Taskforce Worksheet Responses
(Generalized Qualitative Grouping)

1. **Bed Capacity and Access**
   - Increase bed capacity in state operated services.
   - Create incentives for partnerships that address the capacity crisis (for example, enhanced payments to hospitals or other providers that care for people at the state-operated level of care).
   - Expand capacity for inpatient and community based "beds" along the continuum of needs.
   - Increase bed capacity in state operated services by expanding the multi-disciplinary workforce.
   - Increase accessibility to state operated facilities specifically for inpatient mental health & emergency departments by building more beds/facilities including long term and permanent placements for patients with severe and chronic behavioral health needs, creating a specialized unit and/or building a “fast track” system for patients boarding in community hospital settings.
   - Add capacity at DHS in a variety of service types.
   - Increase the number of beds categorized as Community Behavioral Health Hospital beds. These beds are critical to provide services to mentally ill adults who are most often civilly committed and in rural Minnesota. Community hospitals in most rural areas of the state are not equipped, nor have the specialized resources to serve this population.
   - Increase the number of beds within the Forensic Mental Health Program. Individuals in this program have unique needs that are not served well in other areas of the mental health system. The security, monitoring, and length of treatment are factors that cannot be addressed through other hospitals. FMHP capacity has been overflowing and taking up critical resources within AMRTC. A substantial number of beds in FMHP are needed to accommodate new admissions (including initial evaluations), ongoing placements, and to address the short term needs of former FMHP patients who need to return to FMHP to receive hospital-level health care, as medically indicated. Efforts for expansion should be addressed in all three areas.

2. **Admissions to a DCT facility**
   - Implementation or changes to policy, legislation, or procedures regarding priority admissions. The person who needs the DCT bed the most gets it. Create collaborations between DCT, community mental health providers to provide care while someone is in jail waiting to be deemed incompetent to stand trial. And let's implement the new CR law!
   - Allow all hospital patients who are civilly committed to DCT onto the list for admission to AMRTC, and/or allow a patient from a community hospital to be admitted for every 3-4 patients from jails.
   - The admissions process must clearly articulate the standards for triaging and prioritization of individuals. Agreed upon benchmarks should be established to help guide prioritization determinations as well as guide discussions about where the system continues to fail to meet aspirations. Similarly, the discharge process must consist of understandable and definable criteria so that the process is more transparent and acceptable as evidence of appreciable stabilization. An approachable review process should be agreed upon to allow for reconsideration of reasonably disputed determinations.
   - Refresh the Central Pre-Admissions “Wait List” policies/procedure to be a more sophisticated process which allows patients awaiting hospital or bed placement to be not limited to one wait list, but to allow a triage and bed/facility placement process that is responsive to patient acuity. This should align with DHS’s desire to allow medical triage to influence patient placement. The caveat is that medical triage should not assume a person’s placement in another facility (such as a jail) is “safe” or receiving treatment that they are not. The success of this recommendation will be significantly dependent on an increase in DCT bed access, capacity, and availability.

3. **Right Level of Care at the Right Time**
   - Study and address the gap in assessments where people who do not meet criteria for mentally ill and dangerous are deemed not sick enough for state-operated services and are released back into the community.
   - Change the process for admission decisions to consider clinical needs of patients in jails, hospitals, and state-operated services and the continuum of care available, and how shifting patients from a hospital could free space to care for more patients from jails.
   - Prioritize admissions to state operated programs based on clinical need, not location.
   - Create a 3rd party team for case review of patients in DCT system to increase accountability and transparency. Purpose of this group would be to review patients within DCT system and identify areas of opportunity for expedited treatment/discharge.
   - Prioritize admittance into state operated services by clinical need, not the mechanism they are being referred from.
   - Those with the highest level of need should be prioritized for admission; irrespective of their current location (i.e. hospital or jail). To ensure fairness and equity in this process; however, clear assessment criteria/tools and some sort of due process provision should be incorporated.

4. **Mental Illness Programming and Treatment Changes**
   - Adopt and offer models of care in all DCT facilities that embrace specialty care for co-occurring disorders. All too often patients require transfer from one DCT facility to another to address their co-occurring health care needs (including mental health, substance use disorder, and intellectual and developmental disability disorder). It is widely studied and documented that through providing integrated care a more complete recovery of co-occurring illnesses is possible. Technology may assist in providing specialized care in more remote facilities, or facilities experiencing workforce concerns. Relocating the services to the patient is more efficient and effective than moving the patient to the services.

