

Governor's Task Force on Mental Health

CONTINUUM OF CARE PROBLEMS AND SOLUTIONS DOCUMENT draft as of 9/22/16

At the September 12 Task Force meeting, the Continuum of Care Formulation Team received encouragement to move forward with the characterization of the Continuum of Care and recommendations that would follow from that characterization. This document proposes a general logic for the “Continuum of Care” section of the Task Force report.

The Task Force is committed to designing a continuum that meets the needs of children and adults with mental illnesses, families, and communities. As Shauna Reitmeier pointed out at the September 12 meeting, this means that we have to address two levels simultaneously: the micro level to understand the experience of people going through the system, and the macro level of designing an overall system that will work for people and be sustainable, meet federal and state law, etc.

I. Starting Point: People, Families, Communities (micro level)

From presentations, we've heard that people served by the mental health system want these things:

1. That the general public has an understanding of mental health and mental illness so that reactions and decisions aren't made based on stigma. So people know what they can do to maintain their mental health and wellbeing, and they know what to do or where to go if they want to engage in wellness/prevention activities. They also understand when their experiences might go outside the norms of sadness or worry or creativity and might be the emerging symptoms of a mental illness.
2. People know enough about the mental health system that they know where to go to learn more when they need to, and where to turn for help.
3. That there's a place to go and people to help when people first need help, rather than waiting until people are really sick.
4. That those helping places should be responsive to their individual and cultural backgrounds so the help makes sense to them. And that the help must be flexible—in how it helps, over time, where it's provided, etc. People want options.
5. That the relationship between providers of services and those receiving them is paramount to the success of the help and that both parties need to support strong, trusting relationships. This requires that providers understand people's personal and historical backgrounds and that they understand the role of trauma, and the need for healing from trauma, in order to avoid mental illness.
6. That the person is engaged in their treatment planning and it is related to their personal goals.
7. That the services should be person- and family-centered—i.e., that the person and the family can articulate what they want, the system offers options, and then the people/family decide how to move forward.
8. That the person has choices—in services, treatments, and providers.
9. That the services and provider options be responsive to the person's cultural background and that they reflect an understanding of how trauma and other social factors can influence mental health.
10. That the person or family seeking help can be assured that any services or treatments being offered are supported by the best evidence available and that the individual, family, and care team support collaborative decision-making about choices among the options.

11. That the services needed are available no matter what form of insurance the person has.
12. That the care should be as local as possible. Common treatments should be available close to home, and only very specialized treatments should require significant travel.
13. That the help that is received has to be integrated into one understandable package of support—it can't be cutting across different providers in different settings with different rules and different access points. If it's too hard to negotiate, they won't use it or they will try to use it but it will fail them.
14. That mental health services are integrated with community supports, including affordable and stable housing, to increase effectiveness of services and a more sustainable recovery.
15. That the system should be built on the fundamental assumption that recovery is possible and that the person involved can have a rewarding, satisfying life and make contributions to the community.

II. Comprehensive Continuum of Care

A continuum of care that would meet the criteria listed above would need to comprise seven categories of activities and services:

- Health promotion
- Prevention
- Early intervention
- Basic clinical services
- Inpatient and residential services
- Community supports
- Crisis services

In addition, the continuum should support three categories of coordination and collaboration mechanisms:

- Collaboration among services/activities in the continuum: care coordination, discharge planning, care management, shared record-keeping, transition protocols, etc.
- State-wide collaboration and oversight functions: Governance and funding structures; centralized assessment, forecasting, and planning; quality assurance and metrics; workforce development; etc.
- Collaboration with other sectors: Substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and natural community supports.

