Governor's Task Force on Mental Health

TASK FORCE MEETING SUMMARY

Monday, October 17, 2016
8:30 a.m. – 5:00 p.m.
Dan Abraham Health Living Center
Mayo Clinic, 565 First Street SW, Rochester, MN

Governor's Task Force on Mental Health members present: Commissioner Emily Piper, Melissa Balitz, Brantley Johnson, Kim Stokes, Crystal Weckert, Lynn Sando (for Sue Abderholden), Shauna Reitmeir, Pahoua Yang, Paul Goering, Bruce Sutor, Sara Suerth, Deputy Commissioner Jeanne Ayres (for Commissioner Ed Ehlinger) Commissioner Tom Roy, Cathy ten Broek, Roberta Opheim, Representative Roz Peterson, Representative Clark Johnson, Angie Youngerberg (for Commissioner Jim McDonough), Hon. Jamie Anderson, Assistance Commissioner Daron Corte (for Commissioner Brenda Cassellius)

Governor's Task Force on Mental Health members absent: Senator Julie Rosen, Senator Tony Lourey, Chief Rodney Seurer and Liliana Torres Nordahl

Governor's Task Force on Mental Health staff present: Susan Koch and Mariah Levison

8:30 a.m. Welcome

- Commissioner Piper welcomed the Task Force members and guests to the sixth 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 John H. Noseworthy, M.D., President and CEO of Mayo Clinic. Dr. Noseworthy welcomed the Governor's Task Force on Mental Health.

8:40 a.m. Overview of Today's Meeting

- Commissioner Piper informed the Task Force members that the meeting summary for September 26th, 2016 is posted on the Task Force website at: https://mn.gov/dhs/mental-health-tf/. For questions about the meeting summary, contact Sue Koch at Susan.e.Koch@state.mn.us

8:45 a.m. Discussion of nine categories of recommendations

- Mariah Levison gave an overview of the Governor's Task Force on Mental Health Draft Recommendations. This document is posted on the Task Force website at https://mn.gov/dhs/assets/draft-integrated-recommendations-10-13-16_tcm1053-260167.pdf.

- The draft recommendations are organized in the following nine areas:
  - A Comprehensive Mental Health Continuum of Care
  - Governance in Minnesota's Mental Health System
  - Using Cultural Lens to reduce Mental Health Disparities
  - Workforce Development
  - Parity
  - Heath Promotion and Prevention
  - Housing to Support Recovery
  - Inpatient Psychiatric Bed Capacity and Level-of-Care Transitions
  - Implement Short-Term Solutions to Improve Crisis Response

9:25 a.m. Discussion of Recommendation #1: Continuum of Care

- Feedback and comments from Task Force members
  - Is using the cultural lens embedded in everything?
  - Are we too specific in how we specify services in the Medicaid State Plan? How can we be flexible to address new needs that might arise?
  - I am uneasy about not being specific as we define services. Sometimes flexibility is good but how does flexibility impact accountability? We need to be mindful of this.
  - How prescriptive are we now in the mental health service definitions?
  - We are being prescriptive by saying that an array of services should be defined as what should be available. Creating the matrix and making changes to it would be where the flexibility would come in.
  - How does governance fit into this? We should be discussing that within all the recommendations.

9:45 a.m. Recommendation #2: Address Governance Issues in Minnesota's Mental Health System

- Feedback and comments from Task Force members
  - Highlight populations and communities experiencing disproportional amounts of health and mental health concerns into this recommendation. That is not standing out within the current recommendations.
  - Integration of services needs to be strengthened.
  - How is the governance model going to work? Collaborative oversight body, has this happened before? If so, how does it work? Is this a workable or feasible model?
  - Other advisory groups have existed in the past and currently exist; what would be the difference with this new oversight body? It's unclear what the roles of this body would be.
  - Can Adult Mental Health Initiatives be looked at as an example of how to ensure governance?