5. **Mental Illness Treatment in Jail Setting**
   - Require and fund/incentivize mental health care for those in jails, in particular access to medication and the prompt initiation of a Jarvis petition for clients with known neuroleptic medication needs, at the time of the civil commitment petition, as outlined in MN Statute 253B.07. This could include partnerships between jails, local community mental health centers, and DHS.
   - Increase the level of psychiatric support in jails to go beyond strictly medication and provide therapeutic interventions as well.
   - Provide expanded treatment and mental health services in jails.
   - Provide resources to jails so they may be able to safely enforce Jarvis Orders for administration of neuroleptic medication. Most jails are not staffed with the level of nursing needed for the enforcement of a Jarvis Order, and most jails have such a small need for this that staffing in this way is not efficient or even realistic. When individuals are without their neuroleptic medications for any period, the likelihood of psychiatric decompensation is high, often resulting in the need for hospitalization. Options to be made available to jails include: (1) State funding should be offered to jails so they may contract with a medical provider to provide 24/7 access to services (nursing, etc.) to administer neuroleptic medications under a Jarvis Order and (2) State response teams should be developed using medical expertise to provide on-site response to jails that do not have medical resources to enforce Jarvis Orders. This option may be essential for remote, smaller, or jails with infrequent need or a lack of local medical resources.
   - While capacity is being built out at state facilities, a regional pilot project should be created to ensure that individuals in jail, awaiting placement in a state facility, can get the necessary treatment jails can reasonably provide. This pilot project would require funding to allow for additional capacity in select regional jails, the creation of a diagnostic team inclusive of medical and mental health professionals, and incentives for smaller

counties to transport this population to a regional pilot project location. There should continue to be a reasonable time benchmark for placement.

6. **Work Force and Staff Development**
   - Support workforce development for mental health workers by offering scholarships for education to build the future workforce, increases in pay for those already in the state's workforce, and providing "emergency" pay bonuses to mental health workers in high acuity settings outside of state-operated treatment centers until reimbursement rates increase to a point that higher wages are sustainable from organizations' own budgets.
   - Study attrition in jail and mental health workers (Why exactly are individuals leaving this field and what might have helped them stay?) and incorporate workforce strategies to address burnout for both jail and medical staff.
   - Provide comprehensive training and ongoing education for direct care providers in community mental health settings and group homes on topics such as mental health symptomology, behavior management, de-escalation, early intervention, etc while also increasing wages to encourage longevity and investment in the field.
   - Increase training, technical assistance, and on-site supports to improve workforce abilities. Working with individuals with complex needs requires specialized training and support, and all too often we rely on a workforce that is under-trained and under-paid. To broaden the ability for people exiting hospitals to live successfully in the community, more training and supports are needed for the workforce that cares for them. Themes are present among many individuals discharging from facilities like AMRTC or CBHH's, and the workforce could greatly benefit from more training, technical assistance and on-site supports from expert teams. The following categories were identified by a DCT/County workgroup as themes: trauma-informed care, legal/forensic services, emotional dysregulation, cultural-specific supports, traumatic/acquired brain injury, vocational services, and more.

7. **Funding**
   - Expand state operated preadmission services to include mental health providers and liaison workers to triage referrals and assign workers to assist with placement and diversion.
   - Incentivize hospitals, jails, and outpatient programs to provide competency attainment services.
   - Redirect funds collected from counties for the AMRTC per section 246.54 from the bottom line of the general fund to jail and hospitals boarding high needs patients waiting for state-operated services.
   - Bolster funding to create more secure treatment spaces in hospitals or other providers to support higher need patients who may pose a risk to staff and patients.
   - Permanent funding mechanisms for providers to develop and maintain services to support behavioral health needs.
   - Expand funding for voluntary engagement services.
   - Complete the Behavioral Health Provider Rate Study and consider legislative proposals for funding to add capacity to a variety of community provider types across Minnesota.
   - In the meantime, add funding to the Acute Transitions Team in DHS to build a tracking sheet of patients needing to be transitioned out of hospitals and into other community settings and to offer counties and providers needed investments in buildings and staff to allow them to admit these patients.
   - If funding is needed to implement changes to the priority admissions process, provide suggestions of where funding shall be focused to best effect change. Increase funding for community providers so that they can serve more people who have complex needs.
   - Seek federal authority and federal funding match (FFP) for providing services to address social determinants of health needs - housing, nutrition, transportation, care coordination/ engagement, etc.
   - Seek the ability to cover services to help folks being released from incarceration connect with services, as much as 90 days before release, under Medicaid.
   - Establish infrastructure building allocations that are available to counties to develop innovative, local, and specific solutions for serving individuals being discharged from the Forensic Mental Health Program. Utilizing

