

# Mental Health Acute Care Needs Report

Children and Adult Mental Health Divisions-  
Chemical and Mental Health Services  
Administration

March 2009



Minnesota Department of **Human Services**

## Legislative Report

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## **Mental Health Acute Care Needs Report**

### **A Report to the Chairs of the Senate and House Health and Human Services Committees**

### **Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, Minnesota Department of Human Services**

**March 2009**

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## **I. EXECUTIVE SUMMARY**

The 2008 Legislature directed the Minnesota Department of Human Services (DHS) to convene a workgroup of stakeholders from the child, adolescent and adult mental health systems and staff of the health economics program, Minnesota Department of Health (MDH) to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. The workgroup was also charged with developing recommendations on how to best meet the acute care mental health needs of children, adolescents and adults. An examination of current and future workforce issues and recommendations to address any shortages was also a required part of the report.

A Steering Committee of 17 individuals representing key stakeholder organizations provided regular oversight and direction to three subcommittees. The subcommittees- child/adolescent, adult, and workforce- met monthly over the course of four months and prepared individual reports with recommendations for review by the Steering Committee. The subcommittees included members of the Steering Committee and other individuals who were interested in participating.

The three subcommittees used existing state and national reports as well as available data sources. The absence of a comprehensive set of data was identified as a limitation of the report findings. This was compounded by the lack of any nationally recognized methodology to determine the numbers of acute care inpatient beds needed by a population who also receive community-based services. The workforce subcommittee also commissioned a survey of hospital and community-based providers of mental health services from across the state to obtain information from the field about position-specific shortages, service impacts due to any shortages and recommended strategies to address the issue.

A set of recommendations specific to each of the three areas was developed and are included at the end of each section of this report. A good number of the recommendations can be accomplished without legislation or additional funds. Many of these related to continuity of care issues requiring improved communication between and coordination among the various levels of care and including the individual and his/her family in developing and understanding the plan of care.

For both children, adolescents and adults, the numbers of persons with complex care needs is increasing. Both systems lack the right mix of services to appropriately serve this population. The lack of intensive services geared to the challenging needs of these individuals often results in increased use of and prolonged hospital stays as systems struggle to piece together services that may not result in optimal client outcomes. The right service models and funding to support them requires further discussion and action.

Work force shortages were identified by many of the survey respondents, most notably for psychiatrists and advanced practice nurses (psychiatric nurse practitioners and clinical nurse specialists). Average time to successfully recruit these professionals was a minimum of one year. The workforce subcommittee received many comments regarding regulatory, funding and

training programs changes that could help to address shortages of key providers. It was also acknowledged that it is important to balance strategies to address workforce shortages by lowering requirements and standards with continuing to assure quality treatment and care.

Due to the short time line and the difficulty in obtaining and analyzing data about the entire system, there was agreement that some of the recommendations require further study. There was a willingness on the part of many of those who participated in the process to continue these studies.

## II. INTRODUCTION

The 2008 Legislature requested the Minnesota Department of Human Services (DHS) to convene a workgroup of stakeholders from the child, adolescent, and adult mental health systems and members of the health economics program at the Minnesota Department of Health (MDH) to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. The workgroup was also charged with developing recommendations on how to meet the acute mental health needs of children, adolescents, and adults.

A Steering Committee of seventeen individuals was convened in September 2008. The committee members represented children and adult mental health advocates, children and adult community mental health providers, hospitals, counties, health plans, MDH health economics and rural health programs and the DHS staff from the Chemical and Mental Health Services Administration. The Steering Committee served as an oversight group providing direction and suggestions to three subcommittees. The subcommittees- child/adolescent, adult and workforce- were created to discuss in greater detail the information requested by the legislature and to prepare a report with recommendations for review by the Steering Committee. The subcommittees were larger and open to those interested in participating. Additional input was also gathered from various organizations and individuals through surveys or presentations at meetings.

As requested by the Legislature, the child/adolescent and adult subcommittees analyzed the current capacity and utilization of:

- (1) inpatient hospital psychiatric beds;
- (2) partial hospitalization programs;
- (3) children's and adults' residential treatment facilities;
- (4) mobile crisis services and adult crisis homes;
- (5) intensive outpatient services; and
- (6) supportive housing arrangements.

These two subcommittees used existing data from the Minnesota Department of Health, DHS Minnesota Health Care Programs and public mental health service utilization tables and data collected from individual hospitals.

To address the request for an analysis of the number of practicing psychiatrists and other mental health professionals, the workforce subcommittee reviewed a series of reports on behavioral health workforce issues. In addition, the subcommittee commissioned a survey that was distributed to 396 behavioral health agencies statewide asking about position-specific staff shortages, the service impact of any shortages and suggestions on regulatory, scope of practice and training changes to address shortages.

It was clear from the work of the subcommittees and as reviewed and discussed by the steering committee that there is a problem with meeting the acute care needs of children, adolescents and adults with mental illnesses. What was harder to discern was the number of beds needed in facilities or the capacity needed for community based programs.

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, their 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).

A 2008 Minnesota Medical Association Psychiatric Bed/ER Diversion Task Force report identified a consensus among the task force members that there was an absolute and functional shortage of psychiatric beds. The Task Force also identified a number of factors contributing to the bed shortage and subsequent backup of psychiatric admissions in emergency departments. Among the identified factors were lack of bed availability at admission due to 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 (Minnesota Medical Association, 2008).

No studies or reports addressed specific alternatives for children/adolescents. A recent report entitled “Child and Youth Emergency Mental Health Care: A National Problem” finds that mental health emergency department visits are on the rise across the nation. The report found that over one-fifth of the children presenting in emergency departments exhibited dangerous behaviors and two-fifths had prior hospitalizations. Children in foster care were more likely to use the emergency departments. The report contained ten policy actions including ones specific to changes in the emergency department, more community treatment, better training of emergency department staff, and more effective emergency care. These recommendations did not include expansion of psychiatric hospital beds.

This report is divided into three sections. Sections One and Two provide the report from the child/adolescent and adult subcommittees; Section Three contains the findings and recommendations from the workforce subcommittee. Each section contains a comprehensive set of recommendations that are specific to each area.

Several areas of commonality are apparent between the child and adult sections. Both reports speak to the need for attention to and service development for children, adolescents and adults

with complex clinical needs, multiple diagnoses and chronicity. Approaches to addressing these service gaps may be different based on the clinical presentation of the target population. Both reports also identify continuity of care as a critical area in need of attention. Improving continuity of care does not require additional fiscal resources but rather a commitment across all providers to communicating across the array of services and to developing uniform reporting and treatment protocols.

Work force shortages were also identified in the child /adolescent and adult subcommittees as critical. The Steering Committee also identified the importance of a balance between addressing workforce problems through lowering requirements and standards and the need to continue assuring quality treatment and care.

Due to the short timeline and the difficulty in obtaining and critically analyzing data about the entire system, some of the recommendations contain suggestions for further study. The need for developing, collecting, reviewing and acting upon a uniform set of metrics was recommended by both the child/adolescent and adult workgroups.



### **III. CHILD/ADOLESCENT SUBCOMMITTEE REPORT**

#### **A. Subcommittee Composition/Process**

The Children's Subcommittee met four times on October 14, November 11, December 9 and January 6. Approximately 30 representatives including parents, advocacy organizations, educators, children's mental health providers, state operated services, counties, health plans, hospitals, corrections, and others. There were representatives from outside of the metro area.

