

Governor's Task Force on Mental Health

IMMEDIATE IMPROVEMENTS IN INPATIENT BED CAPACITY AND LEVELS OF CARE TRANSITIONS: PROPOSED SOLUTIONS

draft 9/9/16

The first meeting of the Inpatient Bed Capacity and Level of Care Transitions Formulation Team took place Friday, Sept. 2. The team members noted the complicated nature of the inpatient psychiatric bed capacity issue and considered options for the best way to engage the entire Task Force on the issue while moving efficiently toward recommendation formulation. The team concluded that they would 1) develop an overview of the issue that summarizes the complexities involved; 2) review past recommendations and create a list of possible options that have not already been implemented; and 3) identify several options that the team felt could help address the problems within a 1-2 year time frame.

I. Issue Overview

A. Inpatient Psychiatric Hospitalization

When a person is in a mental health crisis, there are several options for how to respond. Some crises can be addressed at home with the help of family and friends or professionals including mobile crisis teams. In some cases, however, a decision is made (by the individual, his or her family, or first responders) that the person in crisis should go to a hospital. In the hospital's Emergency Department, the person is evaluated and is either sent back home, referred to psychiatric treatment elsewhere, admitted to a general inpatient ward of the hospital, or admitted to specialized inpatient psychiatric treatment (at that hospital or another hospital).

People coming to community hospitals in a mental health crisis are sometimes not admitted for inpatient care because hospitals have very strict admittance guidelines. Admittance for a mental health crisis is based on a decision about a person's capacity to harm themselves or others, or neglect themselves to the point of self-harm. People in the most serious crises are placed on an emergency, or 72 hour, hold and often have legal commitment proceedings begun. Individuals are also brought to hospital Emergency Departments by law enforcement on a hold.

