Governor's Task Force on Mental Health

DRAFT CONTINUUM OF CARE TRANSFORMATION ISSUE OVERVIEW DRAFT 8/30/16

I. Overview of this Transformation Issue

A. What do We Mean by Continuum?

Minnesota has worked hard to develop an array of publicly-funded mental health services that support recovery. We are working toward transforming this array of services into a "continuum of care," which has four dimensions:

- Complete range of services: We would have services that respond to the entire range of mental health needs of Minnesotans.
- Universal access: The services would be *accessible* to all Minnesotans (awareness of services available; geographic availability; capacity of providers to serve everyone in their service area; accessible to people with disabilities; culturally-specific; etc.).
- Transitions: A person's experience of services would have continuity across levels of care (for example, from an inpatient hospital stay to outpatient services in their community).
- Coordination and integration: The various services that a person receives (for example, health care, income supports, housing, child welfare, and parole) would be coordinated or integrated so that the person isn't faced with conflicting expectations and doesn't have to struggle to put all of the pieces together as he or she pursues recovery.

Our current array of publicly-funded services is not yet a continuum of care because:

- We have defined a range of services but have not allocated funding to make them universally available.
- We have focused most of our resources on treatment and secondarily on recovery/resilience supports. Little has been spent on prevention or early intervention, and almost nothing on wellness promotion. We are thus losing the opportunity to prevent illnesses or address them when they first appear.
- We have focused most of our resources on treatment for the people with the most serious and persistent mental illnesses, which means that many people don't get services until their mental illnesses are advanced and significantly compromising their lives.
- The services we've defined are not available everywhere in the state for a variety of reasons.
- The services are not designed flexibly enough to respond the diverse needs of Minnesotans.
- We have focused on creating a continuum of *publicly-funded* mental health services, but only about one-third of Minnesotans are eligible for these services.
- We have not given adequate attention to the importance of "natural supports"—all the family, friend, and community relationships and efforts that help a person pursue recovery. These supports struggle to fill in the gaps and turn an array of services into a true continuum of care for the individual.

B. Two Focal Points for Work toward a Continuum of Care

Creating a true continuum of care will require a transformation in the ways that we define, deliver, fund, and oversee our mental health services. There are two focal points in this transformational work:

- Widening our understanding of the "continuum of care" to reflect the fact that people's conditions can range from wellness to mental health to mental illness to severe & persistent mental illness. We thus need a continuum of care that is responsive to needs at all of those levels so that we can become radically prevention-focused. The continuum of care comprises not just medical services, but also public education services, public health services, and community support services (like transportation, housing, etc.). It also must include mechanisms to coordinate or integrate with all of the related sectors, including substance use disorder services, primary care, substance use disorder treatment, education, housing, employment, criminal justice, etc.
- Within the mental health services segments of the continuum of care (early intervention, treatment, recovery supports, and crisis response [note—do we want to limit it to that?], create a map toward a continuum:
    - Spell out the minimum or optimum set of services necessary to support recovery, the service-level expectations for each service, the graphic gaps and practical challenges, and the strategies to achieve full access to the service.
    - Identify the integration, coordination, and/or work processes necessary to maximize the impact of the services (e.g., discharge planning, care coordination, case management, data exchange).
    - Lay out the system-wide functions necessary to make the continuum work (centralized assessment and planning where needed, metrics and quality improvement, workforce development, etc.).

The Task Force can't finish this work in the time allotted, but it can lay out what's needed, point to promising models, and suggest ways that the work could be completed.