The discussion of the first meeting focused on the "before" and "after" of hospitalization. The state of crisis services was discussed including the data on informational needs and barriers to access. Access to and intake at hospitals was reviewed with particular focus on data needs and barriers. At the second meeting presentations were made on the results of the 2007 DHS Metro Child and Adolescent Hospital Based Services Task Force and from the Children's Mental Health Division on Mobile Crisis Response Services. Lastly, existing hospital data that was requested at the first meeting was reviewed. At the third and fourth work group meetings members reviewed additional data and the draft report.

The subcommittee concluded that there is a problem accessing inpatient hospital beds. Access is a problem, in part, because 10% of child and adolescents patients occupy 46 % of the bed days. These children have complex needs and the services, including community alternatives and supports, that they need are either limited in number or do not exist at all. The workgroup recommends that the needs of these children for more intensive, longer term service alternatives be developed and funded in order to decrease inpatient bed utilization and thus free up beds for other children and adolescents.

#### **B. Description of the System**

Children and adolescents with acute mental health needs have varied histories and involvement in the mental health system and thus different approaches can be used to address a crisis. For some, this is their first incident. He or she may or may not have a diagnosis and may or may not be receiving treatment. An incident such as a suicide attempt, contact with the juvenile justice system, eruption at school, etc. causes the parent or other adult to seek immediate help. Some children and adolescents are in the mental health system, have a case manager, may be receiving special education and are receiving Children's Therapeutic Services and Supports (CTSS) or other community services.

When there is an acute mental health need, children have the following options:

- a) call the primary care physician or mental health provider
- b) call 911
- c) call mental health crisis team
- d) go to the emergency room

Under option (a) the child may be seen as promptly as possible, or at night or on weekends, the caller may receive an answering machine stating that they should call 911 or go to an emergency

room. Under (b) it could be the police or EMTs responding and the child could be brought to the emergency room or juvenile detention. Under (c) the child could be referred to the emergency room or receive assessment or stabilization services in their own home. Under (d) the child may or may not be admitted to the hospital and may or may not receive a referral to services in the community.

Access to hospitalization is based upon an open bed which is influenced by (a) time of the year (b) availability of psychiatrists, and (c) occupancy rates. The new bed finder system is helpful in that it identifies bed availability and limits time on the phone for emergency department staff. This system is continually updated so while there may not have been an available bed at 9 a.m., there may be by 3 p.m.

Once hospitalized, plans are made for when the child will be discharged. Some children are in for a short amount of time, up to 7 days, and are discharged home with a therapy appointment or maybe a medication change. Others take longer to be stabilized in the hospital and need more intensive services to return home. A few children need longer term intensive residential services. Any delays in accessing the services and supports needed to be discharged from the hospital result in an unnecessary over-utilization of a hospital bed.

System Numbers:

- 12 crisis teams serving children and adolescents covering 57 counties and 4 tribes in the state
- 157 hospital beds for children and adolescents in 6 hospitals with either separate or combined (child/adolescent and adult) units
- 585 beds in 17 children's residential facilities licensed under the Umbrella Rule for mental health treatment
- 8 spaces in 1 subacute psychiatric facility, at University-Fairview Medical Center
- 120 spaces in 9 partial hospitalization programs, located and administered by either hospitals or community mental health centers
- 1,466 children and adolescents served under Medicaid fee for service in 36 day treatment programs in FY 2008
- 121 credentialed CTSS programs

### **C. Detail of the Problem**

The purpose of the subcommittee was to analyze the current capacity and utilization of:

- (1) inpatient hospital psychiatric beds;
- (2) partial hospitalization programs;
- (3) children's residential treatment facilities;
- (4) mobile crisis services; and
- (5) intensive outpatient services.

#### **1. Inpatient hospital psychiatric beds**

According to the Minnesota Department of Health, of the 157 inpatient child psychiatric beds, 91 are in the metro area. According to a recent MDH report, "Children and adolescents living in

Greater Minnesota were the most likely to travel outside their own region for psychiatric and chemical dependency care, because there is very little hospital capacity in Greater Minnesota for these services. Some of these patients are also hospitalized on non-psychiatric units. The Department of Human Services lists the following hospitals as having designated psychiatric beds for children and/or adolescents for which they pay for care under the Minnesota Health Care Programs: Abbott Northwestern, Mayo, Fairview University Medical Center, Miller-Dwan, St. Cloud, United, Willmar Regional Treatment Center, and two additional hospitals in states bordering Minnesota.

The subcommittee reviewed data from the Minnesota Health Care Programs (MHCP). For calendar year 2007 there were 2100 children and adolescents hospitalized for psychiatric care. Of those, 62% were in psychiatric beds and 38% were in general hospital beds. The average length of stay was 13 days and the median was 8 with total bed days of 36,320. There were 210 children and adolescents (10% of total) whose average length of stay was 33 days and whose total days were 16,672. This means that just 10% of the children and adolescents used 46% of the total bed days. Additionally, they were admitted an average of 2.4 times versus the overall admission rate of 1.3. Of these 210 children and adolescents, 37% had also been hospitalized in 2006. The top diagnoses included disruptive behavior disorders, bipolar disorder, depressive disorders and anxiety disorders. It is important to note that 20% had a second diagnosis, 10% a third diagnosis and 3% a fourth one.

The subcommittee also reviewed hospitalization data provided by several hospitals: The group found that there were children and adolescents who didn't need to be in the hospital but were there because the post-discharge services the child needed were not available. The total number of non-acute days between December 10, 2007 through January 27, 2008 was 344 days for 71 patients. The primary reasons for non-acute days were delays in securing new placement, inability to access state beds, parental decision, problems with access to day treatment or case management, and delays in processing paperwork. Summarized, this means that delays in helping children and adolescents leave the hospital because of inability to access a new placement or alternative service quickly result in fewer available beds not because of inadequate capacity but because of inappropriate utilization.

The subcommittee also requested that one of the hospitals provide more specific data as to the diagnoses of the children and adolescents who were hospitalized for more than 10 days and for more than 30 days to try to get a clearer picture of these patients. For children and adolescents there longer than 30 days they found (with 32 cases annualized) the principle diagnosis was bipolar for 37%, oppositional defiant disorder (ODD) for 25%, and mood disorders for 38%. Additional diagnoses were significant and included: post traumatic stress disorder (PTSD) 87%, mild to moderate mental retardation 25%, attention deficit hyperactivity disorder (ADHD) 50%, and fetal alcohol effects (FAE) 33%.

The length of stay was a range of 30 – 79 days with the average being 42.45. This, again, demonstrates that a group of children, who present with complex problems, often including some level of cognitive impairment, are requiring longer stays than the “typical” child or adolescent in inpatient psychiatric hospitals.

For children and adolescents in hospitals longer than ten days, there were 360 cases with the principle diagnoses of depressive disorder 19%, episodic mood 9%, dysthymic disorder 7%, conduct disorder 7%, and ADHD 4%. Secondary diagnoses were ADHD 32%, ODD 22%, anxiety disorder 16%, PTSD 14% and tobacco use 13%. The range of the length of stay was from 11 – 28 days with the average being 15.67.

It became clear in analyzing the data that problems with accessing inpatient hospital beds was related to children and adolescents with intense and complex needs occupying beds because other options are not available. Thus adding new beds to the system will not address the underlying problem. Using the MHCP data, if the number of bed days for those 210 children and adolescents could be reduced by even 25%, an additional 521 children and adolescents (based on an average length of stay of 8 days) would be able to access inpatient care. Thus capacity – in terms of the number of children and adolescents served – could be increased by over 12%.

