Governor's Task Force on Mental Health

CRISIS FORMULATION GROUP

Background Document

Updated for 9/26/16

Staff contact: Benjamin.Ashley-Wurtmann@state.mn.us

Prior Workgroups/Recommendations[1]

Rural Health Advisory Committee's Report on Mental Health and Primary Care (2005)

- Promote mental health emergency quality improvement projects in Critical Access Hospitals

Mental Health Acute Care Needs Report (2009)

- Create a single treatment plan across all service categories
- Uniform data practices, including release of information
- Standardized intake for IRTS (Intensive Residential Treatment Services) and ACT (Assertive Community Treatment)
- Expand Crisis Intervention Team (CIT) training for law enforcement and dispatch staff to cover all regions of the state and require that CIT be incorporated into day to day operations.
- Streamline barriers and approvals on weekends and nights for short term alternative service assessment at emergency departments regarding risk level, crisis bed access, funds for temporary housing and medications and on-line access to apply for Medicaid.

Offenders with Mental Illness Report (2015)

Recommendation	**Status**
Sustainable payment rate for mobile crisis	Will be included in the rate study commissioned by 2015 Legislature, report due January 2017.
Require private insurance to include crisis response as a benefit	State defined crisis as a potential emergency service, putting it on similar footing with physical emergency care.
Develop uniform service standards and training.	In process. Stakeholder meetings and planning are taking place at a finer level of detail than the formulation group is likely to operate.

[1] Selected recommendations, based on closest relevancy to crisis services.

Recommendation	Status
Training and protocols for how mobile teams work with law enforcement and other responders.	On the table as part of the standards redesign process.
Single statewide phone number.	Funded in 2015, will be piloted in metro area first. Available technology has limitations in serving both land lines and cell phones.
GPS assisted dispatch for crisis teams and location monitoring.	On the table as part of the standards redesign process.
Clarify statute to indicate crisis teams can be dispatched in addition to law enforcement and/or other responders.	On the table as part of the standards redesign process.
Address rate issues for room and board in residential crisis.	Will be included in the rate study commissioned by 2015 Legislature, report due January 2017.
Create sustainable funding for mental health urgent care services. Consider connecting urgent care to existing resources like detox or hospitals.	Some projects exist, but we do not have a plan for wider replication.
Integrate mental health and crisis de-escalation into required annual “use of force” training. Integrate basic education on mental health into educational coursework required for new officers.	
Develop a Peace Officers Standards and Training (POST) model policy for responding to mental health crisis.	
Establish discharge teams in jails (supports for medication access, housing). Improve county social service collaborations with jails, including faster assessment so that diversions can be done in a timely fashion.	

Current Work

Standards for Crisis Services and Providers

Minnesota made substantial investments in the startup and operation of Mobile Crisis in 2015, and is on track to have 24/7 mobile response throughout the state by January 1, 2018. As the increased allocations are becoming effective and teams are added or expanding, disparities in service models have become more apparent. This need was anticipated in the funding language from 2015, directing the Commissioner to “establish and implement state standards for crisis services” (§245.469 Subd 3.3).

Variations in how people access the service can discourage people from calling in, and create challenges for other responders, including law enforcement. DHS has been working on this area already, and has opened a stakeholder feedback process to take a very detailed look at these issues. Key issues under discussion include:

- Standardizing expectations and criteria for dispatching mobile crisis response
- Promoting better collaboration between rural hospitals and mobile crisis teams
- Realigning standards for who may authorize a transportation hold, so that more of this work is done by mental health providers
- Improving training for crisis teams, including broader offerings from DHS

Mobile Teams and Residential Stabilization Expansion

In 2015, Minnesota invested $8.6 million for the next biennium into improved crisis services for children and adults. This includes a charge to revise and strengthen service standards, as detailed above. Highlights include:

- Funding to establish "one number" access. As above, this will first be done as a pilot in the metro area. Currently available technology limits our ability to accurately reroute calls from both cell phones and landlines.
- Phone based consultation for teams serving individuals in crisis who also have co-occurring intellectual disabilities or traumatic brain injuries.
- Crisis services defined as "emergency service" for the purpose of private insurance coverage. Invokes parity requirements to cover to the same degree as emergency services covered for physical conditions.

Provides start-up funding to expand crisis residential services for adults and requires DHS to develop recommendations for children's mental health crisis residential services models that don't require county authorization or a child welfare placement

With this funding, DHS awarded $500,000 for start-up costs to expand Adult Residential Crisis Stabilization (RCS) statewide. These grants provide funds for start- up costs for a 6 bed CRS program in Itasca County and three new IRTS programs which will include RCS beds in Sherburne, Scott and Hennepin counties. We expect that the addition of these 12 beds will be completed by July 1, 2017.