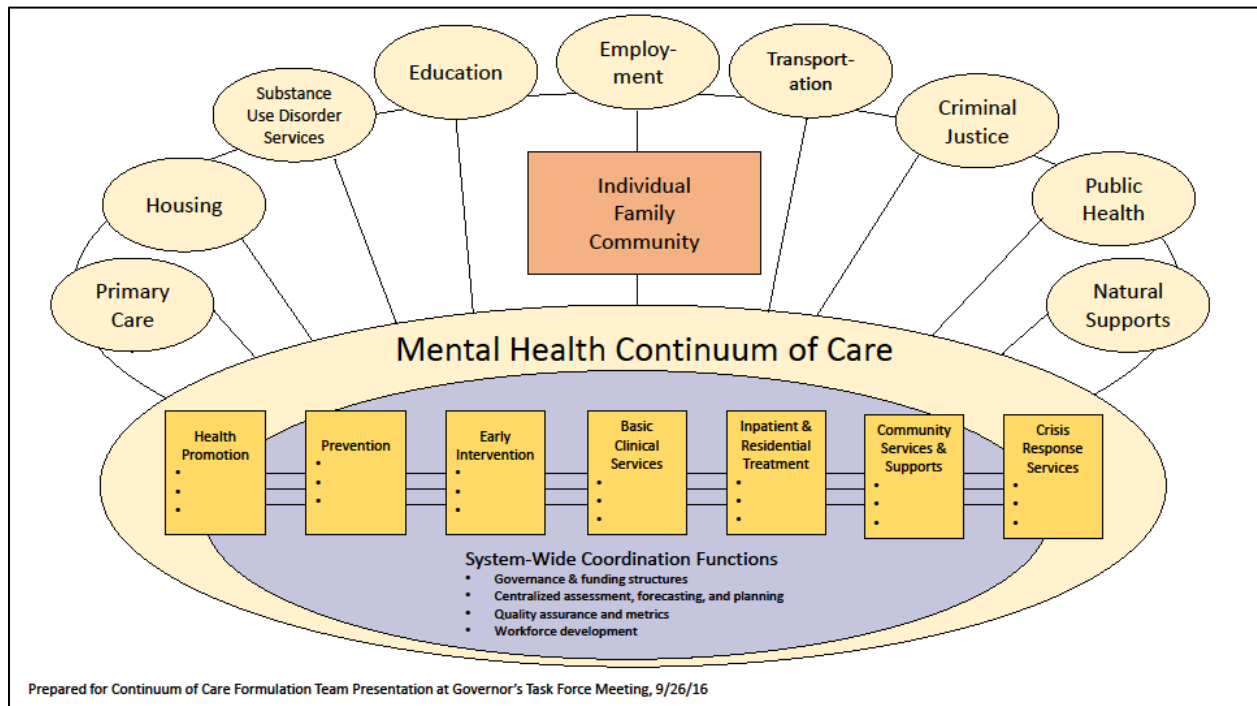


FIGURE 1: COMPREHENSIVE CONTINUUM OF CARE

III. The Current Mental Health System

This section would describe the current mental health system in Minnesota using the matrix of activities and services presented at the September 12 meeting. We still need to prepare a “current situation” description for the collaboration functions of the system: the collaborative mechanisms among the services and activities, the system-wide coordination functions, and the coordination with other sectors.

IV. Barriers to Achieving a Comprehensive Continuum of Care

The Formulation Team has identified these barriers to achieving a comprehensive continuum of care.

A. Public Understanding of Mental Health and Mental Illness, and Wide Continuum

1. Limited understanding about what creates mental health and well-being, and about the potential impact and breadth of mental health promotion and prevention activities. While such understanding will not always prevent mental illnesses, it can help reduce stigma and it could create more public support for funding and building a complete mental health continuum of care.
2. Limited understanding that different kinds of efforts are necessary to maximize the full potential of prevention and promotion. A multigenerational and community approach is necessary to support safe, stable, nurturing relationships and environments. Supports are needed across the lifespan and community plays a critical role in improving mental health.

3. Funding, legislation, and historical focus is on individual treatment model to exclusion of population based strategies.