## **2. Children's residential facilities**

There are 585 beds in 17 children's residential treatment facilities that are certified to provide mental health treatment. These facilities offer an intensive treatment environment that includes individual, group and family therapy in addition to onsite education and recreational and skill building activities. A high degree of supervision and medication management and education are also provided. Staff include mental health professionals and practitioners as well as consulting psychiatrists. According to the Minnesota Council of Child Caring Agencies (MCCCA), all children's residential facilities certified to provide mental health services in Minnesota have contracted psychiatric consultation services, with consultation being provided once a month at minimum, and more frequently in response to specific child needs.

Data collected by the Minnesota Council of Child Caring Agencies includes information on a sample of 359 children and adolescents served in residential treatment centers. Almost 20% of those clients were admitted after being discharged from an inpatient setting and over 50% had experienced at least one prior hospitalization. The average length of stay was 237 days and presenting problems for a significant percentage included a combination of depression, oppositional behavior and impulsiveness.

The incidence of cruelty to animals, fire setting, self-mutilating behaviors, and enuresis is two to three times greater for youths in residential treatment centers than other types of residential programs.

Many of these residential facilities have to limit the number of children and adolescents on Medical Assistance they can admit to the program because of the poor reimbursement rates. The private insurers pay a higher rate and so a mixture of payers is needed in order to remain viable. The publicly funded per diem rates range from \$190 - \$342, with an average of \$214.

It is interesting to note the relatively low percentage of children and adolescents going into residential treatment from inpatient psychiatric care. While no formal analysis of this referral pattern has been undertaken, the 2007 DHS Metro Hospital-Based Services Task Force

speculated that a lack of match between specific child needs, based in complex diagnostic and functional presentations, and available residential treatment options might be a source of difficulty. Alternatively, there were also speculations that post-hospital placements were often based on the knowledge and experience of case managers, who might not be familiar with a range of program options statewide.

### **3. Partial hospitalization programs**

Partial hospitalization is a nonresidential program that emphasizes a therapeutic milieu, and includes therapeutic, recreational, social and vocational activities, individual, group, or family psychotherapy, psychiatric, psychological and social evaluations, medication evaluations and other activities under medical supervision. It is more intense than outpatient treatment programs and is at least 3 hours a day but is less than 24-hour care. These types of programs must have a close relationship with an acute psychiatric inpatient service. Staffing is high with a staff/patient ratio of four to twenty. Federal regulations require oversight by a psychiatrist and the program must employ mental health professionals and provide a minimum amount of psychiatric time. All children and youth have a treatment plan and parents/guardians are involved in reviewing the plan. There should be an educational component. The cost for this type of program ranges from \$465 to \$850 per day with an average of \$676.

In Minnesota there are eight partial hospitalization programs, with a capacity to serve 133 children or youth. Four are in the metro area, and the remaining four are in Duluth, St. Cloud, Willmar and Northeastern St. Louis County. The average length of stay varies from 4 to 18 days up to 4 to 6 weeks. Most of the programs run at 100% occupancy. There is a waiting list for most of the programs of about 2 to 4 weeks and even higher for children versus adolescents.

If a partial hospitalization program would be appropriate for the highly complex children and adolescents then efforts need to be made to increase the capacity to serve those particular children/adolescents.

### **4. Day Treatment Programs**

There are currently 40 day treatment programs in Minnesota that receive funding from the Minnesota Health Care Programs. A survey was developed by The Minnesota Council of Child Caring Agencies, Minnesota Association for Children's Mental Health, NAMI Minnesota and the Department of Human Services. The purpose of the survey was to gather information about day treatment to inform the working group on Day Treatment as they seek to establish definitive practice standards throughout the state, as well as establish efficient integration of the many systems involved in children's mental health treatment.

The survey contained 41 questions and the web-based Survey Monkey methodology was used to gather the information. The survey was e-mailed out to all day treatment providers through various organizations, DHS and to special education directors.

Day treatment or day program is a term that is used by many programs. The special education statute refers to "day program" and "day treatment" without any definition. There are references in the statute to the effect that special education can be provided in co-ops,

establishment of special classes, and by contracting with public, private or voluntary agencies. Intermediate districts offer day programs or call them alternative learning programs.

"Day treatment," "day treatment services," or "day treatment program" under the children's mental health act means a structured program of treatment and care provided to a child in:

- (1) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections [144.50](#) to [144.55](#);
- (2) a community mental health center under section [245.62](#);
- (3) an entity that is under contract with the county board to operate a program that meets the requirements of section [245.4884, subdivision 2](#), and Minnesota Rules, parts [9505.0170](#) to [9505.0475](#); or
- (4) an entity that operates a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts [9505.0170](#) to [9505.0475](#), that is under contract with an entity that is under contract with a county board.

Day treatment consists of group psychotherapy and other intensive therapeutic services that are provided for a minimum three-hour time block by a multidisciplinary staff under the clinical supervision of a mental health professional. Day treatment may include education and consultation provided to families and other individuals as an extension of the treatment process. The services are aimed at stabilizing the child's mental health status, and developing and improving the child's daily independent living and socialization skills. Day treatment services are distinguished from day care by their structured therapeutic program of psychotherapy services.

Day treatment services are not a part of inpatient hospital or residential treatment services. Day treatment services for a child are an integrated set of education, therapy, and family interventions. The minimum time requirement for day treatment makes it a less intensive service than partial hospitalization, and day treatment also carries no requirement for psychiatric consultation within its time parameters. Some day treatment programs located in hospitals and mental health centers may have access to psychiatric consultation.

A day treatment service must be available to a child at least five days a week throughout the year and must be coordinated with, integrated with, or part of an education program offered by the child's school.

"Day treatment program" provided through CTSS under Medical Assistance means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

Additional research is needed regarding the role of day treatment in meeting the needs of children and adolescents with complex needs and the role of funding and program quality. Many of these providers have seen their funding reduced as partnerships with counties and school districts have dissolved in direct response to budget challenges. Reliance on Medical Assistance to fund this level of care is not sustainable nor is it an adequate way to promote a

comprehensive program that includes broader care coordination with the child's education and home environments.

## **5. Mobile crisis teams**

Mobile crisis teams are a new service to address the acute mental health needs of children and youth. A crisis is defined as a child's behavioral, emotional or psychiatric situation that without intervention would likely result in significantly reduced levels of functioning in primary activities of daily living, an emergency situation, or the child's placement in a more restrictive setting including inpatient hospitalization.

Crisis teams are available 24/7 and can provide a number of services: a) face to face screening and assessment, b) mobile crisis intervention services to help the child cope, identify resources and strengths and return to baseline functioning, c) crisis stabilization services designed to restore functioning which can be provided in a number of settings.

Crisis teams are in their infancy with teams in all seven metro counties developed since 2003 and an additional 12 regional teams in greater Minnesota having been initiated in the past year. With limited data it appears that the teams are having an impact and refer far fewer cases for hospitalization than for example emergency departments.

Despite their infancy and their effectiveness in preventing hospitalizations, they are not widely known about by families. There is no "one" number to call and 911 operators do not route calls to mental health crisis teams. Few mental health professionals or clinics leave the number of the crisis team on their voice mail. There is also not a uniform understanding of what services they provide, there are not common definitions, and not all work closely with hospitals in their communities. Crisis stabilization for children and adolescents does not allow for stabilization from hospital discharge, given that the reasonable goal of inpatient hospitalization is stabilization. Although this was considered a problem by some committee members, the structure of the crisis response benefit was intended to prevent unnecessary hospitalizations. The workgroup agreed, however, that children and their families need greater support in the period immediately following hospital discharge.

