To: Task Force on Priority Admissions Co-Chairs, Commissioner Jodi Harpstead and Attorney General Keith Ellison

From: Association of Minnesota Counties: Tarryl Clark, Stearns County Commissioner
Minnesota Association of County Social Service Administrators: Angela Youngerberg, Blue Earth County Human Services Director of Business Operations
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Re: Response to Task Force on Priority Admissions to State-Operate Treatment Programs 10 Best Ideas Assignment

Date: October 23, 2023

Thank you for the opportunity to engage in the important work of envisioning an improved priority admissions system. The signatories below represent many of the statewide county government associations including the Association of Minnesota Counties, the Minnesota Association of County Social Service Administrators, the Minnesota County Attorney's Association, and the Minnesota Sheriff's Association. Our associations, continue to submit a unified response due to our shared perspectives on the challenges we face.

Collectively, we believe the guiding principle in this conversation is enabling access for individuals to the most appropriate treatment available for their health care needs by ensuring that solutions address all levels of needs and services, including assisting with challenges faced by hospitals, jails, state agencies, and local governments. As stated previously, expanding upon both capacity and cooperation is foundational to any comprehensive solution that safeguards the constitutional and humane treatment of some of our state's most vulnerable individuals.

Listed below are the top ideas we collectively believe are critically necessary to carry out the priorities identified above and take meaningful short- and long-term steps to improve the priority admission process. The collective priorities listed below are not listed in any particular order.

1. <u>There is a clear need to increase bed capacity across the state-operated system.</u> Boarding in emergency departments and jail facilities is becoming "normalized" and is unacceptable as we look to our guiding principles for this work. While access to psychiatric beds is needed across the entire system, the two areas of focus should be:

    a. Increase the number of beds categorized as Community Behavioral Health Hospital beds. These beds are critical to provide services to mentally ill adults who are most often civilly committed and in rural Minnesota. Community hospitals in most rural areas of the state are not equipped, nor have the specialized resources to serve this population.

    b. Increase the number of beds within the Forensic Mental Health Program. Individuals in this program have unique needs that are not served well in other areas of the mental health system. The security, monitoring, and length of treatment are factors that cannot be addressed through other hospitals. FMHP capacity has been overflowing and taking up critical resources within AMRTC. A substantial number of beds in FMHP are needed to accommodate new admissions (including initial evaluations), ongoing placements, and to address the short term needs of former FMHP patients who need to return to FMHP to receive hospital-level health care, as medically indicated. Efforts for expansion should be addressed in all three areas.

    c. Establish a new level of service for residential beds that exists between hospitalization and long-term community placement for individuals that require an extended level of psychiatric treatment and have security or behavioral needs. A "secure IRTS" model has been explored, but the private provider community is not stepping into this space due to funding, liability, and clinical model concerns. The state should develop and provide a level of service in this space which provides secure, extended treatment and care for a length of time up to 6-12 months. Individuals having success in a setting like this will undoubtedly provide some confidence for private community providers to accept them into their homes for long term housing.

2. <u>Resource jails to provide immediate resources to serve individuals while larger systemic changes are being made.</u>

    a. Provide resources to jails so they may be able to safely enforce Jarvis Orders for administration of neuroleptic medication. Most jails are not staffed with the level of nursing needed for the enforcement of a Jarvis Order, and most jails have such a small need for this that staffing in this way is not efficient or even realistic. When individuals are without their neuroleptic medications for any period, the likelihood of psychiatric decompensation is high, often resulting in the need for hospitalization. Options to be made available to jails include:

        i. State funding should be offered to jails so they may contract with a medical provider to provide 24/7 access to services (nursing, etc.) to administer neuroleptic medications under a Jarvis Order.

ii. State response teams should be developed using medical expertise to provide on-site response to jails that do not have medical resources to enforce Jarvis Orders. This option may be essential for remote, smaller, or jails with infrequent need or a lack of local medical resources.

b. While capacity is being built out at state facilities, a regional pilot project should be created to ensure that individuals in jail, awaiting placement in a state facility, can get the necessary treatment jails can reasonably provide. This pilot project would require funding to allow for additional capacity in select regional jails, the creation of a diagnostic team inclusive of medical and mental health professionals, and incentives for smaller counties to transport this population to a regional pilot project location. There should continue to be a reasonable time benchmark for placement.