- We need to be looking at all the pieces collectively- mental health, children's mental health and public health boundaries as all of these currently vary.
- How prescriptive does this group want to be with these recommendations?
- The concern is, are we creating more bureaucratic layers so that people who need and utilize these services are not getting them? We don't want to do that.
- We shouldn't be recommending a one size fits all model- we should be trusting that people know what is going on in their local communities and they develop the services their communities need.
- Governance could be an internal state agency with the representatives being the state agency commissioners.
- Other governance bodies have state agency representatives but also include external members (i.e. consultants). This is a model that has been used in and we can look into this as an option.
- Overly prescriptive guidance may be going the wrong direction for the work and scope of this oversight body.
- Would like to see a department or someone (i.e. a particular position) that does the work. An example would be, a state director that is responsible for doing the work of coordinating and collaborating with the Oversight Body. This person would work with already-existing councils and the state agency commissioners to implement the recommendations of the Task Force.
- We went from looking at the county administered and state supervised discussion to creating a body for Governance? This wasn't the focus on the Governance Formulation Team when we started initially, it's taken a different direction.
- Sue Koch (Task Force staff) explains that this draft contains two parts in the Governance section. One part is the discussion of how the Task Force's recommendations should be overseen, and the other is the discussion of how governance of the whole system should be re-designed. The latter is the work of the Governance Formulation Team. Perhaps these two should be divided into separate sections.
- The Olmstead Subcabinet is working well and has been able to be the governing body for the Olmstead work. Additionally, there is an Implementation Office with 2-3 staff that are doing the day to day work. We can model this Mental Health Oversight Body after this.
- Example of the Olmstead Subcabinet- How does feedback from outside groups, communities and individuals that are not from state government get heard? This can be an issue.
- We are using the word governance but it's really about accessibility, responsibility, accountability, quality assurance and authority. That is what is needed for this work to be done and to ensure that the Task Force recommendations are carried out.

- This governance group should not be dictating how state agencies and state agency commissioners do their work.
- Interagency teams or agencies- is there an interagency mental health director? Could there be one? It seems that we need to take a similar model to the interagency model that is used to end homelessness in Minnesota.
- Would prefer to move towards a state administered and supervised mental health system instead of having 87 counties administering mental health services differently in their communities. This should be what the governance group should be recommending.
- A Mental Health Commission with a coordinator or director to oversee this commission- this may be a way to centralize and have the oversight body do the work.
- Seems that there is a general agreement that governance is important but this Task Force can't come to an agreement on how to go about going forward about how the current recommendation is worded.
- We should recognize the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health have already been doing some of the work we are proposing the Oversight Body to do.
- Suggestion- we should all read the statute for the State Advisory Council on Mental and the Subcommittee on Children's Mental Health and discuss this further- we don't want to create another body that does something similar things.
- Statutorily prescriptive bodies are not as flexible and the Oversight Body needs more flexibility on how it can get this work done.
- There should be a funded effort to gather a biennial report that coordinates the work of all the mental health councils, oversight body and progress on the Task Force recommendations.
- There should be three members of the state government- hire a person to take charge of the mental health system in MN- then the State Advisory Council on Mental Health would be the advising body to the person in charge and the Oversight Body.
- Adult Mental Health Initiative redesign- is it working? What is not working? Should we be looking into this further?
- Purpose of the Oversight Body group and the scope would be the following:
    - The State Advisory Council on Mental Health- they advise the State Mental Health Director or the interagency office on Mental Health in addition to their current role.
    - State Mental Health Director or Interagency office on Mental Health would be the one that will make sure that the governance recommendations are carried out and in progress.
    - Three state agency leadership (e.g. the Lt. Governor, DHS Commissioner and MDH Commissioner) would be the ones that would be leading the governance Oversight Body.

- Counties should have a role and a seat at the table if there is going to be a governance body or interagency office on mental health. They should also have the same decision making authority as the DHS Commissioner, MHD Commissioner, etc.
- Tribal representation needs to be there are well as federally recognized tribes have to be recognized in this process and within this Oversight Body structure.

10:45 a.m. Break

11:00 a.m. Continued discussion of Recommendation #2: Address Governance Issues in Minnesota's Mental Health System

- Feedback and comments from Task Force members:
  - We have to extend this to existing bodies in addition to the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health as there are councils focusing on this from the American Indian Mental Health perspective (i.e. the American Indian Mental Health Advisory Councils). Will this oversight body be a short term thing or a long term solution? It seems that this should be a short term plan.
  - This recommendation is a good start but it's not clear what the specific role of this oversight body will be. Can this proposed recommendation and recommendations around the oversight body be clear?
- A new proposal of draft recommendation for governance from this discussion was shown on the overhead screen: The state should establish an Oversight Body that include tribal, county and state representation. This body shall advise the Governor and Legislature on the reconstitution of existing bodies to effectively advise the Oversight Body on implementation of the Task Force's recommendations. Additionally, the Oversight Body shall develop plans, convene workgroups, assign responsibility and periodically report to the Governor and Legislature. This group should hire appropriate staff to lead this work.
- Feedback from Task Force members:
  - It's good that tribes have been added
  - We need to make sure we hire appropriate, high-level staff
  - Leave it flexible enough that the details can be figured out later
  - If shouldn't be so broad that people come back later and say, "We already have the State Advisory Council so we don't need anything else."
  - I'm not opposed to the State Advisory Council, but we just don't know enough now to make this recommendation.
  - We need to consider and evaluate the existing bodies before we make a decision.
  - Would the scope of the work of the Governance Workgroup include the possible dismantling of the State Advisory Council?