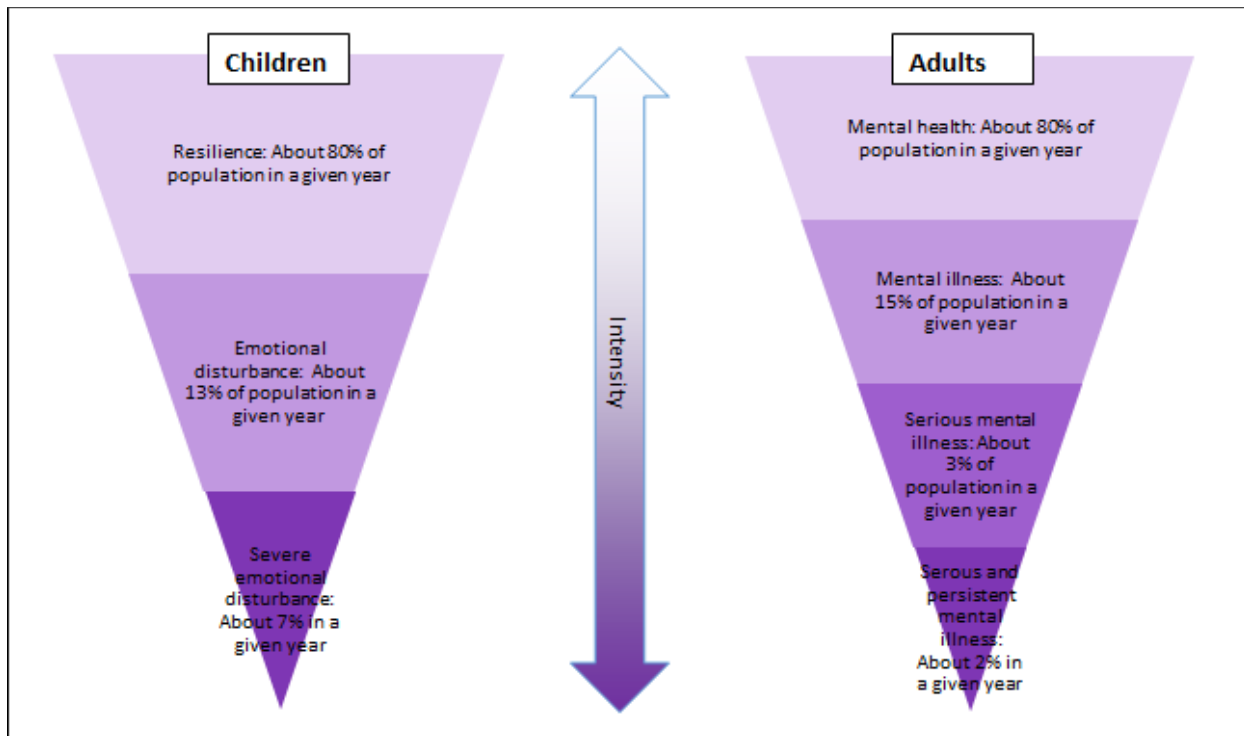


Figure 1: Intensity Continuum of Emotional Disturbance (Children) and Mental Illness (Adults)
 Governor’s Task Force on Mental Health: Draft Mental Health Overview, p. 5

Figure 1 shows the intensity continuum of emotional disturbance for children/adolescents and mental illness for adults.¹ Individuals in an acute mental health crisis needing hospital-level care will most likely fall in the emotional disturbance and severe emotional disturbance area for children and youth, and serious mental illness and serious and persistent mental illness for adults.

The purpose of inpatient psychiatric care, like other inpatient stays for other medical emergencies, is to stabilize patients so they can be transferred to the appropriate treatment setting to continue recovery. This transfer includes supportive housing options in a person’s own home. For psychiatric emergencies, this can take several days or weeks, or longer. For people with complex mental illnesses and co-occurring conditions that include substance use disorders, intellectual disabilities, chronic physical illnesses, and aging-related dementia, stabilization can take even longer.

For a small number of patients, their symptoms include aggressive or self-injurious behaviors that pose a risk to personal and public safety. A court can decide that the person needs to be legally committed to psychiatric care, an action that severely limits the person’s right to make decisions about the nature and location of their mental health treatment. People under commitment are treated at several large community hospitals and at state-operated psychiatric facilities. Children and adolescents are much less likely to be civilly committed, because this requires parents to relinquish their parental rights.

¹ *Governor’s Task Force on Mental Health: Draft Mental Health Overview* (St. Paul, State of Minnesota, July 2016), 5.

Providers, law enforcement, and community members have focused particular attention on this sub-population in recent years because our system does not currently have the capacity to meet their complex needs. This is similarly the case for children and youth living with serious emotional disturbance and co-occurring conditions. These conditions include but are not limited to Autism Spectrum Disorders with self-injury or aggression, mental illness with brain trauma, and mental illness and complex medical issues.²

B. Psychiatric Hospital Statistics

Forty-five Minnesota hospitals have non-forensic inpatient mental and behavioral health units for adults and children/adolescents. This includes:

- 34 community hospitals
- 7 Community Behavioral Health Hospitals (CBHHs), state-operated
- Anoka Metro Regional Treatment Center (AMRTC), state-operated
- Children and Adolescent Behavioral Health Services, state-operated
- 2 Veterans Administration hospitals, federally-operated

Including all 45 hospitals and their licensed beds reported for inpatient psychiatric capacity, there are 1,424 licensed beds for inpatient mental health treatment for adults and children/adolescents.³ In reality, there are fewer than this available. AMRTC is licensed for 175 beds, but it operates at 110. At the same time, CBHHs are licensed for 16 beds but currently operate at about 10 beds each. CABHS, also licensed for 16 beds, currently operates at less than 5. In addition, community hospitals report instances of taking beds offline for security or treatment purposes.

The vast majority of hospitals treat adults, not children or youth. Eight hospitals have inpatient children/adolescent beds, while 43 have adult or adult and children/adolescent beds. Hospitals with psychiatric beds are concentrated in the metro area, particularly for children and adolescents, and regional population centers such as Willmar, St. Cloud, Rochester, and Duluth.

The Minnesota Hospital Association released a white paper in 2015 which included statistics showing average inpatient mental health occupancy rates. The Association found average occupancy rates of:

- 80 percent statewide
- 87.4 percent in the Twin Cities
- 76.6 percent in Greater MN⁴

In contrast, the average occupancy rate for all conditions statewide is 40 percent.⁵ The contrast is particularly apparent for children and youth.

² *Mental Health Acute Care Needs Report* (St. Paul: Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, March 2009), 13.

³ Minnesota does not have a separate license for inpatient psychiatric beds. Community hospitals treating a variety of medical conditions license all of their beds and report how many are designated for use as inpatient psychiatric beds. Stand-alone psychiatric hospitals such as AMRTC do not treat general medical conditions as a primary condition, and therefore all of their licensed beds are for inpatient psychiatric care.