Children's Residential Crisis

The 2015 Legislature gave instructions for the Department of Human Services (DHS) in consultation with stakeholders to develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. In June 2016, the Department of Human Services, Mental health division published a Professional Technical Request for Proposal (PTRFP) to contract with a qualifying vendor to conduct a study on funding around this benefit. A vendor has been selected and are currently in the contracting phase.

The duties for the contract are to research and interpret best practices including researching other state's coverage for children's crisis residential services. Research will include state laws, literature search and other related research to inform policy and standards around treatment coverage such as funding, staffing, eligibility criteria and overall oversight. Research on funding models would include state Medicaid plan and private insurance, particularly on room and board to inform any research around this level of care, cost effectiveness, quality and outcomes. Conduct surveys and interview key stakeholders and providers to define problem, identify barriers and level of care needed. Facilitate and coordinate stakeholder meetings under the guidance of the children's mental health division. Identify topics for each meeting such as crisis models, target population, licensing and certification, authorization authority, review interviews and research. Submit final report of recommendation to the Department of Human Services by June, 30 2017 with a summary of research findings, meetings, interviews and other sources included.

Recommendations submitted to the department's mental health division will be used to inform establish children's mental health crisis residential services without requiring county authorization or child welfare as a new benefit with Center for Medicaid Services (CMS) approval.

Models In Use or Exploration

Northwestern Mental Health Center[2]

Task Force member Shauna Reitmeier recently presented to a stakeholder workgroup on crisis standards. The focus was on two collaborative models they have established in a very rural area.

Northwestern Mental Health Center has sought agreements between themselves and Critical Access Hospitals (CAH.) These are rural, 25 beds or under. Northwestern provides clinic based services, such as outpatient therapy. Many people are already getting their primary care at a clinic that is a part of the CAH. Both providers and clients benefit from ease of accessing multiple kinds of care from a single site. Better care of mutual clients, and opportunities for joint system engagement. In crisis situations, mental health staff are on site, and can offer consultation.

Alternately, the NWMHC has developed mutual agreements to provide crisis services through onsite and telehealth arrangement. Biggest telehealth challenge: telehealth can be tricky to implement with various technological interfaces that need testing, overcoming negative early experiences. Develop a detailed plan and chart out responsibilities: build predictability into the system wherever possible.

- When does the hospital call? How much lead time is needed to get set up and connected?
- Remote clinicians has access to nurse's/hospital staff to send them back to the patient room when done working with client, so the person isn't left isolated.
- Mental Health Professional makes recommendations, physician/attending provider on site makes final determination. This complies with federal regulations on emergency medicine. In practice, the process is very collaborative and physicians are very open to the input.

[2] Thank you to Shauna for corrections. This version is clarified from an earlier version.

CentraCare[3]

CentraCare is in process to establish telehealth for psychiatric consultation to the emergency rooms of the smaller hospitals in its system. Mental health staff would be based at St. Cloud. Hiring the needed workforce has been a challenge, especially to get 24/7 coverage. CentraCare participates in a regional planning effort, including law enforcement, county health and human services, and Central Minnesota Mental Health, the local community mental health center. They are exploring further improvements, including urgent care for mental health that would be co-located with physical urgent care.

Urgent Care For Adult Mental Health (East Metro Mental Health Crisis Alliance)[4]

This project originated in discussions hosted by then Attorney General Mike Hatch in 2002, regarding the increasing problem of individuals experiencing long waits (boarding) in emergency rooms. Stakeholders continued this conversation about how to reduce ER and in-patient volume through appropriate diversions. In 2009 Ramsey County sought a solution that would consolidate several different crisis services under one roof and worked with the Alliance partnership to develop the Urgent Care for Adult Mental Health.

The Urgent Care for Adult Mental Health combines Rule 25 (chemical dependency assessment), withdrawal management, crisis response services (mobile and walk-in), crisis stabilization services, and urgent access to psychiatric service. Prior to combining these services, the Ramsey Crisis team served about 900 people with face to face services via mobile response. After, they served about 600 people through mobile services and 900 through walk-in care.

The Urgent Care has successfully combined many different chemical and mental health emergency services under one roof, leading to better collaboration and care. About 20-35% of urgent care clients would have gone to the emergency room if they hadn't been able to access care there. However, overall volume at the ER is still rising, indicating that there are still significant unmet needs.