- The Oversight Body should be the group that is forming the other workgroups.
- Should it be long-term or short-term?
- I think it should be temporary.
- I think it should be long-term. It should get embedded in the governmental structure.
- We've already done a lot of work to create the existing organizations. We shouldn't add new bodies. We already have to do targeted recruitment to get members. And it takes time to train people and it would be a shame to lose that.
- We do need long-term accountability.

- Mariah brought the discussion to a close. Staff will take all of this input and draft a new version of this section.

11:15 a.m. Discussion of Recommendation #6: Health Promotion and Prevention

- Feedback and comments from Task Force members:
  - Include non-profit and private sector in this recommendation.
  - Suicide prevention and Postvention should be added.
  - Can we define campaign within these recommendations?
- Feedback and comments from Task Force members:
  - Crisis Intervention Team (CIT) training: feedback has been heard that law enforcement would like to get this before getting in the field. Maybe this is something that can be implemented in law enforcement programs so individuals pursuing law enforcement careers can take this training while they are in school.
  - We have found that law enforcement's knowledge of diversion options doesn't depend on whether they have received CIT or not.
  - Take an in-depth look at the quality of Crisis Intervention Team (CIT) trainings in the state.
  - I am concerned that certain programs being called out within the recommendations but others are left out. This may make it seem as though there is a preference for certain programs.
  - Staff of the Crisis Response Formulation Team explains: Programs were mentioned, specifically, in the recommendation document because there was information available about them. It was not to indicate a preference for a certain program.
  - Suggestion from Task Force members- Keep program names in the footnote so it is more neutral.
  - This recommendation is starting out from less intensive services. Will this be re-arranged in terms of ordering?
  - This section might need an introductory section- as is right now it is not addressing the underlining problems related to crisis response services.

- Suggestion- primary care providers are not a part of the same continuum in this section. We have to be careful on how this gets worded.
- All recommendations have fiscal impact but only some recommendations are calling out the fiscal impact. Shouldn't all recommendations call out the fiscal impact? Either call it out in all recommendations or leave it out in all recommendations.
- Tele-Health works well when you have formed relationships. We can make the next option a better option if we know the local services that are available.
- Encourage stronger wording around the crisis response recommendation.
- Concerns about the definition of what a crisis is and when does it start and end. This needs to be clarified for recommendations in this section. The introduction maybe a good place to clarify this definition. The following are the current difference in the definition of crisis:
  - The person experiencing the crisis defines their own crisis differently than a health provider or clinicians would.
  - Clinicians also define the crisis they see differently than the individuals that are experiencing it.
- American Indian and Native American communities as well as federally recognized tribes should be recognized as partners as well as called out within these recommendations. Currently, they are not called out in all recommendations.

11:50 a.m. Recommendation #8: Short-term Solutions to Improve Inpatient Psychiatric Bed Capacity

- Feedback and comments from Task Force members
  - The inpatient psychiatric bed issues are a serious crisis and the state is looking for the Task Force to look into this in depth.
  - Set a bar for the service standard and what that would look like.
  - A lot of the issues are related to stigma; we haven't built capacity in this area in a while.
  - We need to start partnering with community hospitals and service providers that already exist in order to increase the bed issue.
  - The issue with more beds is that it doesn't solve the local issue. We need to agree as a state to increase capacity in all areas in an equitable way, not just increasing capacity in some areas.
  - There needs to be discussion of the 48 hour rule, the state as the safety net, and the impact of parity. These need to be strategically thought out.
  - Patient flow issues are the reason we are discussing the inpatient bed issues, but we need talk about people who don't need to be in the hospital. We need to create sustainable capacity in the community to serve people in their homes and in their communities.