⁴ *Mental and Behavioral Health: Options and Opportunities for Minnesota* (St. Paul: Minnesota Hospital Association, December 2015), 9.

Mood disorders like depression are the top reason for all inpatient admissions for children and adolescents, including non-psychiatric conditions. The average length of stay for mood disorders is 6 days.⁶

Minnesota hospital emergency department visits for mental health and substance use disorders have increased substantially from 2007-2014. Minnesota hospital emergency departments (EDs) experienced a 49 percent increase in all mental health and substance use disorder visits. For all conditions, the increase was 20 percent. During that period, emergency department visits in the metro increased 34 percent and 40 percent in Greater MN.⁷

C. Inpatient Psychiatric Bed Shortage

As stated above, there has been much focus paid to the lack of capacity in the system for people with complex needs. The focus has often centered on the shortage of psychiatric inpatient hospital beds in Minnesota.

The 2009 *Acute Care Needs Report* states,

“A review of the empirical research literature revealed no population-based standards or methodology to determine the number of psychiatric inpatient beds that are needed to serve a population receiving community-based mental health services.

“Several reports have identified specific community-based mental health services that can directly impact the utilization of inpatient psychiatric capacity. The 2008 Treatment Advocacy Center report on the shortage of public psychiatric hospital beds recommends 50 public psychiatric beds per 100,000 population. However, the report also states that the use of assertive community treatment teams, club houses and other community supports would directly decrease the number of beds needed (Torrey, et al., 2008). A 2007 National Health Policy Forum issue brief also reported that comprehensive intensive outpatient services such as assertive community treatment, mobile crisis response teams and partial hospitalization produce lower rates of hospitalizations (Salinsky, 2007). A 2006 national focus group convened by the National Association of State Mental Health Program Directors concluded that the need for public and private inpatient psychiatric beds must be evaluated in the context of the full array of care rather than an absolute “per capita” indicator independent of the rest of a state or community mental health system. (Emery, 2006).”⁸

⁵ Ibid.

⁶ Ibid.

⁷ Ibid 12, 14.

⁸ *Mental Health Acute Care Needs Report*, 2. See also Torrey, E.F., et.al. (2008). *The Shortage of Public Hospital Beds for Mentally ill Persons*. Treatment Advocacy Center, Arlington, Virginia; Salinsky, E. & Loftis, C. (2007). *Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?* Issue Brief – No. 82, August 1, 2007. National Health Policy Forum, George Washington University, Washington DC; Emery, B. (2006). *The Crisis in Acute Psychiatric Care: Report of a National Focus Group Meeting*. National Association of State Mental Health Program Directors, Washington, D.C.

A 2008 Minnesota Medical Association report offers a number of factors contributing to “absolute and functional shortage of psychiatric beds.” These are “staff shortages, high patient acuity levels and a lack of facilities to serve individuals with both mental health and medical needs and discharge barriers such as a lack of housing with supportive services, delays in the commitment process and lack of timely access to outpatient services for medication management.”⁹

Minnesota’s mental health system includes and is expanding the use of assertive community treatment (ACT) teams, mobile crisis, permanent supportive housing, and other community-based services intended to help prevent hospitalization. These services, as well as the workforce necessary to deliver them, are important to keep in mind as discussion of inpatient bed capacity progresses.

D. Patient flow – the Front and Back Doors

The concepts of “patient flow” and “front door and back door” are often mentioned when discussing inpatient hospital care for individuals living with mental illnesses, emotional disturbance, and substance use disorders. “Patient flow” refers to how people being treated for mental illnesses and often co-occurring conditions move through treatment, how they are admitted and how they are discharged. “Front door” refers to getting into a treatment setting; “back door” refers to how they are discharged.

The 2014 Plan for the Anoka Metro Regional Treatment Center summarizes the front and back door situation as follows:

“A lack of adequate community support services results in people in the target population too frequently needing a hospital level of psychiatric care. Once admitted and treated, individuals in the target population often occupy inpatient hospital beds (at AMRTC and community hospitals) even after they no longer meet the criteria for a hospital level of care because an appropriate community-based setting for them is not currently available. As a result, they remain in inpatient beds that are needed by others who *do* meet the criteria for a hospital level of care. Those people wait in inappropriate settings (jails, emergency rooms, and community hospital units) for beds to become available, often for days or weeks.

