u>Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.</u></li> <li>• <u>25 people who receive immediate face-to-face services will be able to remain in their own homes rather than be admitted to a hospital.</u></li> </ul>
<p><b>b. In 2016?</b></p> <ul style="list-style-type: none"> <li>• <u>Of the additional 200 people who will receive crisis response services (7,245 metro-wide) 100 people will receive information/referral or consultation. 100 people will receive immediate face-to-face services.</u></li> <li>• <u>Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.</u></li> <li>• <u>50 people who receive immediate face-to-face services will be able to remain in their own homes than be admitted to a hospital.</u></li> </ul>
<p><b>c. In 2017?</b></p> <ul style="list-style-type: none"> <li>• <u>Of the additional 300 people who will receive crisis response services (7,345 metro-wide) 150 people will receive information/referral or consultation. 150 people will receive immediate face-to-face services.</u></li> <li>• <u>Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.</u></li> <li>• <u>75 people who receive immediate face-to-face services will be able to remain in their own homes than be admitted to a hospital.</u></li> </ul>
<p><b>d. In 2018?</b></p> <ul style="list-style-type: none"> <li>• <u>Of the additional 400 people who will receive crisis response services (7,445 metro-wide) 200 people will receive information/referral or consultation. 200 people will receive immediate face-to-face services.</u></li> <li>• <u>Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.</u></li> <li>• <u>100 people who receive immediate face-to-face services will be able to remain in their own homes than be admitted to a hospital.</u></li> </ul>
<p><b>e. In 2019?</b></p> <ul style="list-style-type: none"> <li>• <u>Of the additional 500 more people who will receive a crisis response service. (7,545 metro-wide) 250 people will receive information/referral or consultation. 200 people will receive immediate face-to-face services.</u></li> <li>• <u>Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as safely possible give the traffic and weather.</u></li> <li>• <u>125 people who receive face-to-face services will be able to remain in their own homes instead being hospitalized.</u></li> </ul>
<b>Rationale</b>
<p><b>3. Why is the number in 2 reasonable?</b></p> <p><u>A lower number of crises is expected among people who are receiving other services than for the individuals who have accessed crisis response services. Approximately half of the individuals who have been served in the past have been receiving no other services. In addition, the capacity within</u></p>

### Olmstead Plan Measurable Goal Worksheet

Updated 2/24/2015

#### Goal – Change in Baseline over time

the metro mobile mental health crisis services, will constrain the number of people served.

a. Is the goal funded or resourced so that it is realistic?

No. Metro mobile mental health crisis teams will need additional staff and training to provide a full range of crisis services to new populations even with significant collaboration and consultation from other partners.

b. Is this goal based upon past performance or historical trends?

The goal to serve an additional 500 persons per year. This is based on past performance of mobile mental health crisis providers. There are many factors to utilization of a crisis service in a new area or by a new group. The goal to divert 50 percent of the 500 (new) people receiving a face to face service recognizes there is no baseline for measuring the effect of crisis interventions for the expanded population (i.e. people with diagnoses of intellectual and cognitive disabilities and/or brain injury). The target population must be informed of the availability of services and must develop trust in the providers. Past experience has shown that a two year development period is necessary to grow these elements.

c. Over a five year period will this projection have significant impact on the lives of people with disabilities? Service capacity must be built by adding additional staff with specialized knowledge in intellectual and cognitive disabilities and brain injury in order to have significant impact on the lives of people with disabilities. Yes, we are optimistic that this will have a significant impact on the lives of those served.

d. Why is this number not higher or lower? The providers may be able to serve this initial number of additional people without increasing staff numbers. To expand further, mobile mental health crisis providers will need additional qualified staff or will need to partner more fully with other programs in order to provide crisis intervention services to a larger number of people with diagnoses of intellectual and cognitive disabilities and/or brain injury.