- I would like to see language in this recommendation on stabilization and assistance for individuals who don't have wrap-around services and supports.
- Crisis residential options for inpatient beds: this may need to be considered. This could be developed to provide an alternative to people who need mental health inpatient services in their communities. Would it make sense to have this on the inpatient path?
- Tighten up the definitions in this recommendation. Define crisis clearly within in this recommendation. Currently, there are multiple definitions on how crisis is defined within this context.
- Have we looked at utilizing other beds that are not in use? Or is it that we don't currently have any excess capacity?
- Staffing issues, bonding issues, workforce shortage issues all contribute to this.
- Post crisis services and inpatient services are needed. Discharge planning is necessary, and community services for individuals experiencing and being impacted by crisis are needed.
- Place for the dialogue is important; call out and make section D clearer.
- The section on page 19—the first paragraph on Psychiatric Residential Treatment Facilities—this needs more clarity.
- Is there a better way to say out-of-home placement?
- Where are the ideas on how we can share burdens throughout the state in terms of the bed capacity issues?
- These are the issues that are a crisis in the mental health system- this is the issue we hear more the most.
- We already have the Intensive Residential Treatment Services recommendations and the Reform on Substance Use Disorder and Addiction Treatment.
- These solutions are going to take longer if we don't use existing buildings creatively. We can remodel or repurpose; this seems more efficient.
- The Minnesota Hospital Association's report recommends having regional dialogues about this specific topic.
- County cost share has increased over 400%. That money now goes back to the General Fund; it doesn't get used by counties. Can the county cost share be called out and redesigning this be recommended?
- Tribes have unique responsibility so it should say Tribes and Counties not just counties. We need to make sure federally recognized tribes and American Indian reservations are being recognized within these recommendations.
- How do we provide incentives to private and nonprofit providers to increase their inpatient beds? Currently, there are no incentives to build or increase these types of beds.
- The system is fragmented and is not set up for individuals and families that are receiving services.

- Change the name of this section from Inpatient Psychiatric Bed Capacity and Levels-of Care Transition to Acute Care Capacity and Level- of-Care Transition so that it is more person centered.
- Transition planning (from the corrections setting) needs to be included in this recommendation as well.
- Transition from hospitals, jail and corrections settings are similar and there are national best practices on this. This is where we can advance the best practices where they exist.
- There are too many people involved with one person's recovery. There are too many people for the person receiving care to keep track of. We need to reduce the number of care coordinators, case managers, and others to just 2-3 people. We need to create a more seamless and more efficient service.

1:10 p.m. Lunch

1: 45 p.m. Recommendation #5: Parity

- Feedback and comments from Task Force members:
  - This recommendation is too technical as is. Can this be revised for the final recommendations?
  - National or state best practice on parity should be included in this section. Add this in the introduction section.
  - We should be more assertive in saying that private insurance and managed care organizations have a part in this.
  - The Presidential task force working on parity will have a report coming out at the end of October. This report may need to be reviewed before this recommendation is finalized.
  - Without a group assigned to parity, how will we make sure that this recommendation is carried out? Should there be an oversight group just for this recommendation?
  - Put more emphasis on the last sentence that states, "Any consumer complains about coverage received should include a requirement for insurance providers to respond within an appropriate timeframe, as crisis situations require timely mental health treatment and services."

2:00 p.m. Recommendation #3: Using a Cultural Lens to Reduce Mental Health Disparities

- Feedback and comments from Task Force members:
  - I have concern about religious based services being funded by the state. There should be a separation between religion and state functions.
  - Faith communities are missing in this conversation and in this setting. I think this community needs to be part of the work in improving the mental health system.

- Similar to the work of peer supports and recovery coaches, cultural brokers would be doing this work with individuals and families impacted by mental illness.
- I am concerned about the word "provider" being used to talk about cultural brokers or healers. Clarity is needed in this section.
- Who is credentialing who and how? Would the cultural healers or brokers need to be credentialed by mental health providers? This part is unclear.
- When we talk about credentialing, what does that mean? What does that look like?
- The first issue is how do we credential individuals from specific cultural backgrounds trying to provide services to specific cultures?
- Reducing barriers in how credentialing works from communities of color and underrepresented communities is necessary.
- How do we make it affordable for people to seek and give consultation about culturally specific services?
- Who are the individuals who already do the healing and are already providing the consultation? Do we know this already?
- This should not be a free for all and we need to have a process. We need to make sense of this within our system and then look at how to expand this beyond our current system.
- This recommendation is a way to figure out how to bridge the gap and collaborate with other services.
- Medicare and Medicaid might have restrictions but we need to think creatively about how we can pay cultural healers and cultural brokers that are already providing the services and doing the work that can't be done by mainstream providers.
- Envisioning a mental health system where people can get access to services they need when they need them may help with understanding why this is necessary to include cultural brokers or healers.
- Grant funding some of these programs would work but it may not be the most sustainable funding mechanism. There have been cultural initiatives that have been funded by state agency departments in the past.

