Draft Findings and Recommendations Section for Priority Admissions Task Force (Version 1)

1. Findings and Recommendation

An analysis of several root causes as noted here drove recommendations.

1. Admissions to a DCT Facility: Because of the Priority Admission Statute, placement within DCT programs is not based on clinical need and individual circumstances, but rather based on the statutory obligation to prioritize those admitted from jails. This results in inequitable access to state operated services, despite recognition that those in jails suffering from acute mental health symptoms remains a critical need. Other variables impacting DCT admissions include legal status, the process of adding individuals to wait lists, and the information shared with DCT at the time of referral. Families have also been told to call the police because their loved one can get into a DCT facility if they are in jail.

2. DCT Bed Capacity and Access: Lack of bed capacity coupled with limited types of beds, increases the likelihood the demand is not met for long term treatment for individuals at high acuity and/or with chronic mental illness, resulting in harm.

3. Community Bed Capacity and Access: Lack of a DCT facility and/or supportive community-based services for individuals at high acuity and/or with chronic mental illness, decreases the likelihood that (1) security and safety can be established and (2) that the individual is able to be treated in the least restrictive setting when receiving services in and discharging to the community.

<u>Proposals to amend Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), to improve the priority admissions requirements and process</u>.

Admissions to DCT facilities should be prioritized based on clinical acuity, allowing for consideration of factors such as community and individual safety and the ability to receive needed services in a non-DCT program.

Individuals civilly committed as Mentally Ill, Chemically Dependent, and Mentally Ill and Dangerous will be prioritized by the DCT Executive Medical Director's Office for admission to Direct Care and Treatment programs into medically appropriate beds based on an established prioritization framework which takes several factors into account. These may include but aren't limited to:

- Any relevant federal prioritization requirements, such as for substance use disorder treatment.
- Length of time spent on a waitlist for DCT admission.
- Medical acuity—significant symptoms of mental illness which place the individual or others at risk of serious harm.

- Whether the referring facility the person is currently in, or any other setting can provide sufficient treatment.
- Other negative impacts to the referring facility, such as the number of beds unavailable because of caring for the referred individual.

A panel of members from the Priority Admission Task Force will review deidentified data on a quarterly basis for one year following implementation to ensure the prioritization framework is carried out in a fair and equitable manner. Suggested data the committee will review includes:

- Numbers of admissions to DCT programs serving those committed as MI, CD, and MI&D during this period.
- Referral sources for admissions and those on the waitlist. (e.g., jail, hospital, other community setting)
- Time spent on a waitlist following referral for admission.
- Time spent in DCT programs after DNMC determination or other readiness for discharge indicator.

<u>Ways to ensure that state-operated treatment programs have medical discretion to prioritize the admission of individuals with the most acute clinical and behavioral health needs or who pose a risk to self and others, regardless of referral path</u>.

- Admissions decisions to DCT programs must be at the clinical discretion of physicians and based upon unique factors, including presence of medically appropriate beds to accept individuals.
- A framework for prioritization of admissions, which allows for transparent and consistent decisions related to admission criteria and rationale for departures from said criteria.
- Real time tracking of trend data to help facilitate decisions and ensure transparency in decision-making.

<u>Additional ways to meet the treatment needs of individuals referred to state-operated treatment programs according to the priority admissions required under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), and other individuals in the community who require treatment at state-operated treatment programs</u>.

- Expand DCT capacity.
- Expand Community (non DCT) capacity.
- Expand access to IRTS level of care, including locked programming (ensure Medicaid can be used)
- Fund jails to effectively utilize Jarvis orders for involuntary neuroleptic treatment, or work so they can contract with CCBHCs or others to provide medication management.

- Expand community capacity through development of types of novel services/levels of care and decreasing the timeline for MNChoices assessments.
- Explore utilization of services by those committed as Mentally Ill and Dangerous
- Expand access to ACT (Assertive Community Treatment)
- Expand access to innovative housing models and levels of support.
- Continue to focus on alternatives to police responses by building the county crisis teams and publicizing 988 and fully implement Travis' law.
- Rate study completion and increases.
- Fund voluntary engagement programs and study their effectiveness.
- Obtain 1115 Waiver for incarcerated individuals.
- Explore psychiatric emergency rooms/intensive care units in community/hospital settings.
- Support mental health workforce through increasing pay, making supervision free, expand training opportunities for integrated substance use disorder and mental illness training, as well as de-escalation. techniques

Other relevant findings, research, or analyses conducted or produced by the task force that focuses on the impact of the priority admission, numbers as it pertains to admissions from jails or correctional institutions, county trends or length of wait lists for admissions.