the AMHI structure for these allocations, which should be voluntary for AMHIs or counties to opt-in or opt-out, would be a potential funding pathway. This could be funded by returning 100% of the county-share of Does Not Meet Criteria days that are currently paid by counties to the state's general fund for days patients are in a state facility and do not meet medical criteria for hospitalization. This county cost is unique to Minnesota and was enacted to incentivize counties to expedite discharge of individuals from state facilities. With over ten years of data showing that the ability for an individual to be discharged from a state facility to the community is not fully within the control of the county (there are often many factors), this cost share should be stricken from law. Additionally, the funds contributed by the county should be returned to the county to develop community capacity. This would be one potential funding source for building infrastructure.

- Fund voluntary engagement services designed to get people the help they need to avoid hospitalization or incarceration.
- Provide permanent, stable, sufficient funding for providers to develop and maintain services to support behavioral health; thereby expanding the mental health workforce to ensure systemic capacity to care for all without extended wait lists unnecessarily delaying needed care.

8. Community Services (non-DHS/DCT operations)

- Fund state programs to provide enhanced services in the community such as consultation teams, outpatient services, and diversionary support.
- Increase reimbursement rates for community hospitals who are boarding long-term patients and/or offer flexible funding for patients who are challenging to place.
- Increase number of flexible/secure IRTS settings & invest in sustainability in community settings by authorizing higher rates.
- Implement early intervention & community outreach programs for patients identified in diversion process before involvement in civil commitment process.
- Additional ways to meet the treatment needs of those referred to and waiting priority admissions as well as other individuals in the community who require treatment at state-operated treatment programs.
- Get MA to pay for locked IRTS facilities. It's not that people need state operated programs they need more secure settings for longer periods of time. Create those.
- Increase capacity to discharge clients ready to move from inpatient/ acute care by: Improve outpatient FFS Medical Assistance rates to accommodate living wages: (1) Increase our RBRVS system to Medicare rates and align MN's RBRVS with Medicare, (2) Geographic Practice Cost Indices (GPCIs) - Implement regional adjustors that increase or decrease RVU factors based on assumed regional cost differences, (3) Conversion Factor - Implement GPCI-adjusted RVUs multiplied by base dollar amount to calculate total reimbursement, (4) Policy adjusters -Similarly to the RBRVS, implement policy adjustors to recognize difference in resource use for some provider types, services, and/or settings by adjusting the relative values or RVUs that are applied to the base dollar amount, (5) Transition non-CPT-based services to tier one, including services billed with a CPT code but not paid under RBRVS and those services currently billed with a non- CPT code but that could be converted to a CPT code, and (6) Streamline behavioral health services billed under HCPC H or S codes.
- Minnesota should continue to reform policies that promote the development of innovative housing models for individuals with mental illness and/or complex behavioral needs. (1) Funding and licensing models for housing and residential-based care can be highly complex. How Minnesota's Unitary Residence and Financial Responsibility Act (Minn. Stat. §256G.01-.12) is applied in each situation creates additional considerations that counties must make as development of such housing models or use of public funding are often influenced or decided by local governments. As housing policy blends with treatment and service policy, there are some models that are more likely than others to be accepted by local governments, due to the likelihood of high service need individuals moving into certain counties and therefore the local government becoming financially responsible for many of their services and cares. In many instances, the use of "excluded time" language has mitigated many of the concerns in these scenarios. Further consideration of "excluded time" designations with services may give local governments confidence to consider expansion of housing

and services for individuals with complex needs. (2) Minnesota has continued to make progress with the state's Olmstead Plan, which has resulted in improved quality of life for people with disabilities. However, a lack of community housing or placement options for individuals leaving state hospitals or facilities has been a reality that many are working to resolve. Many of these individuals also have disabilities to consider when looking at housing options. There are times when the goals of these two efforts appear to be at odds, or there is a lack of technical understanding as to how to navigate them successfully. For example, the concept of a mid-to-large scale housing development (apartments with leases) for adults with mental illness could be designed where it is financially feasible to incorporate specialized 24/7 staffing available to individual tenant's clash with the state's Olmstead plan as it generally is not viewed as an integrated setting. DHS should enhance technical assistance and funding opportunities to developers and local governments about how to expand housing options that provide housing and services that meet the clinical and behavioral needs of individuals with complex needs.