DHS will be collecting information on staffing, contracts with health plans, partnerships, total calls by response type (referred to 911, face to face immediate, face to face within 24 hours, phone consultation, referral), crisis incident report (child specific data, race, age, insurance, diagnosis code) services covered by grant (with service definitions) and data on initial or repeat call, previous intensive treatment, referral source, reason for intervention, coordination, services child received within the last month, assessment data. Thus more information on their effectiveness will be available in the next year.

Crisis teams likely help prevent hospitalizations among some children and adolescents. Preliminary data point out that at least some can be diverted from emergency rooms and hospitalizations when short term crisis stabilization services are provided.

## **6. Intensive outpatient services**

There are a range of intensive community services that help keep children and youth stable in the community. These include:

- Children's Therapeutic Services and Supports (26 providers)
- Day Treatment
- Partial Hospitalization
- Mobile Crisis
- Timely access to child and adolescent psychiatry

Other community supports that are helpful for families include respite care and mental health behavioral aides, a service component of CTSS. Outpatient services include psychotherapy, psychiatric consultation, medication management, neuropsychological assessment and intervention.

Looking at data from the MHCP on those 210 children and adolescents with complex needs it was found that a higher percentage received case management (70%) in comparison to all children and adolescents hospitalized (18%), more had received intensive services (44% versus 24%) and residential treatment (20% versus 1%) but a lesser percentage received outpatient services (79% versus 95%). What was interesting to note was that the average unit of service received per child was the nearly the same between these more complex children and adolescents and all children and adolescents hospitalized. The information on these particular 210 children and adolescents was also reviewed for calendar year 2006 and it was found that 43% had received case management, 30% intensive services, 67% outpatient services and 9% residential treatment. Therefore 71% had received some type of mental health services the year before but still required hospitalization within the following 12 months. This is relevant in that these were not NEW children and adolescents to the system.

This raised questions in the subcommittee about whether in fact these particular children and adolescents were receiving the services in the intensity that was needed. Questions were also raised about whether the "limits" that are placed on services are having an impact in that these children and adolescents may not be receiving them for as long as they need them. This would include both program limits – programs that provide a particular length of intervention and funding, or authorization thresholds, interpreted by some providers as service limits.

### **Summary of Problems**

The subcommittee found that there are several key problems in the current system.

1. Inability to access hospitals beds
2. Lack of intensive alternative services for a small group of children/adolescents
3. Lack of knowledge about crisis teams and referrals to them
4. Lack of coordination between emergency responders, crisis teams and hospitals
5. Need for improved discharge planning out of ERs and hospitals to prevent re-admission
6. Need for longer term residential services for a specific group of children and adolescents
7. Lack of child and adolescent psychiatrists available for consultation and ongoing treatment



The group believes in the importance of promoting a “system of care” but found in its analysis that for children and adolescents who have the greatest and most complex needs, the system falls apart for them. The lack of alternative resources creates huge problems.

Another issue raised by the Child and Adolescent workgroup but not examined in depth was children and youth in our juvenile corrections system who have serious mental health problems and present difficulties in accessing community services or hospital readmission, often due to behavioral difficulties. These children and youth often wind up in detention facilities, or out of state facilities. Another example is youth who have been in child protection for many years, with many failed placements, often without a permanent family and/or with a failed adoption. Ramsey and Hennepin have been developing profiles of the children and adolescents who have had multiple failed placements, and most, if not all, have had a history of multiple hospitalizations. Thus while it is important to look at access to varying levels of mental health services, it is also important to recognize the impact on the juvenile justice and child welfare systems.

## **D. Recommendations**

The highest priority to address the problem is to develop a system of care to address the needs of children and adolescents who have highly complex mental health care needs. Serving these children and adolescents more appropriately will free up the capacity at hospitals and other types of services to serve more children and adolescents. Essentially we have children and adolescents who are “using up” resources inappropriately and are using resources that are not helping them become better and more stable in the community. Providing aggressive and intensive services to these children and adolescents will mean that they will be in the hospital fewer times and for a shorter length of time, thus freeing up hospital beds for others.

### **1. Focus intensive services to specific needs.**

a) Develop additional specialty services that are long term, intensive, supervised, highly integrated and interdisciplinary for children and adolescents with complex needs, with multiple diagnoses and chronicity. There need to be a range of programs from long-term residential to intensive hospitalization to coordinated care. The services for these children and adolescents differ in terms of the length of time treatment is needed, program components, structure and staffing. In order of priority, these specialties could include children and adolescents who have a combination of:

- Autism Spectrum Disorders with self-injury or aggression
- Reactive Attachment Disorder/PTSD with aggression
- Co-occurring disorder of MI/DD and Conduct Disorder
- Mental illness with brain trauma (TBI, fetal alcohol)
- MI and Complex medical issues
- Borderline personality features and severe emotional dysregulation
- Schizophrenia

b) Reconfigure and pay for specialty hospital beds or residential treatment beds that focus on treating these highly complex children and adolescents.

- Link the needs of these children and adolescents to program development at Child and Adolescent Behavioral Health Services (CABHS) Beds.
- Consider Metro Location of (CABHS) Beds.
- Create a “zero reject” facility for the system

c) Clarify and define additional services which might fill out the service continuum at less than a psychiatric inpatient standard of care. This might include the expansion of “sub-acute” hospital services and/or the adoption of a Medicaid option for more intensive residential services, typically identified as “psych under 21” in order to:

- Add sub acute capacity
- Create awareness of resolution of licensure/billing issues for sub-acute care
- Add additional Partial Hospitalization programs
- Increase post-hospitalization resource options available to families

d) Workforce Issues

- More child and adolescent psychiatrist ability to serve inpatient beds

- Utilize psychiatric extenders
- Providers work to the “top of their license,” e.g., by providing consultation to peers trained in other specialties, or providing supervision to tiers of the workforce with lower levels of training
- Use of interactive video technology to expand geographic access to services and make their receipt more timely, e.g., aftercare
- Allocate funds for the administrative costs involved with recruiting and training.
- Change training to include developing expertise in the provision of integrated (health care and specialty mental health) care; interactive video technologies; and, medical home models which embed care coordination in the primary or specialty care practice
- Improve hospital compensation and ability to address recruitment and retention
- Address seasonal variations
- Fund community based services, including those elements that are very effective such as collateral contact/care coordination/family psycho-education.
- Provide incentives to increase the availability of child and adolescent psychiatrists to collaborate and consult with primary care providers

**2. Increase the intensity and availability of community based mental health services to support children and adolescents with complex needs from needing hospitalization.**

- Increase funding to pay for intensity and more highly trained staff
- Investigate expanding systems of care model to target support for these children and adolescents and their families.
- Create other services, like Assertive Community Treatment Teams (ACT) for these children and adolescents
- Create a more intensive case management service

**3. Improve discharge planning from the hospital to reduce re-hospitalizations**

- 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

**4. 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

## **5. Increase the availability of community based mental health services to prevent children and adolescents from needing hospitalization**

- Integrate mental health services within pediatric settings and develop medical homes
- Increase readily available respite care

## **6. Funding**

The subcommittee recognizes that funding is scarce. However, targeting dollars to ensure that there is availability and access to key community-based services will free up usage of the highest cost services – emergency room visits, hospitalization and long-term out of home placements. More examination of the impact of funding on availability, intensity of care and quality needs to be conducted. Related to this are the paperwork requirements that sometimes prevent programs from focusing on delivering services and that prevent programs from providing the services for the length of time needed.