B. Financial

1. Inadequate funding for health promotion and prevention, especially the sustained resources needed to build a common understanding and implement policies that will bring system change
2. Funding decisions for activities and services in the continuum of care are dispersed across federal and state agencies, which makes systematic decisions about priorities difficult.
3. State and local communities need resources to organize efforts across sectors and populations, including tracking gaps and opportunities.
4. Low payment rates for services
5. Difficult payment structures
6. Payment delays cause hardships for providers
7. Some services are supported by public insurance but not private
8. Sustaining programs requires insurance and grant funds
9. Parity not fully implemented
10. Coverage decisions are inconsistent
11. Most payment base on what we do to people, not for them
12. We lack adequate data and tracking to know whether all funds get used as they were intended, and whether they have the outcomes that were intended.
13. Self-selection for exclusion of broad populations based on payer/payer type
14. Historic inequitable funding compared to other areas of health care, including private and corporate donations.
15. Financial disincentives for communities when they do not have a place in their community for a person to return to, however the money that is collected as part of those financial disincentives are never returned back to the mental health system so that money can be reinvested in the mental health system.

C. Work Force

1. Limited staffing (workforce shortage)
2. Inadequate training programs
3. Competition to hire/own instead of share
4. Need a more culturally diverse and competent workforce
5. Stigma: people's incorrect perceptions of mental illness can cause them to avoid careers in mental health fields.

D. Rules/Oversight

1. Lack of clarity about who is responsible for leading population-based prevention strategies
2. Inconsistent authority/accountability
3. Licensure difficulties
4. Discrimination under MA (IMD, TEFRA) and Medicare (lifetime limit and limited type of MH professionals)
5. Eligibility is limited – focus on being very ill or already disabled by the illness

6. Data privacy, sharing records
7. Unclear responsibility for driving and/or allowing the development of new services
8. Responsibility and accountability for implementing parity is unclear.
9. Too much mixing of funding streams to fund a single service, leading to multiple entities having a say in how a service should work or who should be providing it.

E. Operational Challenges

1. It requires certain population base to sustain basic or specialized services
2. Not-in-my-backyard mindset
3. It is difficult to coordinate change across communities or among systems.
4. Funding sources are not willing to fund buildings, making it difficult for mental health providers to expand or build new programs.
5. Complex funding structures to navigate.
6. Some insurers have very narrow networks, making it difficult for the insured to find a provider within their network that has availability when they need it.

F. Lack of Community Infrastructure/Supports

1. Inadequate affordable housing with supports
2. Transportation challenges, especially in rural communities
3. Lack of adequate data infrastructure
4. Lack of adequate and coordinated quality infrastructure

V. Recommendations

In the process of trying to formulate possible recommendations for the Task Force's consideration, the Continuum of Care Formulation Team has struggled with the tension between high-level transformative recommendations and more specific recommendations that respond to particular system gaps. The Formulation Team will ask the Task Force for guidance around this struggle at the September 26th meeting. In the meantime, the Formulation Team proposes the following structure for high-level recommendations.

A. High-level

Recommendation #1: The Governor and Legislature should adopt a wide definition of the Mental Health Continuum of Care (as described in Section II and depicted in Figure 1).

Recommendation #2: The Governor and Legislature should consider improving **availability and access** to mental health services and activities in the continuum to be its highest priority. To fulfill this priority, responsibility for the following process should be assigned, along with the funding and staffing to complete it.

1. Develop a service/need matrix that systematically identifies:
 - a. The services and activities needed in each function of the continuum
 - b. The appropriate service levels for each service or activity (e.g., every person should be within 90 minutes of a mobile crisis team; there should be one psychiatrist for every

- 10,000 people in a geographic area). Identify where services can be co-located (schools, colleges, clinics, etc.) to eliminate barriers such as transportation.
- c. The categories of population that are most relevant for population-based mental healthcare planning, including categories of age, cultural background, ability/disability, etc.
 - d. The regions of the state around which service availability and access will be planned (counties? Regions?).
2. With all of the above dimensions laid out, prepare a “Continuum Map” document that outlines what activities and services are available, where, and for whom, and create systematic outlines of what activities and services are still needed in what areas for what populations.
 3. Assign state and local responsible parties and develop capacity to conduct ongoing tracking of this “Continuum Map.” This will require funding and staff on some level.
 4. Policy planning and funding decisions—including state and county agency strategic plans—should be made with consideration of the Continuum Map. Allocating and building funding for this continuum could take years. The Governor and Legislature are urged to build stable funding for the activities and services outlined in the above Continuum Map. Investments should be considered in three buckets: short term priorities, infrastructure investments, and sustained investments for proven services.