II. Outline of Possible Topics to be Covered

A. Widening the Definition of the Continuum of Care

1. Population health model: Defining the care system begins with defining and assessing needs of populations. So far we have focused mostly on age: children, adolescents, transition-age young adults, adults, and elderly; and on severity of mental illness (describe the intensity continuum). More recently have looked at more specialized populations, including families with parent with mental illness, ethnic and cultural groups, veterans, LGBTQ, people in the criminal justice system, etc. Other criteria that have been used to define specialized populations are stage of illness (e.g., first episode psychosis) and geography (e.g., rural or frontier populations).
2. Defining the functions of the mental health continuum of care: Wellbeing/Health Promotion, Prevention, Early Intervention, Treatment, Recovery Supports, and Crisis Response. Maybe distinguish between public health functions, healthcare functions, and social service functions and briefly explain how activities are organized in each.
    a. Wellbeing
    b. Health promotion
    c. Prevention

d. Early Intervention
e. Basic Clinical Services
f. Hospitalization and Residential Treatment
g. Community Services and Supports
h. Crisis Response

3. People receiving mental health services live in communities and interact with a variety of natural and publicly-funded supports. We will identify and reinforce the importance of the related systems that collaborate with the mental health continuum of care. Explain relationships, directions, and current projects with each of these:
   a. Natural Supports
   b. Substance Use Disorder Services
   c. Primary Care
   d. Housing
   e. Education
   f. Employment
   g. Transportation
   h. Criminal Justice

B. Defining the Model Service Array

1. Define the services needed to fulfill each of the functions [or, focus on just some functions, if we decide that makes more sense]: wellbeing/health promotion, prevention, early intervention, treatment, recovery supports, and crisis services. For example:

Wellbeing/health promotion	**Prevention**	**Early Intervention**	**Basic Clinical Services**	**Inpatient & Residential Treatment**	**Community Services and Supports**	**Crisis Response**
Public education	Public education	Screenings	Primary care	Inpatient psychiatric care	Assertive Community Treatment	Hotlines & warmlines
	Mental health curriculum in schools	Mental health first aid	Psychiatry	IRTS	CADI Waiver	Crisis teams
			Mental Health Center			Crisis stabilization

2. Set service level expectations for each service.
3. Define geographic regions by which services will be organized and delivered.
4. Identify barriers to achieving the service level expectations, region by region.
5. Summarize best practices in coordination, integration, and work process (e.g., discharge planning, care coordination, data exchange, etc.) to be followed by service providers. This would include collaborating or integrating with related systems:
   a. Natural Supports
   b. Substance Use Disorder Services

   c. Primary Care
   d. Housing
   e. Education
   f. Employment
   g. Transportation
   h. Criminal justice
6. Set the System-level oversight/quality/process expectations
   a. Centralized assessment, periodic forecasting, planning, and oversight where appropriate
   b. Metrics and quality expectations—include discussion of the need for critical metrics that actually drive improvements and the elimination of metrics that do not drive performance.
   c. Workforce development
   d. Collaborating with related systems on policies
7. Figure out some way to show all of this graphically. Could be some kind of multi-dimensional matrix that includes all of the services for all of the populations for all of the regions. Then there is a set of system-level functions that operate across that.
8. We could attempt to identify the most critical gaps for attention. Not sure we could get consensus about this in the time we have.
9. We could attempt to identify funding inefficiencies and parity challenges; not sure we could get to consensus in the time we have.
10. We could also talk about possibilities of streamlining or consolidating service definitions and requirements across services to make the service system less complex. This would be especially appropriate now as we embark on Integrated Services Delivery Systems improvements and other major software overhauls.

III. Scope Statement

The Task Force cannot actually fill in the multi-dimensional "map" laid out above for all mental health services; we just won't have time and the data to do it well. But we could lay out the conceptual framework and what it would take for this to be accomplished. Make sure we frame this work as a dynamic document because circumstances will change and our vision for the continuum will need to respond to these changes. The other transformational work (governance, cultural lens) should also introduce the need for changes to our vision.

IV. Why is this Transformational?

Although the MHAG recommended an approach somewhat like this in the early 2000s, Minnesota has not adopted this approach. Our current approach has been piecemeal—adding services for specific populations and not funding them enough to be accessible statewide. If this approach were implemented, it would provide the legislature with a long-term plan that they could fulfill over time.