As a county delivered service, there are strong connections with other county delivered programs. However, integrating care with other health systems and showing cost savings can be a challenge because the Urgent Care is not fully integrated in to a larger health system, such as primary care. Better alignment of incentives with other payers and providers could expand the use of this model.

Hennepin County Acute Psychiatric Services (Psychiatric ER)[5]

Since 1971, HCMC has operated the Acute Psychiatric Services (APS) unit. Initially designed to handle walk-in clients and referrals from other parts of the hospital, APS has expanded services and operates a dedicated psychiatric emergency room with 14 rooms. The waiting room is recently remodeled, and is a more calming and de-escalating environment than a general ER. Walk in clients present with a variety of needs, particularly medication refills if they have lost access elsewhere or are not yet established with another provider. HCMC has made the deliberate choice to use psychiatrists and other prescribing

---

[3] Thank you to Dave Hartford for providing information and feedback.
[4] Thank you to Roger Meyer for providing information and feedback.
[5] Thank you to Megen Coyne for providing information and feedback. This summary was sent back for corrections, but we have not been able to reconnect. Any corrections will be put in the document for 10/17.

providers to perform the psychiatric evaluations, another common service. While this has costs, they see a lower rate of in-patient admission because they are able to address more potential concerns in the assessment process. Many individuals present with a "simple" evaluation, but their more complex needs emerge as they talk with the providers.

APS is capable of handling high acuity: individuals with recent assaultive behavior related to a crisis or individuals with medical needs in addition to their mental health. The presence of security personnel on site and that a portion of the APS unit is secured means that law enforcement can expect a 7-9 minute turnaround when bringing an individual to APS. Rooms for acute clients are physically designed for safety.

Other collaborations help address related needs. HCMC staff push into the jail, to provide higher levels of treatment than could otherwise be delivered. While APS has a fairly high intake threshold for aggressive behaviors, some individuals are most appropriately housed in a corrections setting. APS also offers nursing homes and other community settings a guarantee that they will readmit an individual discharged to that setting but whose needs escalate. This is helping to build trust and create more discharge options, but significant needs remain. Backups in the in-patient unit tend to push back into APS, and then the Emergency Department, which can lead to patient boarding. Director Megen Coyne identifies increased collaboration as a key priority: HCMC and connected systems have both needs and resources all over. Building trust and communication among departments and programs makes it possible to harness the right resources at the right time to deliver the best outcomes to clients.

Range Mental Health Wellstone Center[6]

The RMHC Wellstone Center for Recovery is a community-based program designed to assist adults experiencing a mental health crisis or emergency. The program offers individualized services that meet the unique needs of those being served and is staffed around the clock by highly trained mental health practitioners and skilled nursing staff. Each resident has a private room. Most insurances, including Medicaid, is accepted.

The program utilizes evidence-based, recovery-oriented services including:

- Individualized Assessment and Treatment
- Psychiatry Medication Management
- Onsite Diagnostic Assessment
- Onsite Alcohol and Drug Assessments (Rule 25)
- Illness Management and Recovery
- Integrated Mental Health and Substance Abuse Program
- Family Psychoeducation
- Holistic Skills Training focusing on Prevention, Wellness and Self-Care
- Discharge Planning and Referrals to ongoing/follow-up services and resources

[6] Adapted from materials provided by Kim Stokes. The Wellstone Center is a great example of our residential crisis model.

Admission Criteria

- Experiencing a mental health crisis
- Minnesota resident
- Between ages 18 and 65
- Medically stable
- No imminent danger to self or others
- No substantial alcohol/chemical impairment
- Comply with a medical screening
- Bring a two-week supply of prescription medications in bottles

Admissions are taken 24 hours a day, 7 days a week, 365 days a year. The Mobile Crisis Team began in September of 2014 as an additional service out of the Wellstone Crisis Stabilization Center. The mobile crisis team serves adults and children, seven days a week. The mobile crisis team provides an on-site assessment at a common entry point in the community to persons experiencing a mental health crisis.

The geographic area served is Northeastern Minnesota. This area includes Northern St. Louis County, Koochiching County, Lake County, Cook County, and within the vicinity of the three tribes including but not limited to Bois Forte and Nett Lake.

Beltrami County Jail Diversion Program

Funded with $2M in one time startup grants in 2015, Beltrami County is designing programs to address the mental health needs of individuals who come into contact with law enforcement. The county is required to show sustainability for the services and provide integrated care. This funding has supported the development of an Assertive Community Treatment (ACT) team, and the hiring of a project coordinator to represent the interests of Tribal Nations in the development of new services. This project may also include the development of Intensive Residential Treatment Services (IRTS).