“The factors that force people to wait for access to inpatient psychiatric beds are called *front door* issues, and the factors that prevent a patient from leaving AMRTC or a community hospital at the appropriate time are called *back door* issues. Both front door and back door problems prevent people from making smooth transitions to the right care in the right place at the right time. The lack of community services underlies the failure to prevent people from needing a hospital level of care and too much demand forces people to wait (front door). The (back door) problem of people “stuck” at AMRTC and other hospitals exacerbates the front door problems and forms a serious barrier to recovery. Both problems waste scarce resources that could be better spent on appropriate care and prevention programs. Both problems are further

⁹ *Acute Care Needs Report*, 3. See also Kathol, R., Sterner, S, et.al.(2008). Psychiatric Bed/ER Diversion Task Force Report. Commissioned by the Minnesota Medical Association.

exacerbated by inefficient legal processes, complicated eligibility and funding processes, and inadequate coordination among agencies.”¹⁰

A recently-released study from Wilder Research on behalf of the Minnesota Hospital Association shows nearly 20 percent of inpatient psychiatric bed days in 20 community hospitals were potentially avoidable. In other words, a person on an inpatient mental or behavioral health unit who reached stability and no longer needed treatment in a hospital was not able to be discharged from the hospital because of a lack of appropriate treatment capacity. According to this pilot study, 14 percent of these potentially avoidable days were due to a patient waiting for transfer to a state-operated Community Behavioral Health Hospital. 11 percent were waiting for substance use disorder treatment. Ten percent awaited Intensive Residential Treatment Services.¹¹

The inpatient psychiatric bed capacity issue thus has several facets:

- Inadequate community-based services and recovery supports such that a person does not receive the support they need when mental health symptoms first arise and they thus get sicker until they are in a mental health crisis.
- Inadequate *coordination* of services to support individuals toward recovery.
- Inadequate crisis-response services that could help divert some individuals from needing inpatient psychiatric care.
- Problems with discharge planning, which should start at admission, resulting in people being ready for discharge but not having a destination in their home community (with whatever level of supports required) to go to.
- Inefficient administrative processes (especially in the commitment process, funding eligibility determinations, and community placements) that delay both treatment and recovery in community settings.¹²
- The long waiting times for admission to community psychiatric inpatient beds and especially for state-operated psychiatric beds for people who are under commitment.
- The “cycling” of some patients through Emergency Departments, inpatient hospital stays, and discharge back to the community without adequate supports.
- The “trickle down” effects of these psychiatric patient flow problems on other people and services, including friends and families, community hospitals and their other patients, lower-intensity psychiatric services, law enforcement, courts, etc. “These patient flow problems reverberate throughout the service system, creating backups at community hospitals and preventing people from receiving the ‘right time, right place’ care they need to successfully pursue recovery.”¹³
- Questions about what the appropriate number of inpatient psychiatric hospital beds in Minnesota should be and about where policymakers should best invest in order to ensure that people receive “right place, right time” care.

¹⁰ *Plan for the Anoka Metro Regional Treatment Center*, 43.

¹¹ *Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot* (St. Paul: Wilder Foundation, July 2016), 1.

¹² *Plan for the Anoka Metro Regional Treatment Center*, 1.

¹³ *Ibid.*

E. Roles and Responsibilities

Underlying the patient flow problems is confusion between the state, providers, counties, law enforcement, and the judiciary, among others, about the roles each plays. In particular, who is responsible for the “safety net”—the provision of services for a person whom other providers have declined to treat? While the state has historically been the safety net provider, deinstitutionalization, financial incentives, and the Olmstead decision have been driving Minnesota to a community-based care model for decades. As these changes have occurred, roles have not been clarified and confusion continues about who has the ultimate responsibility for treating individuals with the most complex and serious mental illnesses and substance use disorders. What are the expectations of community providers? What are the expectations of the state? What level of involvement should law enforcement play in responding to calls about a person in a mental health crisis? Where does the county fit into the equation? These are difficult questions to answer and they are intertwined with issues of funding and liability.

II. Possible Solutions for Consideration of the Governor’s Task Force on Mental Health

The Formulation Team identified the following solutions for consideration by the Task Force because they could be implemented within one year and could have a positive impact in 1-2 years. The Formulation Team does not see these as total solutions, but as strong first steps to take while the Governor and Legislature also undertake the more comprehensive planning and coordination needed to solve the inpatient bed capacity issue.