3. <u>Streamline and clarify the admissions and discharge processes within Direct Care and Treatment (DCT) to address concerns with the standards for various determinations.</u>

a. The admissions process must clearly articulate the standards for triaging and prioritization of individuals. Agreed upon benchmarks should be established to help guide prioritization determinations as well as guide discussions about where the system continues to fail to meet aspirations. Similarly, the discharge process must consist of understandable and definable criteria so that the process is more transparent and acceptable as evidence of appreciable stabilization. An approachable review process should be agreed upon to allow for reconsideration of reasonably disputed determinations.

b. Refresh the Central Pre-Admissions "Wait List" policies/procedure to be a more sophisticated process which allows patients awaiting hospital or bed placement to be not limited to one wait list, but to allow a triage and bed/facility placement process that is responsive to patient acuity. This should align with DHS's desire to allow medical triage to influence patient placement. The caveat is that medical triage should not assume a person's placement in another facility (such as a jail) is "safe" or receiving treatment that they are not. The success of this recommendation will be significantly dependent on an increase in DCT bed access, capacity, and availability.

c. Hospital systems must have a transparent process for Utilization Management and Review, which is a process that evaluates appropriateness and medical necessity of treatments and facilities provided to patients on a case-by-case basis according to CMS standards. In concurrent utilization management review models (similar to what DCT does), the patient's progress, prognosis, treatment plan, and other data are reviewed to determine if the individual does or does not meet criteria to remain hospitalized. In many hospital systems, this is completed by a third party as a form of quality assurance. In the current DCT system, this is conducted by DCT employees, most often mental health professionals. It is recommended that the state consider contracting with a third-party to conduct utilization reviews and reassign the high-demand mental health professionals to

fill the numerous MHP vacancies in the DCT system. This recommendation achieves three goals: (1) reducing the possibility of a conflict of interest (the state determines when a person no longer meets criteria for hospitalization, triggering a financial responsibility in which the counties must pay the state for cost of care for any days remaining in the hospital), (2) achieving higher quality of care through assurance of the most effective treatment and better data, and (3) utilizing current state employees to fill vacancies due to workforce shortages.

4. Support key recommendations coming out of the Competency Restoration Task Force and resource the recommendations swiftly so that systemic relief may be felt. The Competency Restoration Task Force extensively reviewed the systems relating to individual caught up in both the mental health and criminal justice systems. The number of recommendations make outlining them in this document unrealistic, however, this task force should review those recommendations for areas of agreement and achievability. Such key recommendations should be supported and implemented.

5. The qualifications necessary to be a Rule 20 examiner must be examined and a robust certification program should be implemented to ensure timeliness of reports and quality of the exams and reports. There has been difficulty getting timely Rule 20 evaluations, resulting in delays in the process and in receiving necessary health care. Additionally, concerns about the quality of reports are increasing. Simply, the pool of qualified examiners is not large enough to address the need in the state and steps need to be taken to address current barriers.

    a. Examiners should have to qualify through a robust certification process that ensures an examiner is qualified to give an expert opinion in the area. The process must be more than a review of applicable standards or review and should mirror certification programs in other jurisdictions. With a robust certification program, licensing requirements can be reconsidered. To increase the pool of trained examiners it is recommended that additional professional licensures be allowed to provide examinations with the expectation that they have received the required certification on the topic area.

    b. Reimbursement rates for these examiners should be increased as many private examiners have opted to no longer provide the service due to the rate not being commensurate with the time to complete the examination and the associated liability that the examiner holds. Any reduction in private examiners will increase the responsibility of the state to provide examiners, who are already backlogged.

6. Establish infrastructure building allocations that are available to counties to develop innovative, local, and specific solutions for serving individuals being discharged from the Forensic Mental Health Program.

    a. Utilizing the AMHI structure for these allocations, which should be voluntary for AMHIs or counties to opt-in or opt-out, would be a potential funding pathway. This could be funded by returning 100% of the county-share of Does Not Meet Criteria days that are currently

paid by counties to the state's general fund for days patients are in a state facility and do not meet medical criteria for hospitalization. This county cost is unique to Minnesota and was enacted to incentivize counties to expedite discharge of individuals from state facilities. With over ten years of data showing that the ability for an individual to be discharged from a state facility to the community is not fully within the control of the county (there are often many factors), this cost share should be stricken from law. Additionally, the funds contributed by the county should be returned to the county to develop community capacity. This would be one potential funding source for building infrastructure.

7. Adopt and offer models of care in all DCT facilities that embrace specialty care for co-occurring disorders. All too often patients require transfer from one DCT facility to another to address their co-occurring health care needs (including mental health, substance use disorder, and intellectual and developmental disability disorder). It is widely studied and documented that through providing integrated care a more complete recovery of co-occurring illnesses is possible. Technology may assist in providing specialized care in more remote facilities, or facilities experiencing workforce concerns. Relocating the services to the patient is more efficient and effective than moving the patient to the services.