## **7. Quality Improvement**

As the children’s community mental health system evolves, there must be a focus on improved clinical outcomes and quality standards of care.

### **E. Areas in Need of Future Investigation**

There was not sufficient time to find or examine all available data. The subcommittee did recognize that there were some areas that needed additional work such as funding, community based services, workforce issues, and the intersection of the mental health, juvenile justice, education and child welfare systems.

One area that needs further investigation is the impact of systems of care grants in Minnesota. Systems of care is not a program — it is a philosophy of how care should be delivered. Systems of Care is an approach to services that recognizes the importance of family, school and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural and social needs. (SAMHSA) There are two programs in Minnesota, System Transformation of Area Resources and Services (STARS) for Children’s Mental Health which operates in Benton, Sherburne, Stearns and Wright counties and Our Children Succeed in Kittson, Marshall, Norman, Polk and Red Lake counties.

In looking at the most complex 10% of children and adolescents, only 13 of these children and adolescents were from the STARS counties. Their numbers per eligible 10,000 children and adolescents were also low (8, 2 and 12 respectively) compared to other counties where the range was between 0 and 49. More research must be done to discern what impact systems of care grants are having on these particular children and adolescents.

Another area for further investigation is why children and adolescents are being served in regular hospital beds. Using MHCP data we found that the hospitals in the following counties had children and adolescents in non-psychiatric beds.

Table 1. Admissions for child/adolescent mental health treatment to non-psychiatric inpatient beds

<b>Hospital Location</b>	<b>Total Days</b>	<b>Total Admissions</b>
Blue Earth	12	4
Brown	75	11
Crow Wing	178	25
<b>Dakota</b>	7	3
Douglas	7	2
Fargo	182	6
Freeborn	5	1
Grand Forks	1181	70
<b>Hennepin</b>	6730	607
Isanti	2	1
Kandiyohi	30	5
LaCrosse, WI	13	3
Lyon	11	3
Mahnomen	214	36
Non-border states	36	6
Olmsted	285	39
Otter Tail	130	20
Pennington	167	27
<b>Ramsey</b>	522	61
Rice	2	1
Scott	450	75
Steele	525	71
Wilkin	2	1
Winona	3	1
Wright	5	2
<b>Total</b>	<b>10774</b>	<b>1081</b>

We need more data and analyses to determine why these children and adolescents were admitted to non-psychiatric hospital beds. For example, it would be important to understand whether child/adolescent beds were not in close vicinity, lengths of stay were exceedingly short or if these stays were the result of awaiting a transfer to a child/adolescent inpatient psychiatric unit.

Additionally, it should be noted that the 2007 Mental Health Initiative is just being implemented. It is too soon to evaluate the impact that investments in respite care, crisis teams and in preferred integrated networks are or will have on this problem.

In moving into the future, the subcommittee also wants to collect other data such as:

- a) Readmission data, profile of children and adolescents with stays longer than average, from all hospitals
- b) Number of diversions from ED or inpatient
- c) Utilization rates of all intensive services
- d) Who uses crisis services
- e) Recurring visits to the ED
- f) Does use of crisis teams decrease need for inpatient beds
- g) Are there data from other states or counties
- h) Is the team serving current people in the system or “new” people

## **IV. ADULT SUBCOMMITTEE REPORT**

### **A. Subcommittee Composition/Process**

The Adult Subcommittee included individuals representing community-based providers, hospitals, consumers, family members, advocacy organizations, counties, managed care organizations and the Department of Human Services adult mental health division and state operated services. Additional input was elicited from a group of psychiatrist administrators of inpatient psychiatric units in metropolitan community hospital systems; executive directors from the Minnesota Association of Community Mental Health Programs and county directors/supervisors from the adult subcommittee of the Minnesota Association of County Social Service Administrators.

The subcommittee met five times from October 2008 through January 2009. The group began its work by reaching agreement on a common definition of acute care that would frame further discussions. The group agreed to use the following definition from the New Freedom Commission Subcommittee on Acute Care report which states: “acute psychiatric care is short term with a median length of stay of approximately 30 days or fewer; 24 hour inpatient care and emergency services provided in hospitals; and treatment in other crisis and urgent care service settings”

The group also agreed with the following statement from a national working group report on access to psychiatric inpatient care titled “Crisis in Acute Psychiatric Care” that states: “More recently, alternatives to 24 hour acute care have been developed and added to the list of generally defined acute care services that include crisis centers, 23 hour observation and stabilization beds, mobile crisis response teams, crisis residential programs for adults . . .”

Consistent with the legislative charge and direction, subsequent meetings focused on identifying system/service gaps that either result in unnecessary referrals to emergency departments and inpatient psychiatric settings or create barriers to timely discharges from inpatient care for individuals who no longer clinically require acute care services. A smaller subgroup also reviewed and synthesized available service data for a set of six (6) services.

### **B. Description of the Problem**

The subcommittee concluded that there is a problem accessing the right type and intensity of acute/intensive care. The subcommittee felt this was the result of:

- 1) a delivery system that approaches treatment and supports to persons with serious mental illness as episodic and reactive rather than assuring continuity of care across levels of care;
- 2) procedural and programmatic/ policy issues that exist creating barriers to smooth transitions between levels of care;
- 3) a lack of access to community-based services in a timely manner, especially outside of regular business hours;
- 4) variations in service capacity and access across counties, and

5) a growing number of individuals with challenging and complex care needs for whom the current array of services is not designed to meet their needs.

Many of these issues can be accomplished by improved collaboration and coordination across various parts of the service delivery system. However, given that some portion of unnecessary inpatient bed utilization results from a lack of funding to support community-based options, the subcommittee believes that any reduction in community-based services will only exacerbate the over-utilization of inpatient capacity.

### **C. Detail of the Problem**

The legislative language required inclusion in the report of current capacity and utilization of the following services:

1. inpatient hospital psychiatric beds
2. partial hospitalization programs
3. residential treatment facilities
4. mobile crisis services and stabilization beds
5. intensive outpatient services; and
6. supportive housing arrangements

Unless otherwise noted, the available data for each of the above services is based on calendar year 2007 and are limited to information compiled from the Department of Human Services' Health Care Program Reporting System and Adult Mental Health Division's service utilization tables. For several of these services, the data can be reviewed as complete because the service is almost universally used by persons funded through publicly funded programs. Specific hospital data are also included.

A brief description of each service and available data are presented below.

#### **1. Inpatient Hospital Psychiatric Beds**

The Minnesota Department of Health identified 1088 adult/geriatric inpatient psychiatric beds across the state with 746 located in the Twin Cities metropolitan area. Utilization was 89.9 percent for community hospitals with psychiatric units and 74.5 percent for the ten 16 bed state-operated community behavioral health hospitals located in Greater Minnesota.

The Minnesota Department of Human Services (DHS) contracts with 15 community hospitals to provide extended inpatient psychiatric services for persons age 18 and above who are Medicaid eligible and who are either judicially committed or are voluntarily admitted in lieu of commitment and require extended hospital care up to 45 days to complete treatment. These contracts do not require that inpatient beds be set aside for this purpose, rather the funds are available for individuals who are admitted and meet the defined criteria for coverage under the contract. Nine of the 15 contract hospitals that are located in Greater Minnesota also have a subsidy grant contract with DHS to serve uninsured and under-insured adults who do not qualify for Medicaid and who meet the same admission criteria as described above.



