Inpatient Bed Capacity and Levels of Care Formulation Team

Governor's Task Force on Mental Health

September 12,2016

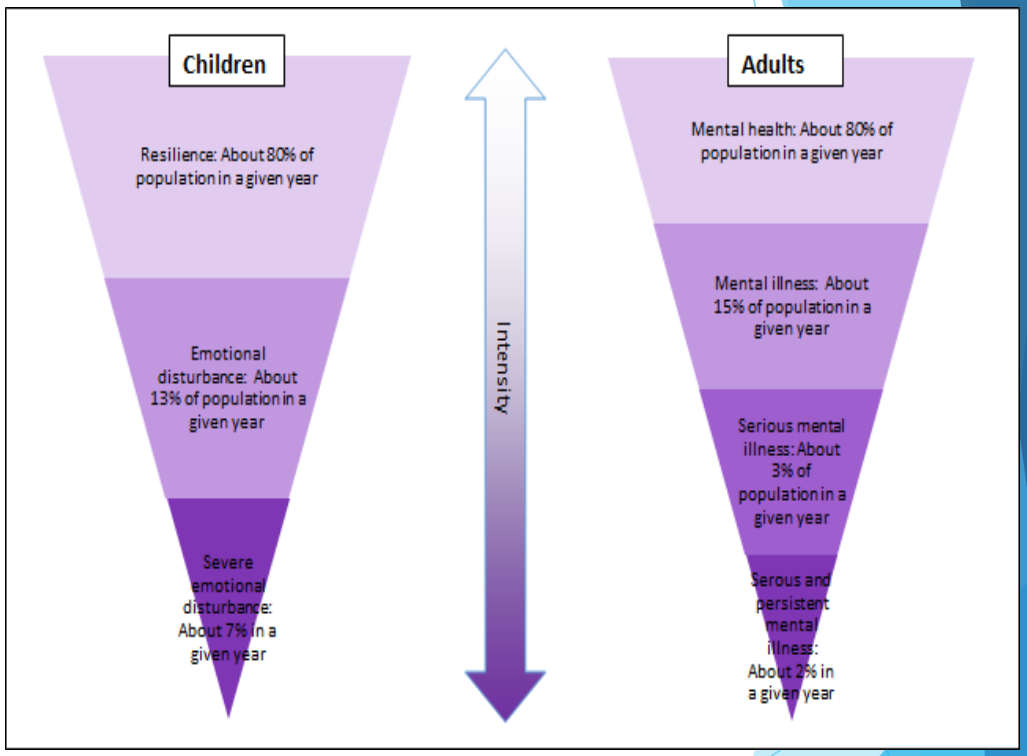
Guiding Themes

- This is a very complex issue
- It is important for the Task Force to coalesce around actionable items that can be implemented within 1-2 years
- Build towards longer-term solutions
- We can't build our way out of the problem

Issue Overview

Who is Hospitalized and Why?

- Children, youth, and adults in a mental health crisis who are at risk of harming themselves or others, or may neglect themselves to the point of self-harm



Purpose of Inpatient Hospital Care

- Like inpatient stays for other medical emergencies, it is to stabilize patients so they can be transferred to the appropriate treatment setting or home to continue recovery.

Civil Commitment

- Decision by a court to mandate treatment for an individual, who is then treated in community or state-operated hospitals. Can also be committed to a less-restricted setting.

Inpatient Psychiatric Hospitals

- Forty-five Minnesota hospitals have non-forensic inpatient mental and behavioral health units for adults and children/adolescents.
- Approximately 1300 beds
  - AMRTC, CBHHs, CABHS not operating at full capacity
  - Community hospitals sometimes take beds offline

Challenges in Inpatient Bed Capacity

Bed Capacity

- There is no agreed-upon number of the “right” number of inpatient psychiatric beds
- The “right” number of beds depends on other available services like ACT, IRTS, crisis, permanent supportive housing
- It also depends on available workforce

Patient Flow

- Front door and back door issues
- Minnesota Hospital Association/Wilder Potentially Avoidable Days Study

Roles and Responsibilities

- Who is responsible for the safety net?
- Providers, state, counties, law enforcement, judiciary, others confused about each other's roles and responsibilities

Possible Options for Action

Guiding Themes

- This is a complex issue
- Actionable items in the next 1 to 2 years
- Build towards longer-term solutions
- We can’t build our way out of the problem

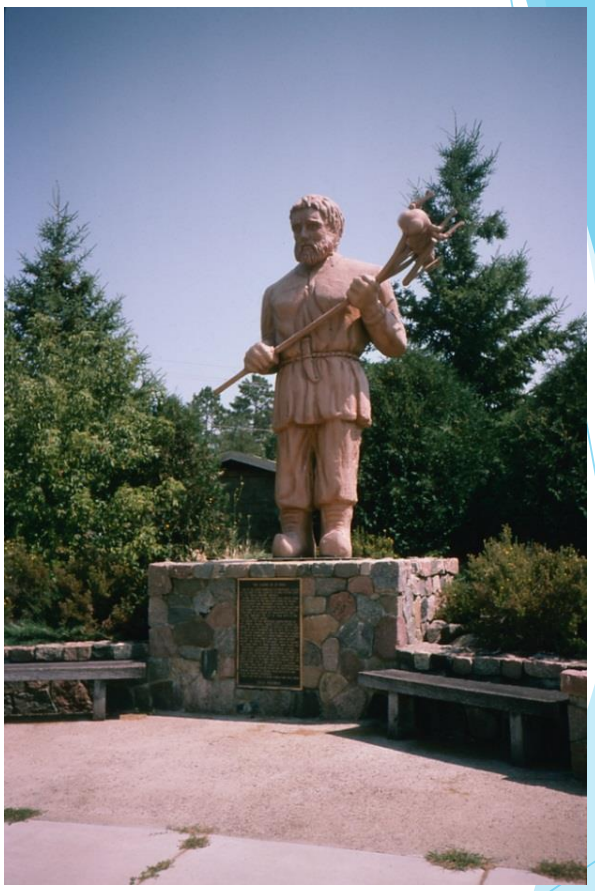
Options for the Task Force's Consideration

- Establish an ongoing body to coordinate and oversee work on inpatient bed capacity
- Increase IRTS capacity
- Consider housing and supports

Options, continued

- Community-based competency restoration
- Civil Commitment, small changes
- Improve local coordination around crisis response

Previous Recommendations



Recommendations in Process

- Person-centered planning
- Strengthen community services
- Reducing readmissions
- Improving care coordination/management
- Improving mental health, substance use disorder, and primary care integration

In Process, continued

- Building workforce capacity
- Streamline and expand competency restoration services
- Discharge Planning/ Transitions to Community
- Improve crisis response

Recommendations not yet Implemented*

- Address financial disincentives to serving people with complex co-occurring conditions in community hospitals
- Assess impact of the recent increase in county share
- Assess state-operated capacity and “safety net” role
- Facilitate regional collaborations around solutions
- Develop metrics to assess problems and track progress

*may be ongoing conversations or occurring at local, but not statewide, level

Questions for the Task Force

- Does this overview present an understanding of the issue?
- What are Task Force members' thoughts on the possible options?
- What options should be added?
- What options should the Formulation Team continue pursuing with additional research and work?