Governor's Task Force on Mental Health

IMMEDIATE IMPROVEMENTS IN INPATIENT BED CAPACITY AND LEVELS OF CARE TRANSITIONS FORMULATION TEAM: UPDATED PROPOSED SOLUTIONS draft 9/22/16

The Inpatient Bed Capacity and Levels of Care Transitions Formulation Team has incorporated feedback from the September 12, 2016 Task Force meeting in Duluth into this updated version of the proposed solutions. There have also been additional options included after discussion within the Formulation Team.

I. Possible Solutions for Consideration of the Governor's Task Force on Mental Health

The Formulation Team identified the following solutions for consideration by the Task Force because they could be implemented within one - two years. The Formulation Team does not see these as total solutions, but as strong first steps to take while the Governor and Legislature also undertake the more comprehensive planning and coordination needed to solve the inpatient bed capacity issue.

A. Establish an Ongoing Body to Coordinate and Oversee Work on Inpatient Bed Capacity

The Formulation Team understands that part of the difficulty of addressing inpatient bed capacity is the fact that the problem is so multi-faceted and that many stakeholders are involved, each with their own missions and goals, legal and administrative requirements, funding models, work processes, and professional perspectives. It is outside the scope of the Task Force's work to completely analyze this situation and formulate the kind of detailed strategies, collaborations, and data that will be needed to solve the problem. Future work on inpatient bed capacity should feed into larger continuum data collection efforts to better plan and coordinate services around the state. The Formulation Team looks forward to talking with the rest of the Task Force about an appropriate structure and process for an ongoing oversight/coordination body.

B. Increase Intensive Residential Treatment Services

Intensive Residential Treatment Services (IRTS) are licensed by the Department of Human Services. An IRTS program is a place for individuals to receive time-limited mental health treatment, usually ranging from 30-90 days. IRTS programs provide around the clock support or assistance as needed while individuals receive intensive mental health treatment consisting of 1:1 therapy, group therapy, treatment planning, nursing services, independent living skills and other activities. IRTS programming is designed to develop and enhance the individual's psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that will help the transition to a more independent setting. Individuals seeking services at an IRTS program often need a higher level of care than outpatient services, or may be transitioning from a more restrictive setting (such as hospitalization or jail). There

are currently 47 IRTS facilities throughout the state of Minnesota that range in capacity levels of 10-16 beds. This includes nine IRTS licensed programs which offer only shorter term crisis stabilization services.

Recent studies[1] cite a shortage of IRTS beds in areas of the state as one factor in prolonged inpatient psychiatric admissions. Increasing the number of IRTS beds could offer a short-term way to help alleviate the current bed shortage crisis in Minnesota through the prevention of hospitalization and through more rapid discharge to appropriate local/regional facilities.

One possibility is to develop IRTS that offer different levels of service intensity, or are different sizes. For example, a smaller setting may be more sustainable in some regions that cannot support a 16 bed IRTS. Offering different service levels will provide access to more intensive treatment for individuals needing that kind of care and less intensive for others. This possibility is being explored in more detail by the Crisis Response Formulation Team.

There are some challenges that would be need to be addressed to expand IRTS. Because of the IMD exclusion, IRTS are limited to a maximum occupancy of 16 individuals, making the addition of beds to existing programs problematic. IRTS face the same workforce shortages as other mental health providers; some have reported having plenty of beds but not enough staff to take more clients. In addition, funding continues to be an issue. Funding will be examined in the Mental Health Rates Study currently being conducted. Part of the funding issue is also the lack of coverage by some private commercial health plans. There are also challenges regarding the requirement that providers have contracts with a county before being able to build or open a new IRTS.

This does not preclude the importance of increasing the capacity of other community-based services, as noted in Past Recommendations in the Sept. 9, 2016 Proposed Solutions document.

C. Strengthen Housing and Supports

Homelessness has a significantly negative impact on health. The 2012 Wilder study *Homelessness in Minnesota*[2] identified that 26 percent of the homeless adults had received health-related services at an emergency room during the month of the survey. The survey also found that emergency department usage was higher among women in battered women's shelters (36 percent) compared to adults living in other settings. Seventy-six percent of adults experiencing homelessness who reported a significant mental illness also reported receiving inpatient or outpatient mental health care in the previous two years.