A. Establish an Ongoing Body to Coordinate and Oversee Work on Inpatient Bed Capacity

The Formulation Team understands that part of the difficulty of addressing inpatient bed capacity is the fact that the problem is so multi-faceted and that many stakeholders are involved, each with their own missions and goals, legal and administrative requirements, funding models, work processes, and professional perspectives. It is outside the scope of the Task Force’s work to completely analyze this situation and formulate the kind of detailed strategies and collaborations that will be needed to solve the problem. The Formulation Team looks forward to talking with the rest of the Task Force about an appropriate structure and process for an ongoing oversight/coordination body.

B. Increase Intensive Residential Treatment Services

Intensive Residential Treatment Services are licensed by the Department of Human Services. An IRTS program is a place for individuals to receive time-limited mental health treatment, usually ranging from 30-90 days. IRTS programs provide around the clock support or assistance as needed while individuals receive intensive mental health treatment consisting of 1:1 therapy, group therapy, treatment planning, nursing services, independent living skills and other activities. IRTS programming is designed to develop and enhance the individual’s psychiatric stability, personal and emotional adjustment, self-sufficiency, and other skills that will help the transition to a more independent setting. Individuals seeking services

at an IRTS program often need a higher level of care than outpatient services, or may be transitioning from a more restrictive setting (such as hospitalization or jail). There are currently 47 IRTS facilities throughout the state of Minnesota that range in capacity levels of 10-16 beds. This includes nine IRTS licensed programs which offer only shorter term crisis stabilization services.

Recent studies (MHA-PAD, DHS gaps analysis, Five County Metro Psychiatric Patient Flow Study) cite a shortage of IRTS beds in areas of the state as one factor in prolonged inpatient psychiatric admissions. Increasing the number of IRTS beds could offer a short-term way to help alleviate the current bed shortage crisis in Minnesota through the prevention of hospitalization and through more rapid discharge to appropriate local/regional facilities.

There are some challenges that would be need to be addressed to expand IRTS. Because of the IMD exclusion, IRTS are limited to a maximum occupancy of 16 individuals, making the addition of beds to existing programs problematic. IRTS face the same workforce shortages as other mental health providers; some have reported having plenty of beds but not enough staff to take more clients. In addition, funding continues to be an issue. Funding will be examined in the Mental Health Rates Study currently being conducted. Part of the funding issue is also the lack of coverage by some private commercial health plans. There are also challenges regarding the requirement that providers have contracts with a county before being able to build or open a new IRTS.

C. Consider Housing and Supports

Supportive housing is often cited as a gap for individuals living with mental illnesses. Providing housing with supports creates a level of stability that serves as a basis for recovery. In addition, bringing services to a person's home lessens the need for transportation and can help a person de-escalate who may be in crisis or cycling through their illness. Supportive housing has been shown to decrease the need for hospitalizations and involvement with law enforcement. The Formulation Teams would like to work with the Task Force to explore possible housing models that Task Force recommendations could support.

D. Competency Restoration

The Formulation Team felt that there are opportunities to expand community-based competency restoration that would open up beds at the State Security Hospital and at AMRTC, which would make those beds more available for others.

E. Civil Commitment

Minnesota's Civil Commitment Act currently allows courts to commit individuals to settings less restrictive than a hospital. The law can be clarified to emphasize the ability for individuals to be committed to lesser-restrictive settings. In addition, allowing dual-commitments to hospitals and the Commissioner gives hospitals the opportunity to discharge an individuals without waiting for a provisional discharge from the state. This is used in Hennepin County and is working well.

F. Improve Local Coordination Around Crisis Response (Crisis Response Formulation Team Will Handle This, but this Team Supports It)

A concern strongly voiced by the Formulation Team was that of addressing individuals in crisis who need immediate services. Law enforcement and hospitals both see the results of a system that was not designed to provide services outside of acute settings to people experiencing a crisis. There is an opportunity to improve the connection between hospitals and law enforcement with mobile crisis teams, for adults and children and youth. Mobile crisis teams are able to come to a person, whether they are in a home, in a hospital, or another place. They can be called by law enforcement and hospital staff as well as other providers and community members. Crisis teams can assess an individual experiencing a mental health crisis for the right place for treatment, including non-hospital level of care services. For example, crisis stabilization services offer short-term residential treatment to help an individual stabilize without needing to be hospitalized. Many crisis stabilization services are offered in IRTS settings.