Recommendation #3: Workforce challenges are, and will continue to be, the most daunting barrier to development of a robust continuum of care. The Governor and Legislature should continue to fund the recommendations of the Mental Health Workforce Report and assign specific responsibility for tracking progress on mental health workforce development.

Recommendation #4: Parity—treating mental health services in the same way that physical healthcare services are treated—has not been achieved in either Minnesota law or in common practice. The Governor and Legislature should push toward parity with the following basic steps:

1. Require private insurers to cover the model mental health benefit set.
2. Parity should be implemented in Minnesota statute and there should be allocated funding and accountability assigned to the state to review and ensure health plans are providing the coverage required to meet mental health parity.
3. Require the Departments of Commerce and Health to review health plans to assess alignment with parity laws and establish a complaint mechanism to enforce parity laws.
- 4.

Recommendation #5: We will not achieve a sustainable mental health continuum of care unless we can build robust health promotion and prevention functions within the state. The Governor and Legislature should take the following steps:

1. Partner with existing efforts to implement and expand anti-stigma campaigns.
2. Build understanding about what creates health and well-being. Include statewide communication and awareness about resilience, trauma, social determinants, positive psychology practices and anti-stigma, with targeted preparation for those who work with children and families (primary care, child care, schools, local public health).

3. Improve public education about mental health and mental illness so that people know how to support their mental health, how to support others who are experiencing mental health challenges, and where they can go for help if needed. Include basic education about how to enter the system.
4. Support community planning and implementation across the state to increase resiliency and improve mental health and well-being. Local initiatives would focus on assessing local needs and customizing statewide models or policies in response to needs and community strengths. For example, a community could come together around needs and opportunities to improve mental health and well-being for adolescents.
5. Expand evidence based home visiting models to all high risk families.
6. Integrate mental well-being and health strategies into primary care; develop mental health and well-being learning community and fund implementation of identified best-practices for Health Care Homes and community partners.
7. Develop infrastructure and implement mental well-being programs that are evidence based or promising, culturally responsive, multi-generational, and support individuals and families who are experiencing risk factors. Some examples include Living Life to the Full, and the Mother and Babies Program.
8. Build capacity to collect and analyze population health data regarding risk and protective factors associated with mental well-being and illness, such as the Minnesota Student Survey, Pregnancy Risk Assessment Monitoring System, and Behavior Risk Factor Survey.

Recommendation #6: The entire mental health continuum of care cannot keep Minnesotans mentally healthy if the underlying social determinants of health continue to create stress and trauma for individuals and families, especially from generation to generation. The availability of affordable, safe, stable housing is the most basic of these determinants. The Governor and Legislature should take the following steps to ensure that housing—including housing with supports for people with mental illnesses—is available to all individuals and families who need it.

1. Protect existing state investments in housing and support services serving people with mental illnesses.
2. Support the 2017 policy and budget requests for housing and supports that are recommended by the Commissioners on the Interagency Council on Homelessness.
3. Request that DHS, Minnesota Housing, the State's Office to Prevent and End Homelessness, and the Olmstead Office work together to provide an analysis (modeling) of existing resources, strategies to leverage additional housing opportunities utilizing existing resources, and to identify the remaining gap of supportive housing opportunities needed to ensure all Minnesotans living with mental illnesses have access to affordable and stable housing and supports.