Supportive housing is an evidence-based intervention for people experiencing homelessness or at risk of homelessness. Supportive housing is also successful for individuals living with disabilities who are in

[1] *Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot* (St. Paul: Wilder Foundation, July 2016), 1. *DHS Gaps Analysis Study* (St. Paul: Wilder Research, August 2015). Five County Metro Psychiatric Patient Flow Study

[2] *Homelessness in Minnesota: Findings from the 2012 statewide homeless study* (St. Paul: Wilder Research, September 2013), 37, 39.

institutional settings but are able to live more independently in the community. Lack of supportive housing is often cited as a gap for individuals living with mental illnesses. Providing housing with supports has been shown to create a level of stability that serves as a basis for recovery. In addition, bringing services to a person's home lessens the need for transportation and can help a person de-escalate who may be in crisis or cycling through their illness. Supportive housing has been shown to decrease the need for hospitalizations and involvement with law enforcement.[3]

In permanent supportive housing models, affordable housing is paired with or linked to services to assist individuals to remain in their homes. Individuals have leases with landlords and have full tenant rights, including rights under the Fair Housing Act. Current affordable housing and rental assistance programs in Minnesota include Bridges and Bridges RTC, which are rental assistance specifically for people living with serious mental illnesses who are experiencing homelessness or at risk of homelessness after leaving Anoka Metro Regional Treatment Center or Minnesota Security Hospital. Other assistance is available from the Minnesota Housing Trust Fund and the federal Section 8 housing program and limited Federal Continuum of Care resources. However, the current available resources are not enough to meet the need. The annual point-in-time data, which provides a snapshot of homelessness in MN, shows nearly 800 people experiencing homelessness have a disability, the majority of which are mental illnesses.

The Formulation Team would like to work with the Task Force to explore the expansion of evidence-based intervention housing models that Task Force recommendations could support.

The Formulation Team also suggests support for Medicaid coverage for housing supports, also called individualized community living. While Medicaid (Medical Assistance in Minnesota) does not pay rent, the Centers for Medicare and Medicaid Services (CMS) is now much more open to paying for services to help people get into and stay in housing. The Task Force can explore support for efforts to implement Medicaid coverage for these services in Minnesota.

Increasing access to supportive housing, particularly permanent supportive housing, will help Minnesota address the Olmstead Plan by increasing community integration for people living with mental illnesses. It could also help address so-called "pipeline" issues with people who are unable to return to residential settings after a hospitalization. Instead, individuals can return to their own home and have wrap-around services to support their recovery.

D. Competency Restoration

The Formulation Team felt that there are opportunities to expand community-based competency restoration that would open up beds at the Minnesota Security Hospital in St. Peter and at AMRTC, which would make those beds more available for others.

There are currently competency restoration program pilots in Minnesota, including one in Olmsted County. Olmsted County utilizes Whatever it Takes grant money (part of the Transitions to Community

[3] For more information see https://www.usich.gov/solutions/housing/supportive-housing.

Initiative) to minimize the time spent in Anoka Metro Regional Treatment Center or Minnesota Security Hospital competency restoration programs. The grant funds a team of staff who work with an individual during their time in AMRTC or St. Peter. The team includes two forensic social workers and an Adult Rehabilitative Mental Health Services (ARMHS) worker who work together to support the client and navigate the civil, criminal, and social services systems. The team helps the competency restoration program determine when a person is treated to competency, at which point the individual either returns to jail or is discharged to the community after a plea agreement. The team starts the discharge planning process before an individual's release and continues with up to 90 days of case management post-discharge.

The Whatever is Takes grant allows for flexible spending to bridge the discharge from the competency restoration program to the community. It can pay for holding a bed, medications until a person is enrolled in Medical Assistance, basic needs, among other things. All flexible spending gets approved by the clinical supervisor and then the Department of Human Services.

One of Olmsted County's long term goals is to work with individuals who do not require inpatient hospitalization by providing case management and rehab while at the same time addressing competency restoration in an outpatient setting. They would use the current curriculum being used at AMRTC and St. Peter.

Hennepin County is also piloting competency restoration outside of AMRTC and St. Peter. More information on this program is forthcoming.

There is additional interest in examining competency restoration program transitions out of the Security Hospital in St. Peter and into the community. Olmsted County provides one example of how this could work.

E. Civil Commitment

Minnesota's Civil Commitment Act currently allows courts to commit individuals to settings less restrictive than a hospital. The law can be clarified to emphasize the ability for individuals to be committed to lesser-restrictive settings. In addition, allowing dual-commitments to hospitals and the Commissioner gives hospitals the opportunity to discharge individuals without waiting for a provisional discharge from the state. This is used in Hennepin County and is reported to be working well.

