Governor's Task Force on Mental Health

CRISIS FORMULATION GROUP

Background and Agenda for 9/12/16

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Time	Topic	Presenter/Moderator
10m	Questions and comments on background document	Ben Ashley-Wurtmann
30m	Task Force member's vision for crisis services in MN, including how participants in the Formulation Group have answered. Each member should be prepared to briefly answer the following: • "Crisis services need to be able to _____." • "I think the biggest obstacle to providing better crisis response is _____."	Mariah Levinson
5m	Wrap-up and overview of how Crisis Formulation Group will be moving forward	Ben Ashley-Wurtmann

For information on upcoming meetings, see Task Force website: https://mn.gov/dhs/mental-health-tf/

This document is intended to summarize some of the major developments and reports on mental health crisis response services in Minnesota. The group is not bound by any prior work, but it may be helpful in thinking about next steps.

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

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

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.
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.

Recommendation	Status
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.
- DHS was charged with developing recommendations for children's mental health crisis residential services models that don't require county authorization or a child welfare placement. An RFP was issued and DHS is currently in contract talks to assign this work.
- 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.

Northwestern Mental Health Center

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.

Northwest Mental Health Center has sought agreements between community mental health centers and Critical Access Hospitals (CAH.) These are rural, 25 beds or under. Northwestern provides clinic based service, 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 crisis team can develop a telehealth arrangement. Biggest challenge: telehealth can be tricky to implement, and some hospitals have had 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 station/hospital staff to send them back to the 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.

CentraCare[2]

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

[2] Thank you to Dave Hartford for providing information and feedback.

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)[3]

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.

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).

Other Settings?

Are there are projects and programs that the formulation group would like me to research and report on? I've reached out to HCMC, but we have not been able to schedule a call yet.

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[3] Thank you to Roger Meyer for providing information and feedback.