The 15 extended stay hospitals served a total of 726 individuals in CY 2007 with an average length of stay of 26 days.

A 2006 Patient Flow Study in the seven county Twin Cities Metropolitan area found that approximately 550 patients per year were admitted unnecessarily from emergency departments and 45,000 inpatient bed days were occupied by individuals who no longer needed acute care services and were waiting for intermediate resources to become available. Anoka Metropolitan Regional Treatment Center data for the same period found an average of 88 individuals per month were determined to not be in need of acute care treatment.

Many of these individuals present clinically with one or more of the following characteristics: a history of aggression; multiple diagnoses; cognitive issues; medical problems including delirium; elderly psychiatric patients with medical concerns; sexual acting out behaviors and individuals who present in the Emergency Department with suicidal threats but homelessness or avoidance of criminal consequences is underlying. A better model for management of this group of individuals would result in greater accessibility and more appropriate use of acute inpatient psychiatric beds.

Data from a large East Twin Cities metropolitan hospital indicate that unnecessary bed days continued to grow in 2008 for inpatients awaiting access to Intensive Residential Treatment facilities, chemical dependency programs, case managers and services for persons who have a developmental disability. The number of bed days at this hospital awaiting patient transfer to Anoka Metro Regional Treatment Center (AMRTC) remained above 2000 per year. Another metropolitan hospital reported excessively long wait lists, at times up to 80 days, for transfers to AMRTC.

Calendar year 2007 data provided by a hospital in a western border state indicate that approximately 1078 or about one half of their admissions were Minnesota residents. The majority of these admissions were residents of counties that either border that state or persons residing in Central Minnesota. Admissions from the Twin City metropolitan area totaled 121; the majority originating in Anoka County. An analysis by age for all Minnesota admissions to this hospital found that well over 50 percent of the admissions were individuals aged 21 or younger.

The availability of acute care psychiatric beds is related to a number of factors including professional staff shortages, availability of intermediate resources, days of the week and practice patterns of referral sources that identify hospital emergency departments as the only after hour and weekend option. Despite these barriers, several large hospital systems have increased bed capacity in the past one to two years.

The web-based bed tracking system has been operational for about two years and has helped to locate available inpatient bed capacity in real time. All of the community hospitals with psychiatric units are voluntarily participating. The system also interfaces with the Department of Human Services (DHS) state –operated hospital’s central admission. The availability of beds in crisis stabilization and Intensive Residential Treatment (IRT) settings have recently been added to the tracking system.

The use of the bed tracker website has resulted in fewer individuals and their families having to travel distances to access inpatient care. However, it should be noted that a three month analysis of the data using a consistent daily point in time and conducted in the late summer-early fall of 2008 found that available inpatient adult psychiatric beds are either significantly reduced or non-existent in the Twin City metropolitan area on Monday mornings or following a holiday. A lack of community based services after regular business hours, on weekends and holidays results in hospital emergency departments and inpatient units serving as the safety net. Adding to this pattern is the common practice of community-based providers referring callers to 911 or the emergency department of their local hospital rather than to local crisis services.

**It appears that there are an adequate number of acute care inpatient psychiatric beds in the system.** However, several factors negatively impact access. The lack of a range of community-based services, including supportive housing, creates backlogs on inpatient units. The system also lacks service models for individuals with complex care needs. Once admitted, this group of individuals often occupies inpatient beds long after their acute care needs have been met. Lastly, the increased numbers of individuals with co-morbid psychiatric and chronic medical diagnoses create clinical and fiscal challenges with providing efficacious and cost effective treatment in both inpatient and community-based settings.

## **2. Partial Hospitalization**

In 2003, Medicare-certified community mental health centers were added to Minnesota Medicaid as allowable providers of partial hospitalization programs. Prior to that time, only outpatient hospitals licensed under Minnesota Statutes, Sections 144.50 to 144.55 and accredited by JCAHO were allowable providers. The goal of this expansion was to intervene earlier in the treatment of adults experiencing an acute episode of mental illness and to divert from or reduce lengths of stays on inpatient psychiatric units.

Providers report that Medicare rules and regulations do not fit well for certain individuals such as young adults and have limited the development of this model for that population.

There are currently 15 Minnesota providers of partial hospitalization. Two programs located in North Dakota also provide this service to Minnesota residents. Six Minnesota community mental health centers also offer this service. Six hundred thirty two (632) adults representing a total of 24,196 hours received this service in CY 2007. The data for the use of this service for privately insured individuals was not available.

## **3. Residential Treatment Facilities**

There are currently 35 Intensive Residential Treatment (IRT) facilities located across the state. These facilities, with enhanced staffing and a shift to rehabilitation and shorter stays, were created in 2003 to divert individuals from unnecessary inpatient psychiatric care and to provide intensive services to adults who no longer needed acute inpatient care but who required a 24 hour supervised settings. Lengths of stays greater than 90 days require prior authorization. These settings are limited in size to 16 beds in order to qualify for Medicaid reimbursement.

In CY 2007, service utilization was 80.1 percent. One thousand nine hundred eighty three (1,983) individuals averaging 70 bed days per client received this service. No population-based adequacy and utilization standards for this service exist. Hence, it is difficult to objectively determine whether this percent of utilization compares to similar settings. It is also important to note that there are no comparative models regionally or nationally. Each state has designed and funded their residential component differently. Several states have contacted Minnesota for information about the IRT model.

A recent 2008 survey of the IRT facilities found that the majority of these settings accepted admissions only during normal business hours. Only six facilities conducted admission intake on weekends limited to the day shift. Since that survey, several facilities have expanded their admission hours and are beginning to accept direct referrals. This is still not uniform across all 35 provider facilities.

Standardization of admission procedures across all IRT settings and the ability to directly refer would help with greater access to these facilities. Hospital staff also would benefit from information about the criteria for admission. A work group of IRT directors, county and hospital representatives from the three east metropolitan counties and the DHS Adult Mental Health Division have begin to meet to standardize procedures and protocols. The final products from this effort can be extended to other IRT's settings across the state.

A critical gap in the system is IRT settings that can accommodate individuals who have both mental health and medical care needs. Current staffing and rate structures create challenges in designing and operating this model.

#### **4. Crisis Response Services**

Prior to the 2007 legislative funding to develop statewide crisis capacity, the availability of this service outside of the Twin Cities metropolitan area was largely dependent on local funding decisions. With the support of one time funding in 2002 from managed care organizations and subsequent state funds, the three counties in the East and four counties in the West metropolitan areas began to design and implement regional models of crisis response services.

In February 2008, crisis response grants were awarded to 11 regional Adult Mental Health Initiatives in Greater Minnesota. These funds support 36 crisis projects.

In Calendar year 2007, crisis assessment, intervention and stabilization services were provided to 5,725 adults. Service utilization for crisis stabilization services in the metropolitan area was 75.5 percent. In Greater Minnesota, utilization for this service was 29.2 percent perhaps reflecting the number of programs that are not yet fully operational.

The East Metro Adult Crisis Stabilization Service, a collaborative partnership of three counties, three community hospitals, three managed care organizations, consumer and advocacy organizations and DHS, have been meeting monthly for a number of years and are in the process of developing a business plan to design and implement an urgent care psychiatric setting to add

to their crisis capacity. Since its inception in 2002, the current service design has provided crisis stabilization services including rapid access to psychiatry and health care navigator services to over 3100 individuals.