F. Improve Local Coordination around Crisis Response

A concern strongly voiced by the Formulation Team was that of addressing individuals in crisis who need immediate services. Law enforcement and hospitals both see the results of a system that was not designed to provide services outside of acute settings to people experiencing a crisis. There is an opportunity to improve the connection between hospitals and law enforcement with mobile crisis teams, for adults and children and youth. Mobile crisis teams are able to come to a person, whether they are in a home, in a hospital, or another place in the community. They can be called by law

enforcement and hospital staff as well as other providers and community members. Crisis teams can assess an individual experiencing a mental health crisis for the right place for treatment, including non-hospital level of care services. For example, crisis stabilization services offer short-term residential treatment to help an individual stabilize without needing to be hospitalized. Many crisis stabilization services are offered in IRTS settings.

Strengthening connections between mobile crisis teams and hospitals and law enforcement will assure individuals experiencing a crisis receive the right care, while relieving the pressure on hospitals and law enforcement to address acute crises with limited resources. There is also an opportunity for strengthening crisis teams to work with families, along with children and youth. The Formulation Team believes that this possibility is being pursued by the Crisis Response Formulation Team and strongly supports that work.

H. Expand Options for Parents and their Children

There are few treatment options available for parents and children in mental health crisis, including options that allow parents and children to stay together during treatment. The Formulation Team believes this work is best included in the work of the Continuum of Care Formulation Team.

J. Private Insurance

Private insurance coverage of community mental health services affects patient discharge as well as preventing hospitalization in the first place. As noted above, the lack of coverage within commercial plans for residential treatment contributes to funding issues for IRTS providers. This lack of coverage can also cause problems with the discharge process if an individual is referred to an IRTS from hospitalization but cannot get insurance to cover the cost of the treatment. Information on how Minnesota's health plans cover residential treatment is currently being gathered.

Private insurance coverage is an issue across the continuum of mental health services and is best explored by the Continuum of Care Formulation Team.

K. Support Efforts to Reform Addiction Treatment

Waiting for an available addiction treatment setting has been cited as one reason why individuals become stuck in inpatient hospital unit after they no longer need hospital level care. According to the MHA/Wilder study, 11 percent of potentially avoidable days were due to a lack of availability of addiction treatment settings.[4] The Formulation Team suggests the Task Force support efforts to reform Minnesota's addiction treatment system.

[4] *Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot*, 1.

L. Adopt Previous Recommendations on Discharge Planning

Transitions to Community

The Transitions to Community Initiative is a grant program that pays for services not otherwise covered by a waiver to help an individual successfully transition out of AMRTC or St. Peter. As of March 2016, 99 people were transitioned out of these facilities: 65 from AMRTC and 34 from St. Peter.[5] Transitions to Community could be expanded to include community hospitals; there have already been successful pilots with certain hospitals. Individuals eligible for the expansion are in community hospitals, on the AMRTC waiting list, and with necessary resources, could return to the community without treatment at AMRTC. Legislation authorizing this expansion was introduced in the 2016 legislative session but did not pass.

RARE

The Reducing Avoidable Readmissions Effectively (RARE) campaign worked to lower hospital inpatient readmissions. A RARE campaign work group released a report with recommendations for mental health and substance use disorders. There are five areas that influence readmission and affect successful transitions of care, each with a number of recommended measures specific to mental health and substance use disorders. The five areas are:

- Patient/Family Engagement and Activation
- Medication Management
- Comprehensive Transition Planning
- Care Transition Support
- Transition Communication[6]

The Formulation Team encourages the Task Force to adopt the RARE recommendations for transitions of care.

Additional discharge planning recommendations are also suggested for consideration by the Task Force.

Culturally-sensitive discharge planning

Discharge planning should include tribes and racial, ethnic, cultural providers to ensure individuals identifying as members of these communities are connected with services relevant to their experiences and traditions. Culturally-relevant care is key to recovery. Improving discharge planning can be included in the Cultural Lens Formulation Team work on culturally-sensitive care.

County involvement in discharge planning

Counties are very interested in increasing their involvement in discharge planning and doing so from the point of an individual's admission to an inpatient hospital unit. Examples of early involvement include a pilot project that placed a social worker Navigator in hospitals to work with people and begin discharge

[5] *Transition to Community* (St. Paul: Department of Human Services, State of Minnesota, March 2016), 2.
[6] *Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders* (St. Paul: Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health, October 15, 2012), 1, 9-10.

planning soon after admission. There are also county liaisons with AMRTC who are able to work with AMRTC, county social workers, and the individual at AMRTC to plan the discharge.

II. Discussion of Increasing Anoka Metro Regional Treatment Center Bed Capacity

Members of the Inpatient Bed Capacity and Levels of Care Transition Formulation Team encourage the Task Force to discuss whether increasing bed capacity at Anoka Metro Regional Treatment Center is a feasible response to the current bed capacity situation.

