DEPARTMENT OF HUMAN SERVICES
DIRECT CARE AND TREATMENT

Priority Admission Task Force Member Recommendations

Part Two: Policy and Funding Recommendations

Question 2: What are your policy and funding recommendations for improvements or alternatives to the current priority admissions requirement? Recommendations must ensure that state-operated treatment programs have medical discretion to admit individuals with the highest acuity and who may pose a risk to self and others, regardless of referral path.

General Policy Recommendations

Clinical Discretion/Alternative Means for Admissions

A. Individuals who need the level of treatment should get priority admission.
B. Decisions should be made by DCT medical staff and not governed by a specific rule that prioritizes one group of people over another.
C. Establish a system for clinical teams in jails, hospitals, and state-operated services to look statewide at current patients and their acuity, with the ability to shift locations to free capacity.
D. Create a comprehensive decision-making tool that considers the unique requirements and circumstances of individuals. This could be made accessible through an online platform that prioritizes patients based on the urgency of their needs.
E. Strike down the priority admission statute. Allow medical discretion in admitting people when clinically necessary or when the referring case manager/hospital is unable to ensure safety or adequate treatment.
F. Provide timely access to treatment based on symptoms and individual's needs as recommended by a physician or other mental health professional rather than admission being determined by an individual's presence in specific location, such as jail.
G. Create a mechanism for establishing acuity, need, and triage to ensure access throughout the system.

Courts/ Commitment Modifications

A. Expand the number and type of specialty courts to include veteran's courts, drug courts, mental health courts, etc.
B. Reserve civil commitments for those who are not competent to stand trial and unlikely to be restored in the foreseeable future.
C. Study the criteria for competency and capacity to cooperate with court proceedings and the criteria commitment to determine if they should be aligned to eliminate any treatment gaps.
D. Collect data on the number of people waiting for transfer, the number of individuals whose criminal charges are dropped secondary to "the gap," and the number of individuals who were considered but not referred secondary to perceived lack of capacity.

E. Expand mental health treatment courts with specially trained staff, to work with this patient population and their legal needs.

Other Policy Recommendations

A. Patients with severe mental illness or those unable to make their own decisions should never be held in a corrections environment and should be transferred as soon as this is determined.
B. Consider a fair and equitable appeal process or other due process provision.
C. Increase communication and collaboration between hospitals, community organizations, and state-operated programs.
D. Improve the provision of co-occurring disorder treatment.
E. Establish a system for clinical care teams in jails, hospitals, and state-operated services to look statewide at current patients and their acuity, and capacity to shift locations to maximize the use of limited resources.

General Funding Recommendations

Increase Capacity

A. Develop systemic capacity to ensure everyone has access to care when they need it.
B. Fund voluntary engagement program so that we aren't waiting until someone is in danger to themselves or others.
C. Fund the First Episode of Psychosis programs to meet the demand of all who need it and fund similar program for people with bipolar disorder.
D. Build substance use treatment facilities (not withdrawal management centers) that accept admissions 24/7.
E. Build long-term mental health institutions.
F. Provide permanent funding for providers to develop and maintain services to support behavioral health.
G. Adequate funding and workforce are needed to support development of community, AMRTC capacity, and Forensic Services capacity, so that we prevent people from needing institutional care or corrections involvement.
H. Add high-security housing options for unhoused individuals.
I. More mobile crisis intervention teams.

Workforce

A. Expand mental health workforce to ensure there is capacity to care for all without an extended wait list.
B. Fund workforce development programs to alleviate the staffing shortages.
C. Increased pay, sign-on bonuses, training funds to help with workforce shortage.
D. Increase staff to ensure entire system is appropriately staffed.

Reimbursement

A. Remove the exclusion on Medicaid funding for incarcerated people to allow for services to be provided and reimbursed while in jails and other correctional settings.

B. Advocate for higher reimbursement rates so that more people will be willing to work these difficult jobs.
C. Reduce bureaucratic barriers such as insurance, Medicare/Medicaid, etc.

Policy Recommendations for State-Operated Treatment Programs

A. Admit patients to state-operated programs based on clinical criteria reviewed and agreed upon by a team of interdisciplinary professionals.
B. Revise discharge criteria for the Forensic Mental Health Program to allow for medical discretion at discharge rather than Special Review Board, counties, and court.
C. Review current AMRTC admissions and determine if their level of care need is appropriate for AMRTC, transfer those who don't need the level of care to community placement with appropriate infrastructure.
D. Review AMRTC process for admission and discharge planning.
E. Review the situation of those that end up in state-operated services. Did they have housing, insurance, and/or a provider?

Funding Recommendations for State-Operated Treatment Programs

A. Create additional state programs that specialize in the care of patients with chronic serious and persistent illnesses who cannot live in the community independently.
B. Increase bed capacity in state-operated services and create incentives for partnerships that address the capacity issue.
C. Expand the system of CBHHs, IRTS, community mental health centers and other step-down treatment opportunities.
D. Limited number of new beds added to the system.

Policy Recommendations for Community Programs and Services

A. Secure treatment space in some hospitals or other providers to support higher-need patients who may pose a risk to staff and patients.
B. Expand options for community placement for people with complex needs.

Funding Recommendations for Community Programs and Services

A. Increase pay for individuals working in community settings.
B. Increase access to training for individuals working in community settings.
C. Partner with local hospitals and prepare with infrastructure to be a holding place for priority admissions.
D. Increase support for community placements to ensure they have the training, pay, and support necessary for staff.
E. Community hospitals should be funded and incentivized to accept admissions. A tiered system approach may be needed wherein someone needs to be treated at a community hospital for X number of days before referral to the state system.
F. More County Program Aid (or some other dedicated funding source) to allow counties to set up and customize programs that can help keep people in more community-based setting.
G. Increase early intervention efforts in schools, daycares, etc.

H. Do more to prevent people from coming into contact with police, increased use of crisis teams, 911 training, increased awareness of 988.
I. Work to keep people from getting in the system in the first place – how can access to more long-term housing and ensuring proper level of care help keep people from decompensating and requiring more institutional levels of care.

Recommendations for Jails

Enhance Services

A. Encourage jails to partner with a local community mental health center.
B. Correctional facilities should have a minimum of a one psychiatrist or other mental health professional to address needs of those incarcerated.
C. Use state funding to expand mental health care treatment at Hennepin County Jail to accommodate mentally ill inmates from both Hennepin County and other parts of the state.
D. Incentivize jails to provide prompt treatment that meets the standard of care for psychiatric/SUD treatment.
E. Incentivize counties to work with jails and jail practitioners to pursue Jarvis petitions promptly. Nothing currently prevents it, but it is not often done, so treatment is delayed.
F. Create funding and partnership between the state and criminal justice system where the state could provide the resources to jails to help manage and care for such individuals.
G. Create additional mental health programs in jails.
H. Allow for access to medications in jail so individuals don't decompensate while waiting for trial, placement, etc.
I. More jail discharge planning.

Other Recommendations

A. Reform the bail system.
B. Incorporate workforce strategies to take care of patients and address burnout for both jail and medical staff.
C. Eliminate jails as the largest mental health treatment facilities, invest in prevention, school-based treatment, public health campaigns, and collaborative care initiatives.
D. Redirect funds collected from counties for the Anoka-Metro Regional Treatment Center 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.
E. More training for jail staff, court staff, law enforcement, and others to recognize places where handoffs to community-based programs are appropriate.