- The state should expand their Community Supports Services/Synergy team. The expertise of this team is needed with many more individuals than its current capacity can manage. This team begins their work with individuals while hospitalized and assists with the transition to community-based placement by providing on-site support, technical assistance, and training to the support teams in the community to assure a successful transition.
- Improve long-term community placement options/resources to help resolve the flow problem in state-operated and hospital/ER programs. This may include targeted expansion of DCT programs, incentivizing and supporting private providers in serving these populations, and resolving the locked/secure IRTS issues.

9. Community Mental Illness Crisis Management

- Any other thoughts, suggestions, or requests to address the impact of priority admissions to the state, county, or treatment programs. Earlier intervention would help - meet people's needs before there is a crisis - like with voluntary engagement
- Invest in EIDBI services and others that work with parents to know how to support their high-needs children without hospitalization.
- Mandate comprehensive mental health training for community law enforcement as well as officers within jail system to be provided by mental health providers from local community providers, hospital, etc.
- Grow our community-based services to build the continuum to prevent escalation to needing inpatient and/ or discharge to 'step-down' residential and outpatient care.

10. Statute Modification

- Modify the 48-hour rule to allow the hospitals who now have patients stuck in them to also access DCT services.
- Initiate involuntary medication procedures at the time of commitment when someone lacks decision-making capacity to reduce delays in treatment.
- Remove "duplication of service" statutes that don't allow patients to have ACT teams while living in group homes, being on CADI, etc.
- Implement Medical Assistance-covered court-ordered treatment.
- The qualifications necessary to be a Rule 20 examiner must be examined and a robust certification program should be implemented to ensure timeliness of reports and quality of the exams and reports. There has been difficulty getting timely Rule 20 evaluations, resulting in delays in the process and in receiving necessary health care. Additionally, concerns about the quality of reports are increasing. Simply, the pool of qualified examiners is not large enough to address the need in the state and steps need to be taken to address current barriers. (1) Examiners should have to qualify through a robust certification process that ensures an examiner is qualified to give an expert opinion in the area. The process must be more than a review of applicable standards or review and should mirror certification programs in other jurisdictions. With a robust certification program, licensing requirements can be reconsidered. To increase the pool of trained examiners it is recommended that additional professional licensures be allowed to provide examinations with the

expectation that they have received the required certification on the topic area. (2) Reimbursement rates for these examiners should be increased as many private examiners have opted to no longer provide the service due to the rate not being commensurate with the time to complete the examination and the associated liability that the examiner holds. Any reduction in private examiners will increase the responsibility of the state to provide examiners, who are already backlogged.

- Minnesota should expedite a Section 1115 Medicaid Demonstration Waiver application to allow incarcerated individuals to access to proper health care in jails and begin active consideration and evaluation of submitting a Section 1115 Medicaid Demonstration Waiver to update Medicaid's prohibition on paying for mental health treatment delivered in institutions for mental disease. (1) **"**The Social Security Act, Sec. 1905(a)(A) prohibits the use of federal funds and services, such as Children's Health Insurance Program (CHIP), Medicare and Medicaid, for medical care provided to 'inmates of a public institution." While this language was intended to prevent state governments from shifting the health care costs of convicted prison inmates to federal health and disability programs, it has an unintended impact on local jail detainees who are in a pre-trial status and have not been convicted of a crime*." (excerpt from Naco.org website)* Minnesota has not yet submitted a Section 1115 Medicaid Demonstration Waiver unlike many other states in the nation. The federal government has encouraged states to propose innovative Section 1115 waivers that will expand coverage, address whole-person care, work to reduce health disparities, and address topics of special interest to states. Many states have submitted waivers, and some have been approved, Minnesota should look broadly across the nation to learn from the states that have already submitted waivers. States such as California or Washington have received approval for their waivers which allow incarcerated individuals access to certain health care services up to 90 days prior to release from incarceration. Oregon has submitted a waiver which is currently pending approval, requesting adults and youth who are incarcerated and committed receive Medicaid benefits for the duration of their commitment. And (2) The same federal act prohibits Medicaid to pay for care in Institutions for Mental Disease (IMD), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. This federal law prohibits paying for medically necessary psychiatric care based on the size of the facility, not the type of medical care that can be provided. In a time where workforce, access, and clinical expertise are all in short supply, we should be considering how we design systems to treat mental illness like any other health condition. It is recommended that Minnesota consider applying for a waiver from the federal government to allow for short-term stays in psychiatric hospitals regardless of size, so that we may expand access to psychiatric beds and leverage expanded models of medical care that are more efficient and responsive to today's workforce shortages and access needs. Currently, 18 other states have applied for a waiver from the IMD payment exclusion and have been approved or are pending approval.