2:50 p.m. Recommendation #4: Workforce Development

- Feedback and comments from Task Force members:
  - Call out the amount of investment needed in this section. There is fiscal impact but this isn't mentioned.
  - There are a number of reports on this topic. We need to ask ourselves why we are not acting on the recommendations that have already been made.
  - The Gearing up for Action report was submitted to the Legislature in 2015 but we don't know the progress of those recommendations. Can this be mentioned or looked into?

3:45 p.m. Break

4:00 p.m. Recommendation # 7: Housing

- Feedback and comments from Task Force members:
  - Include the need to build more housing since there isn't enough housing in the state.
  - Need to include the need to produce more affordable housing.
  - The word "Describe" is not a strong enough to call out. Can this word be changed?
  - We need to find creative ways to deal with the "not in my backyard" perspective that some cities and counties have.
  - A stronger statement from this group about housing discrimination is necessary in this recommendation.
  - The Legislature should enforce current fair housing laws or the state should work with local communities and the landlord risk mitigation funds.
  - Landlords cannot deny housing to individuals because of their criminal history unless the criminal history has a direct tie with housing-related crimes.
  - Crime free housing addendum- make a recommendation to adjust this language so that it doesn't penalize people who experience a mental health crisis.

4:20 p.m. Discussion on the Task Force report writing process

- Sue Koch discussed the Task Force report writing process with the members and reviewed the information that needs to be included in the Task Force report. Task Force members suggested that background documents will need to be included, most likely in the appendix section.
- Sue Koch explained that the Crisis and Inpatient recommendations look different than most of the other recommendation because they include fiscal implications and are formatted differently. What do member think about the two different formats for the report? Task Force members suggested the same format should be used for all the recommendations in order to be consistent, although there might be more detail in those two sections. The report should not include information about specific fiscal implications; that would be determined later by the appropriate agencies.
- There should be some background provided for each recommendation, then the actual recommendation should be stated.
- Include a context chapter that explains the basic definitions and concepts for the report. Define mental health in that section.
- There need to be an Executive Summary in the report.

4:30 p.m. Public Comment Period

- Kathy Czech, Safety Triage and Mental Health Providers. Kathy introduced herself and gave an overview of the crisis response Co-responder model. The updated documents are available on the Task Force website.
- Beth Kangas, Executive Director of Zumbro Valley Medical Society. Beth introduced herself and gave an overview of the Zumbro Valley Medical Society. They are holding conversations with communities about mental health in the southeast part of the State. She looks forward to connecting with the Task Force's work, and she asked how her group could connect locally with the Task Force's work. A Task Force member responded that the Task Force can provide a road map for local communities to solve their concerns with mental health. Another said that Task Force recommendations will include looking for ways to replicate best practices from one community to others. This could be helpful for local communities to improve their mental health system.
- Commissioner Kiscaden, Olmsted County Board of Commissioners. Commissioner Kiscaden introduced herself and gave an update of what Olmstead County has been doing to improve mental health and housing options for its residents. She thanked the Task Force for their push for a comprehensive continuum, continuing to promote local control, and creating a road map for counties and local communities. These directions are recognized and supported by Olmsted County.
- Joan Somes, Minnesota Emergency Nurses Association. Joan introduced herself to the Task Force members and gave a brief overview on the Minnesota Emergency Nurses Association. Joan indicated that the emergency nurses need training on mental health crises, maybe not Crisis Intervention Team training, but something similar to that. She indicated that emergency nurses are not trained to deal with mental health crisis but they see it often.
- Heather Geerts, Director of Zumbro Valley Health Center. Heather gave an overview of Zumbro Valley Health Center and the improvements it has made in the delivery of services. Heather stated that the integrated care model has been implemented at Zumbro Valley Health Center to better service individuals and families impacted by mental illness and substance use disorder. She suggested the Task Force think about an integrated model when finalizing their recommendations. Heather stated that housing is an important element in the recovery process: housing first matters and housing with supports in a sustainable and safe environment is necessary for individuals and families impacted by mental illness and substance use disorder. Additionally, workforce is an issue and it has been difficult to find qualified mental health providers in the area. Heather explained that Zumbro Valley needed to expand their search nationally when looking for a psychiatrist. Community mental health centers have seen themselves become training grounds for other mental health providers who can pay higher salaries, and retention of mental health and health professionals is getting harder.

5:00 p.m. **Next Steps**

- Commissioner Piper said that the summary of comments received from September 22, 2016 to October 10th, 2016 is available on the Task Force website; handouts were provided.
- Commissioner Piper announced that the final meeting will be in St. Paul, MN on November 7th, 2016. Further meeting details are available on the Task Force website.

5:15 p.m. **Adjourn**