Strengthening connections between mobile crisis teams and hospitals and law enforcement will assure individuals experiencing a crisis receive the right care, while relieving the pressure on hospitals and law enforcement to address acute crises with limited resources. The Formulation Team believes that this possibility is being pursued by the Crisis Response Formulation Team and strongly supports that work.

III. Past Recommendations for Addressing Bed Capacity and Levels of Care Transitions

A number of recommendations have already been proposed in previous reports and studies. This section provides a list of some previous recommendations directly relevant to inpatient bed capacity and levels of care transitions that are currently in process or have yet to be implemented.

A. Ensure that Decisions are Driven by People with Disabilities

- Continue to Implement Person-Centered Planning at all Levels
- Institute patient and family satisfaction assessment and measures and a system of accountability for responding to those assessments.
- Continue to redesign home and community-based services to maximize flexibility for people being served

B. Bolster Sub-Acute Psychiatric Services

1. Intensive Residential Treatment Services Expansion (Adults)

See above.

2. ARMHS & ACT

Minnesota is in the process of implementing improved standards ACT and is also implementing Forensic Assertive Community Treatment (FACT), for individuals exiting incarceration and live with complex needs.

In addition, rates for Adult Rehabilitative Mental Health Services (ARMHS) have recently been raised.

3. Psychiatric Residential Treatment Facilities for Children and Adolescents

Psychiatric residential treatment facilities (PRTFs) are a level of residential service currently being developed in Minnesota. Legislation passed in 2015 to create up to 150 PRTF beds for children and adolescents living with serious emotional disturbance and co-occurring conditions whose needs are currently not being met in the system. The first 50 beds are expected to be available in 2017, with all 150 open by the end of 2018. Private providers are being sought to build and operate PRTFs.

While estimates note the target population of children and adolescents needing this level of care is around 300, some concerns have been raised that the number is actually greater and 150 PRTF beds will not be enough capacity.

4. Other Children's Intensive Services

As in the adult mental health system, increasing the availability of community based mental health services will prevent children and adolescents from needing hospitalization. These services include Youth ACT, intensive treatment in foster care, and mobile crisis.

C. Build Other Community-Based Service Capacity

These include outpatient services, housing, employment, education outreach, peer supports, clubhouses, and other areas of support.

D. Reduce Readmissions

The Reducing Avoidable Readmissions Effectively (RARE) campaign worked to lower hospital inpatient readmissions. A RARE campaign work group released a report with recommendations for mental health and substance use disorders. There are five areas that influence readmission and affect successful transitions of care, each with a number of recommended measures specific to mental health and substance use disorders. The five areas are:

- Patient/Family Engagement and Activation
- Medication Management
- Comprehensive Transition Planning
- Care Transition Support
- Transition Communication¹⁴

E. Improve Care Management Models to Maximize Existing Service Capacity

1. Care Management for Children and Adolescents with Complex Needs

Increase the intensity and availability of community based mental health services to support children and adolescents with complex needs to prevent the need for hospitalization. Increase funding to pay for intensity and more highly trained staff. Create a more intensive case management service. Increase readily available respite care.

¹⁴ *Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders* (St. Paul, Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health, October 15, 2012), 1, 9-10.

2. Care Management For Adults

Design a chronic care model of treatment and services across the service array for the growing numbers of individuals with multiple and challenging diagnoses and complex co-morbidities including medical care and cognitive deficits. The Behavioral Health Homes and CCBHCs will both address this recommendation.

3. Improve Integration of Mental Health, Substance Use Disorder, and Primary Care Services

The Behavioral Health Homes and CCBHCs will both address this recommendation.

F. Address Financial Dis-Incentives to Serving People with Complex Co-Occurring Conditions in Community Hospitals

One reason that community hospitals are reluctant to treat individuals in the target population is that the reimbursement hospitals receive for the care of people's multiple complex conditions often fails to cover the costs of the care. If community hospitals did not have to take on such a financial risk, they would be more willing to treat people in the target population. DHS is looking forward to collaborating with hospitals to consider strategies for reducing hospitals' financial risks when they treat people in the target population.