B. More Specific Recommendations

Aligning with the six recommendations listed above are dozens of specific changes that are needed and that would help make Minnesota's mental health system a comprehensive Continuum of Care. The following items have been identified:

1. Health promotion and prevention¹

1. Establish a statewide Community of Practice on resilience and well-being to facilitate and advance learning about community based and culturally specific strategies.
2. Expand programs to reach all newborns for anticipatory guidance, access to culturally and linguistically appropriate developmental and social emotional screenings and referral, including the Follow-Along program.
3. Prepare health care, child care and early childhood providers to more effectively serve children and families exposed to or experiencing trauma.
4. Local community planning initiatives to address risk and protective factors to mental health and well-being for adolescents and families.
5. Develop supports and education for parents of adolescents that are accessible, evidence based, and teach positive parenting skills.
6. Expand transition supports for new immigrant and their families.

3. Early intervention

7. Expand the number of first-episode programs and include First-Episode Depression and First-Episode Schizophrenia.

4. Basic clinical services

8. Increase reimbursement for assistance provided to someone with mental health symptoms who has not yet received a diagnosis, such as those persons who are at-risk due to exposure to trauma.
9. Ensure that we have adequate clinicians and providers to serve the deaf, deaf/blind, and hard of hearing community. This requires both language and cultural competence.
10. Fund mother/baby programs and support child care for mothers needing to access mental health and/or substance use disorder treatment.

5. Inpatient and residential services

11. Build capacity of children's residential mental health services to serve specific populations and different levels of care such as crisis homes and psychiatric residential treatment facilities (PRTFs).
12. Address shortage of adult inpatient hospital beds (covered in the Inpatient Bed Capacity Formulation Team)
13. Address barriers that limit IRTS development (covered in the Inpatient Bed Capacity Formulation Team)

6. Community supports

14. Build ACT team fidelity and availability as an alternative to inpatient hospital care.

¹ The Continuum of Care Formulation Team is still working on the question of whether health promotion and prevention should be presented as a single category or as two separate categories. We are consulting with experts on this question and will make a recommendation to the Task Force before the October 17th meeting.

15. Expand access to community supports to decrease isolation and support recovery.
16. Expand access to employment opportunities.

7. Crisis services (Covered in the Crisis Response Formulation Team)

17. Add mental health care to urgent care

8. Collaboration among services/activities

18. Improve discharge planning following the recommendations in the RARE report. This should include expectations of specific coordination to support people moving from one level of service to another.
19. Implement more care management models, including CCBHCs and BHHs.
20. Develop mechanisms for better data sharing (while protecting privacy).
21. Support local collaboration to create joint planning and transition protocols among providers
22. Set objective (where able) measures to graduate from or enter/transition along the array of services.

9. State-wide collaboration and oversight functions

23. Define “safety net” services, assign responsibility for providing them, and implement accountability protection to make sure that the responsibilities are fulfilled.
24. Clarify state and county roles as mental health authorities (in Governance Formulation Team)
25. Assign responsibility for centralized assessment, forecasting, and planning of the mental health continuum of care.
26. Assign responsibility for coordination of quality assurance and metrics. Determine the most meaningful metrics required to assess the performance of the system (especially from the client’s point of view) and make strategic and operational changes based on those assessments. Invest in the data infrastructure necessary to do this.
27. Fund a “Mental Health System Innovation” center or unit to research, pilot, and develop innovative solutions to challenges in the continuum of care.
28. Establish staff and funding to support regional collaboration and planning to improve the continuum of care. This could be in conjunction with the re-design of the Adult Mental Health Initiatives, or coordinated with that work.

10. Collaboration with other sectors

29. Continue to align and integration mental health services with substance use disorder treatment
30. Integrate mental well-being and health into primary care; develop mental health and well-being learning community for HCH and their partners and fund implementation of best practices outlined in the learning community.
31. The Departments of Health and Corrections should work together to improve state prisons’ visiting environments and policies to encourage and foster parent child relationships.
32. Support organizations to engage in trauma informed care organizational process, beginning with health care facilities.
33. Support utilization of trauma and resilience assessment tools and an effective implementation process in health care facilities. Coordinate implementation with efforts on Social Determinants of Health.