The Mental Health Drug Assistance Program (MHDAP), funded by HealthEast, United and Regions hospitals and St. Paul and Bigelow foundations, is an East Metropolitan pilot project that provides psychiatric medications as a stop gap measure to individuals experiencing a mental health crisis. These individuals have low incomes and are not eligible for government program coverage or have either no prescription drug coverage or for whom a co-pay or co-insurance is unaffordable. Participating providers include crisis providers in the three county east metro area, Health East (St. Joseph's, St. John's), United and Regions hospitals as well as their associated outpatient mental and behavioral health providers. Of those individuals who accessed this service, there was a significant reduction in hospital admissions.

Several other models across the state of crisis response services have been found to be highly effective in diverting individuals who present in emergency departments and are not in need of inpatient services. The Scott /Carver counties crisis program, the Behavioral Emergency Center at the University of Minnesota Medical Center- Fairview and the Adult Psychiatric Center at Hennepin County Medical Center and the COPE program administered by Hennepin County behavioral health are among the models in the Twin City metropolitan area that can be considered examples of innovative models. Similar creative approaches to crisis services also exist in Greater Minnesota.

**Crisis Intervention Team (CIT) Training.** The DHS is currently funding ten regional efforts across the state to train local law enforcement officers and dispatch units on effective strategies to handle an adult experiencing a mental health crisis. The goal is to train a total of 350 law enforcement officers and their corresponding dispatch personnel by the end of 2009. In addition, funding is being used to support and improve local collaboration and coordination between law enforcement and mental health crisis teams. This national model has been effective in reducing unnecessary emergency department referrals and improving crisis intervention. Additional funding to expand this training model is needed. It was also suggested that CIT training should be required of all law enforcement staff.

## **5. Intensive Outpatient Services**

**Assertive Community Treatment teams.** Assertive Community Treatment (ACT) is a nationally recognized evidence-based practice that has been shown to reduce inpatient psychiatric use. In January 2005, ACT teams were added to the array of adult community-based mental health services across Minnesota. ACT uses a multidisciplinary team to provide a comprehensive approach to service delivery for persons with a serious mental illness whose symptoms cause the most substantial levels of disability and functional impairment. A 1:10 ratio of staff to participant is a generally acceptable staffing standard that has been used in other states that have successfully implemented ACT.

The most comprehensive study, conducted by Cuddeback et.al and funded by the National Institute of Mental Health, of a large urban community in the western United States

recommended that communities develop enough ACT teams to serve approximately 50 percent of their populations with severe mental illness or roughly .06 percent of their adult populations. Based on this formula, Minnesota is at or slightly above the number of needed ACT teams.

Minnesota currently has 27 adult ACT teams distributed across the state. One thousand eight hundred seven (1,807) adults were served in CY 2007 which represents an increase of 247 individuals from the preceding year. The average number of service hours per client was 77 hours.

Based on 2008 data, service capacity was at 64 percent. With the teams at or approaching the required 1:10 staff to participant ratios in the metropolitan areas and 1:8 in rural areas and for three special population ACT teams, it is expected that an additional 800 individuals can be served without further expansion. This additional growth is anticipated to occur by July 1, 2009. Improved communication and collaboration between the teams and hospital emergency and inpatient psychiatric departments as well as direct referrals to the ACT teams should also result in improved capacity.

**Intensive Community Rehabilitative Services** It became apparent that some rural areas of the state lack adequate client or staff capacity to implement ACT. In addition, there is a need for an intermediate level of service for those individuals who were transitioning from ACT services. To address these gaps, DHS funded four demonstration projects in 2008 to determine the clinical efficacy and cost effectiveness of a service of lesser intensity than ACT. These projects are currently serving about 200 individuals. Client outcome measures, funding options and sustainability are being evaluated over the three years of the demonstration. One of the challenges with this model is ongoing funding to maintain this care model.

This service design is one of the areas that the adult subcommittee of the Minnesota Association of County Social Services Administrators (MACSSA) identified as a model that should be expanded to other regions of the state.

## **6. Housing with Support Services**

Significant investments of state funds have been earmarked for temporary rental subsidies to assist adults with a serious mental illness access rental housing until they receive a Section 8 rental subsidy. As the numbers of federal Section 8 vouchers have been reduced over the past several years, the length of time individuals are required to remain on the temporary subsidy has increased. This has resulted in a reduction of the number of new applicants and shortages of temporary Bridges rental subsidies.

The state funded crisis housing assistance program has helped many individuals who have a serious mental illness and who have no other source of funding retain their current housing during an extended hospitalization or treatment in an intensive residential treatment facility. Past data analyses has shown a reduction in hospital bed days for those accessing this funding.

In 2008, a total of \$ 2.5 million in both ongoing and one time funds were awarded to 24 housing with support programs that will result in a range of housing options for adults who have a serious

mental illness. These housing with support options will come on line at varying timelines based on whether the project requires new development or renovation of pre-existing housing stock. New local zoning restrictions in some communities may provide additional challenges in siting new developments.

One of the major gaps in the current range of housing options is housing that serves individuals with challenging behaviors who no longer need acute care services, have experienced repeated failures with independent living and who would benefit from a setting that provided oversight and maintenance level of service. Traditional mainstream funding for the service component of this type of model does not exist.

## **Summary**

The group felt the prevailing episodic approach to mental health treatment rather than assuring continuity of care across levels of care greatly contributes to a reactive, crisis driven system rather than one that fosters recovery and empowerment and assures collaboration and coordination across services. This is further complicated by the concerns about liability and a reluctance to assume risk by serving individuals more appropriately in community settings. Liability and risk factors contribute to longer hospital stays and an emphasis on residential settings as the next level of care even for those individuals who could be safely served in less restrictive settings.

Using available data and direct service experience from subcommittee members and other key informants, the group identified several key areas that could help to reduce the number of unnecessary patient days for adults in acute care facilities. They include:

- The continuing expansion of intermediate and more intensive community-based services has helped to address acute care capacity. However, there remains an over-reliance on acute care emergency departments and inpatient services after hours and on weekends. This is in part due to long standing referral patterns that are hard to change and the lack of admission capability outside of traditional business hours.
- Improved communication and uniform procedures and protocols among providers across all levels of care to improve continuity of care. This includes changing the pattern of discharges from one level of care to another in a more timely fashion that addresses client needs and staffing capacity.
- A chronic care model of treatment is needed that addresses sound clinical practice approaches, fiscal and regulatory barriers for those individuals who present with complex care needs.

Within this context, the subcommittee meetings focused on identifying service gaps that resulted in unnecessary referrals to emergency departments and inpatient hospitalizations and specific barriers to timely discharges of individuals who no longer needed acute care services. These discussions led to the development of a set of recommendations to address these gaps and barriers.

## **D. Recommendations**

### **1. Develop a process that objectively establishes an agreed upon set of metrics to determine- on an ongoing basis- pressure points in the system that are creating barriers to smooth transition across all levels of care.**

- 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. 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. This would begin in the Twin Cities metropolitan area and would begin on July 1, 2009.

### **2. 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.**

- Convene a working group to review national studies addressing acute and continuing care management for adults with clinically complex issues and develop a business plan by December 2009 that includes service design, regulatory changes and funding requirements.
- Realign funding and regulatory silos for persons with co-occurring mental illness and substance use/abuse - learn from strategies developed by the Co-Occurring System Improvement Grant currently administered by DHS.
- Explore the feasibility of specialized psychiatric acute care inpatient and community-based intermediate care settings designed to serve individuals with a serious mental illness and co-morbid medical conditions.
- Create incentives such as the ability to call in a mental health professional to do a temporary care plan or to fund staff to provide time limited one-to-one observations for unstable clients.
- Work with nursing home organizations and the Minnesota Department of Health as a regulatory body to address nursing facilities' reluctance to admit or transfer back to their facility individuals with medical conditions who also have a mental illness.
- Implement a disease management methodology that would assure continuity of critical professional services across levels of care delivery.