G. Assess the Impact of the Recent Increase in the County Share

Assess whether Minnesota's recent increase in the amounts that counties pay to the state for patients at AMRTC and the CBHHS who no longer meet criteria for a hospital level of care. Has the increase driven a decrease in NABDs while maintaining or improving stability in the community? Facilitate dialogue among stakeholders about the best ways to drive expansion of community services for people in the target population.

H. Assess State-Operated Capacity and "Safety Net" Role

A number of factors contribute to determining the appropriate number of state-operated beds. A few include:

- The availability of community-based services to support the recovery and prevent unnecessary hospitalization of people in the target population
- The risk-management philosophy and approach of particular providers and county and tribal staff (including courts)
- The number of people in the target population in a given year (which is itself driven by scores of factors, including changes brought by the health care reform)
- The number and utilization of acute psychiatric beds available at community hospitals
- The legal and financial incentives that encourage counties, tribes, and community hospitals to civilly commit people and refer them to state-operated hospitals
- Changes in treatment approaches
- Trends in arrests and sentencing that affect people with mental illnesses in the criminal justice system
- The financial/political tradeoff of funding more state psychiatric beds vs. funding more community-based services that would ameliorate the need for those beds
- Minnesota's Olmstead Plan

- Workforce recruitment and retention
- The availability of culturally-competent assessment, planning, and treatment¹⁵

I. Build Workforce Capacity

Comprehensive recommendations were offered in the report following the Mental Health Workforce Summit. Some of the recommendations, particularly those around loan forgiveness for mental health professionals, have been implemented. However, many still await funding and implementation.

I. Streamline and Expand Competency Restoration Services

Legislation passed in 2016 allowing for the creation of a stand-alone competency restoration service in St. Peter. This new service will help alleviate some of the pressures in AMRTC and MSH from individuals who are there for competency restoration but do not need AMRTC or MSH level of care.

Another option is community competency restoration, which offers competency restoration to people in the community, either outpatient or in a residential setting. This option is used with success in many states around the country.

J. Improve Discharge Planning and Transitions to Community

- Pay for transition into the community
- Define and clarify good discharge plans
- Discern admitting privileges
- Provide for coordination of care between counties and providers
- Speed up county residential screening team process
- Address procedural and programmatic/policy areas that create barriers to smooth transitions across levels of care
- Improve data-sharing across sectors
- Expand the Transitions to Community Initiative
 - Extend eligibility to individuals in community hospitals who are on the AMRTC waiting list and who, with necessary resources, could return to the community without treatment at AMRTC.
 - Expand support to people over age 65 who are leaving AMRTC, MSH, a CBHH, or who are hospitalized and are on the AMRTC waiting list. Individual budgets available through the Elderly Waiver, which currently are not adequate to support individuals with complex needs, would be increased.
 - Provide additional program administrative capacity to better track individual outcomes post discharge to improve our community system of care and improve the efficiency and effectiveness of the program. This would also provide us with data to inform Olmstead planning and implementation.

¹⁵ AMRTC plan, 99. And *Report on the Utilization of Community Behavioral Health Hospitals* (St. Paul, State of Minnesota, March 30, 2012), 24-27.

K. Facilitate Regional Collaborations Around Solutions

Assign responsibility and staffing to facilitate regional collaborations around the patient flow issues. Some communities have developed useful models but they struggled to move forward with little funding for facilitation, data analysis, and writing/reporting of results. These efforts could be leveraged by small investments in facilitation support and in communication to disseminate useful models around the state.

L. Develop Metrics to Assess Problems and Track Progress

Convene a working group of behavioral health representatives from hospitals, counties, managed care organization, providers, Minnesota Hospital Association and Minnesota Department of Human Services to design standard metrics regarding access to services. This group would also recommend a process to quantitatively monitor the data on a regular basis and to re-allocate resources to ensure adequate safety, access, quality and fiscal efficiencies.

M. Improve Capacity and Local and Regional Collaboration in Crisis Response

- Increase referrals to crisis teams, and collaborations between hospitals and crisis teams.
 - Create one phone number
 - Conduct social marketing
 - Have professionals/providers referring people to crisis services
 - Investigate having children and adolescents leaving ER connecting with crisis stabilization
 - Educate ED staff
 - Train 911 operators
 - Create one system not one for children and adolescents and one for adults
 - Allow for supporting transitions from ER and hospitals