11. Changes to Forensic Mental Health Program

- Revise discharge criteria at the Forensic Mental Health Program in St. Peter to allow medical discretion, rather than the Special Review Board, courts, and counties. Similarly, allow those committed MI&D to be revoked to settings outside of FMHP, when appropriate, based on individual needs and circumstances.
- Reduce delays attributable to forensic mental health (MSH) by reducing length of stay, change conditional discharge processes, and allowing different providers to serve the population when appropriate.

12. Changes to Competency Restoration

- Implement competency restoration.
- Support key recommendations coming out of the Competency Restoration Task Force and resource the recommendations swiftly so that systemic relief may be felt. The Competency Restoration Task Force extensively reviewed the systems relating to individual caught up in both the mental health and criminal justice systems. The number of recommendations make outlining them in this document unrealistic, however, this task force should review those recommendations for areas of agreement and achievability. Such key recommendations should be supported and implemented.
- Fully implement the new competency restoration law

13. **Physical Plant/Infrastructure**
    - Recognize that, while we as a society do not want to return to institutionalization practices that existed prior to the deinstitutionalization movement, there are some individuals who need long-term and even lifelong care in state-operated services, and these individuals are instead cycling between homelessness, hospitals, treatment facilities, and jails. In addition to expanding capacity for state-operated services such as those delivered at AMRTC, we need to create a space like AMRTC that is designed for long-term care for our patients who cannot live safely in any environment that currently exists in our community.
    - Additional investments in our hospital infrastructure should be considered to allow hospitals to staff and handle patients who end up "boarding" in hospitals.
    - stablish a new level of service for residential beds that exists between hospitalization and long-term community placement for individuals that require an extended level of psychiatric treatment and have security or behavioral needs. A "secure IRTS" model has been explored, but the private provider community is not stepping into this space due to funding, liability, and clinical model concerns. The state should develop and provide a level of service in this space which provides secure, extended treatment and care for a length of time up to 6-12 months. Individuals having success in a setting like this would undoubtedly provide some confidence for private community providers to accept them into their homes for long term housing.
    - Make sustained investments into our community-based behavioral health system to build or maintain infrastructure for services - mobile crisis response, children's and families, mental health support services in housing, etc.

14. **Changes to Internal DCT Processes**
    - Hospital systems must have a transparent process for Utilization Management and Review, which is a process that evaluates appropriateness and medical necessity of treatments and facilities provided to patients on a case-by-case basis according to CMS standards. In concurrent utilization management review models (similar to what DCT does), the patient's progress, prognosis, treatment plan, and other data are reviewed to determine if the individual does or does not meet criteria to remain hospitalized. In many hospital systems, this is completed by a third party as a form of quality assurance. In the current DCT system, this is conducted by DCT employees, most often mental health professionals. It is recommended that the state consider contracting with a third-party to conduct utilization reviews and reassign the high-demand mental health professionals to fill the numerous MHP vacancies in the DCT system. This recommendation achieves three goals: (1) reducing the possibility of a conflict of interest (the state determines when a person no longer meets criteria for hospitalization, triggering a financial responsibility in which the counties must pay the state for cost of care for any days remaining in the hospital), (2) achieving higher quality of care through assurance of the most effective treatment and better data, and (3) utilizing current state employees to fill vacancies due to workforce shortages.
    - Reduce administrative reporting burden - excess assessments, data reporting, administrative documentation - that does not provide clinical utility or benefit the clients allow licensed clinicians to exercise their clinical discretion in treatment: (1) Eliminate level of care assessments requirements, (2) Remove added narrative requirements to treatment planning, and (3) Reduce required frequency of reporting and updating assessments, records and planning documents.

15. **Other**
    - Ask the Acute Transitions Team in DHS to also identify systemic issues they find in their work and to develop proposals to address them – such as, county reluctance to offer rate exceptions for high-needs patients; lack of funding for bariatric equipment; unclear guardianship responsibilities; lack of eligibility determination for MA.
    - Allow patients to be on more than 1 list for state operated services at a time.