8. Minnesota should expedite a Section 1115 Medicaid Demonstration Waiver application to allow incarcerated individuals to access to proper health care in jails and begin active consideration and evaluation of submitting a Section 1115 Medicaid Demonstration Waiver to update Medicaid's prohibition on paying for mental health treatment delivered in institutions for mental disease.

    a. **"**The Social Security Act, Sec. 1905(a)(A) prohibits the use of federal funds and services, such as Children's Health Insurance Program (CHIP), Medicare and Medicaid, for medical care provided to 'inmates of a public institution." While this language was intended to prevent state governments from shifting the health care costs of convicted prison inmates to federal health and disability programs, it has an unintended impact on local jail detainees who are in a pre-trial status and have not been convicted of a crime*." (excerpt from Naco.org website)* Minnesota has not yet submitted a Section 1115 Medicaid Demonstration Waiver unlike many other states in the nation. The federal government has encouraged states to propose innovative Section 1115 waivers that will expand coverage, address whole-person care, work to reduce health disparities, and address topics of special interest to states. Many states have submitted waivers, and some have been approved, Minnesota should look broadly across the nation to learn from the states that have already submitted waivers. States such as California or Washington have received approval for their waivers which allow incarcerated individuals access to certain health care services up to 90 days prior to release from incarceration. Oregon has submitted a waiver which is currently pending approval, requesting adults and youth who are incarcerated and committed receive Medicaid benefits for the duration of their commitment.

b. The same federal act prohibits Medicaid to pay for care in Institutions for Mental Disease (IMD), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. This federal law prohibits paying for medically necessary psychiatric care based on the size of the facility, not the type of medical care that can be provided. In a time where workforce, access, and clinical expertise are all in short supply, we should be considering how we design systems to treat mental illness like any other health condition. It is recommended that Minnesota consider applying for a waiver from the federal government to allow for short-term stays in psychiatric hospitals regardless of size, so that we may expand access to psychiatric beds and leverage expanded models of medical care that are more efficient and responsive to today's workforce shortages and access needs. Currently, 18 other states have applied for a waiver from the IMD payment exclusion and have been approved or are pending approval.

9. Minnesota should continue to reform policies that promote the development of innovative housing models for individuals with mental illness and/or complex behavioral needs.

a. Funding and licensing models for housing and residential-based care can be highly complex. How Minnesota's Unitary Residence and Financial Responsibility Act (Minn. Stat. §256G.01-.12) is applied in each situation creates additional considerations that counties must make as development of such housing models or use of public funding are often influenced or decided by local governments. As housing policy blends with treatment and service policy, there are some models that are more likely than others to be accepted by local governments, due to the likelihood of high-service need individuals moving into certain counties and therefore the local government becoming financially responsible for many of their services and cares. In many instances, the use of "excluded time" language has mitigated many of the concerns in these scenarios. Further consideration of "excluded time" designations with services may give local governments confidence to consider expansion of housing and services for individuals with complex needs.

b. Minnesota has continued to make progress with the state's Olmstead Plan, which has resulted in improved quality of life for people with disabilities. However, a lack of community housing or placement options for individuals leaving state hospitals or facilities has been a reality that many are working to resolve. Many of these individuals also have disabilities to consider when looking at housing options. There are times when the goals of these two efforts appear to be at odds, or there is a lack of technical understanding as to how to navigate them successfully. For example, the concept of a mid-to-large scale housing development (apartments with leases) for adults with mental illness could be designed where it is financially feasible to incorporate specialized 24/7 staffing available to individual tenants clash with the state's Olmstead plan as it generally is not viewed as an integrated setting. DHS should enhance technical assistance and funding opportunities to developers and local governments about how to expand housing options that provide housing and

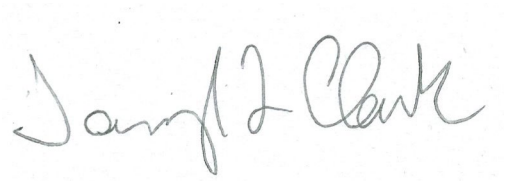
services that meet the clinical and behavioral needs of individuals with complex needs.

10. Increase training, technical assistance, and on-site supports to improve workforce abilities. Working with individuals with complex needs requires specialized training and support, and all too often we rely on a workforce that is under-trained and under-paid. To broaden the ability for people exiting hospitals to live successfully in the community, more training and supports are needed for the workforce that cares for them. Themes are present among many individuals discharging from facilities like AMRTC or CBHH's, and the workforce could greatly benefit from more training, technical assistance and on-site supports from expert teams. The following categories were identified by a DCT/County workgroup as themes: trauma-informed care, legal/forensic services, emotional dysregulation, cultural-specific supports, traumatic/acquired brain injury, vocational services, and more.

    a. The state should expand their Community Supports Services/Synergy team. The expertise of this team is needed with many more individuals than its current capacity can manage. This team begins their work with individuals while hospitalized and assists with the transition to community-based placement by providing on-site support, technical assistance, and training to the support teams in the community to assure a successful transition.

Thank you for the opportunity to continue to share our collective input and vision for improving the priority admissions process to better serve those who find themselves in the priority admissions process and those who work to serve that population. The work of the Priority Admissions Task Force is of the upmost importance to us and our associations and members. We look forward to discussing the responses of the Task Force members and the opportunity to shape policy recommendations that advance these goals.

Signed:



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