AMRTC is licensed for 175 beds. However, due to physical plant capacity and staffing, the current operating capacity is 110 beds.

Community hospitals, particularly those with inpatient psychiatric units, are feeling intense pressure about inpatient bed capacity. This pressure is particularly felt with respect to individuals who are under commitment and in a community hospital waiting for care at a state-operated facility. Another set of pressures comes from individuals with complex needs who are stabilized and waiting for discharge to a community setting. As a result of individuals occupying beds while waiting for other treatment, individuals in acute need cannot access those beds, and a backlog is created. One county reported their local hospital has over 50 percent of the patients in the psychiatric unit committed to the Commissioner but unable to access a state-operated bed, either at AMRTC or one of the community behavioral health hospitals (CBHHs). Another hospital reported individuals waiting 150 days or more for AMRTC or CBHH care.

State-operated hospitals also face pressures with respect to individuals being unable to discharge to another setting from the hospital. The Direct Care and Treatment Administration (DCT), which oversees Anoka Metro Regional Treatment Center, the CBHHs, and other state-operated facilities, reports 30-40 percent of individuals currently in AMRTC no longer meet the level of care necessary to receive treatment there. The seven CBHHs have until recently been unable to staff to the level needed for having a full census of 16 patients; legislation passed in the 2016 legislative session to fully fund staff at the CBHHs. In addition, one CBHH in St. Peter will end those services and shift to offering addiction treatment services. Finally, the mental health workforce shortage has made recruitment difficult in all mental health settings, including state facilities.

DCT indicates there would be significant challenges in adapting the physical plant for additional capacity. It would take legislative authority and funding allocation to increase bed capacity at Anoka, a process which can take significant time. It will also take time to hire new staff. In addition, current funding to increase capacity in Anoka relies on double occupation for some rooms. Further pressure beyond this amount could increase risk of aggressive and assaultive behaviors of patients.

Counties are also deeply involved in the discussion. Counties currently pay 100 percent of costs for their patients who do not meet hospital level of care at AMRTC or a CBHH. This cost is often passed along to county taxpayers. Many counties are reluctant to increase capacity in a system with this level of county

payment required. Some counties instead argue efforts should be put towards fulfilling the promise of the CBHHs, which was to provide high-acuity care for people regionally. Many counties also support an increase in community services, which could be paid for in part from county share funds collected.

The discussion regarding increasing bed capacity at AMRTC should also include people living with mental illnesses and complex conditions. In a person-centered and recovery focused system, decisions are driven by the individual. Discussions of whether to increase the capacity of the most acute level of non-forensic care available must include the people who will be most affected by the outcome of those discussions.

III: For Longer-term Consideration

A. Address Financial Disincentives to Serving People with Complex Co-Occurring Conditions in Community Hospitals

One reason that community hospitals are reluctant to treat individuals in the target population is that the reimbursement hospitals receive for the care of people's multiple complex conditions often fails to cover the costs of the care. If community hospitals did not have to take on such a financial risk, they would be more willing to treat people in the target population. There is an opportunity for future collaboration with hospitals to consider strategies for reducing hospitals' financial risks when they treat people in the target population.

Addressing financial disincentives also provides an opportunity to ensure specialty services for individuals living with complex conditions are available, and that staff are appropriately trained to provide these services.

B. Assess the Impact of the Recent Increase in the County Share

The Formulation Team suggests assessing Minnesota's recent increase in the amounts that counties pay to the state for patients at AMRTC and the CBHHS who no longer meet criteria for a hospital level of care. Has the increase driven a decrease in non-acute bed days while maintaining or improving stability in the community? Dialogue can be facilitated among stakeholders about the best ways to drive expansion of community services for people in the target population, including discussion of re-investing county share dollars into community-based services. Currently, counties pay 100 percent of costs for residents who are in a state hospital without meeting that level of care. All of the funds collected go into the state's General Fund, not back to the counties or DHS to invest in additional community services. Re-investing those dollars into community services is one option for strengthening the community-based mental health system.

C. Study "Pipeline" Issues and Explore Improvements to Address Gaps

Many individuals come to hospitals in a mental health crisis from residential settings like adult foster care or IRTS, or even nursing homes, and are admitted for treatment. When they are ready to be discharged, individuals often learn they are unable to return to their previous living situation or treatment setting. Individuals who are receiving community supports like waiver services are already receiving intensive services. What has led them to be hospitalized, and why are they unable to return to their previous situation? This proposed solution can be explored with the Continuum of Care Formulation Team.