### **3. Address procedural and programmatic/policy areas that create barriers to smooth transitions across levels of care**

- Create a single treatment plan across all service categories
- Create uniform data practices, including standard release of information, for use across all service categories
- Align Minnesota Data Privacy laws with HIPPA
- Require case managers to arrange for annual physical exams for their clients and establish protocols to assure that this occurs.
- Explore continuation funding for expansion of the Mental Health Drug Assistance Program that has successfully reduced hospitalizations.

- Conduct a survey of referral sources to Community Behavioral Health hospitals (CBHH) including suggestions to improve utilization of this service.
- Review existing protocols and develop greater uniformity in placement criteria by piloting the LOCUS level of care criteria for community-based services, beginning July 2009 with expansion statewide by January 2011.
- Examine the current Medicare requirements that limit expansion of partial hospitalization to certain populations and determine if an alternative option exists.
- Develop a working group of key stakeholders to develop strategies and recommendations for greater use of advance directives, shared decision making approaches and service models as alternatives to civil commitments.
- Develop a standardized intake form for Intensive Residential Treatment (IRT) and Assertive Community Treatment (ACT) teams that is used statewide.
- Conduct a comprehensive housing needs assessment that addresses the range of housing options from independent living arrangements to housing with supports for those in need of 24 hour oversight and monitoring.
- Conduct an analysis by the Office of the Ombudsman for Mental Retardation and Mental Health on the data they are collecting on suicides and make recommendations on approaches to improve access to mental health services.

#### **4. Improve access to the full array of intensive mental health services; especially during non-business hours, week ends and holidays**

- Implement a single phone number to access crisis services and educate families, 911 operators, emergency department staff, community-based providers about this number as well as information about crisis services and their availability.
- Monitor the expectation that Assertive Community Treatment (ACT) teams will be at full capacity by July 2009 and accepting direct referrals from hospitals.
- Assure that direct referrals to Intensive Residential Treatment (IRT) facilities for individuals who have health care insurance will be operational by July 2009. Monitor on an ongoing basis, that access to this service is not being restricted by requirements for a case manager prior to admission. Counties will retain the ability to triage individuals and to be involved with admission decisions for individuals who are uninsured.
- Fund 45 day operating subsidy contracts to community hospitals with psychiatric acute care inpatient capacity in the Twin City metropolitan area to serve individuals who are uninsured or under-insured. This option is currently in place for Greater Minnesota hospitals as well as in other states.
- 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.



## **E. Areas in Need of Future Investigation**

A number of limitations – especially in the area of more comprehensive data gathering and analyses-- need to be acknowledged. There was general agreement that an ongoing monitoring of a set of agreed upon metrics and benchmarks for both inpatient and community-based acute care services is needed as articulated in the first recommendation . This process will only be effective if there are also mechanisms in place to re-allocate resources as needed to address barriers that arise. This is especially important since there are no nationally or regionally recognized research methodology that examines the right numbers of acute care and intermediate community-based services in a specific geographic area. It is apparent that the configuration of services in Greater Minnesota will be different from those in either suburban or urban areas of the state.

Possible data elements may include:

1. the number of diversions from emergency departments and inpatient psychiatric units
2. the number and percentage of behavioral health patients in an emergency department greater than 24 hours
3. Utilization rates for intensive community-based services
4. Average time to outpatient psychiatrist or advance practice prescriber
5. Admission and discharge patterns across levels of care

## **VI. WORKFORCE SUBCOMMITTEE REPORT**

### **A. Subcommittee Composition/Process**

The subcommittee met four times between November 2008 and February 2009. Representatives included executive directors of community-based provider organizations, hospital behavioral health directors, direct service professionals, advocacy organizations, human resources staff, county social service directors, post-secondary educators, Rural Health planner, Minnesota Department of Health, Managed Care Organizations and the Adult Mental Health Division, Minnesota Department of Human Services.

The group met to complete the following objectives:

1. Analyze workforce related issues that have a direct impact on acute psychiatric care;
2. Identify critical shortages in workforce across disciplines; and.
3. Recommend workforce policies and practices that would reduce reliance on the acute psychiatric care system in Minnesota, and maximize the effective use of the behavioral health workforce resources.

To complete the work, the group reviewed a series of reports on behavioral health workforce issues. This included the Minnesota Mental Health Action Group (MMHAG) workforce summary and an in-depth analysis of shortage in core occupations in community mental health centers, clinics and program sites and strategies that are in place to recruit and retain staff.

### **Psychiatrists**

The Minnesota Department of Health's Office of Rural Health and Primary Care provided specific data regarding psychiatrist practice. There are 435 psychiatrists in Minnesota. When counties are divided into metropolitan, micropolitan and rural areas, the majority of psychiatrists practice in metropolitan areas (87 %). Only three practice in rural counties two in Staples and one in International Falls. The Office of Rural Health and Primary Care also conducted a voluntary survey of psychiatrists at the time of licensure renewal with the Minnesota Board of Medical Practice. Of the 337 responding to the survey, 58 % of psychiatrists reported they do not provide any inpatient psychiatric care.

### **Advanced Practice Nurses**

Data regarding advance practice registered nurses with current registration and certification indicate that of 2,330 certified nurse practitioners, 41 are certified in adult or family psychiatric/mental health. There are currently 489 certified clinical nurse specialists in the state; 201 are certified in adult psychiatric/mental health and 29 in child psychiatric/ mental health.

The group also determined that it would be important to gather information directly from agencies engaged in the acute care continuum. The subcommittee designed and implemented an online survey in December 2008 - January 2009.

The survey was distributed to 396 agencies and facilities across Minnesota, including 42 Community Mental Health Clinics and Centers. The survey was designed to assess position-specific shortages, the service impact of those shortages, and to glean suggestions on regulatory, scope of practice, and training changes needed that might address current and workforce shortages.

With the understanding that Minnesota will continue to experience shortages in critical positions such as psychiatrists, a nationwide issue, the group sought to understand what changes could be made to alleviate the shortages within the realities of the market today. Subcommittee members also collectively reviewed and provided advice on the recommendations based on their expertise and experience with mental health services and management.

The survey results and a summary of major themes and recommendations are included in this report. A number of the findings are consistent with those recommended in the MMHAG workforce summary.

## **B. Survey Response and Results**

Of the 396 distributed surveys, 146 agencies responded with a total response rate of 37 percent. Agencies were invited to complete more than one survey if they provide more than one type of program in the categories listed below. An additional 21 responses were received for a total of 167 responses. Thirty four percent of responders were metropolitan –based agencies and 66 percent identified their agency as non-metropolitan. Responses by service category are as follows:

- Inpatient hospitals = 27
- Intensive non-residential = 28
- Children residential = 6
- Adult residential = 29
- Mobile crisis/ adult crisis homes = 14
- Mental Health clinics or centers = 42

The major themes from the survey are:

- The **top two** consequences of workforce shortage across all types of facilities are wait lists (44 %) and higher case loads (54%)
- Recruiting psychiatrists and certified nurse specialists/nurse practitioners are the most challenging in terms of length of time. 55 percent of responders reported more than one year to recruit a psychiatrist and 42 percent reported the same time frame for a clinical nurse specialist. This correlates with higher rates of vacancies in these

positions across agencies. Low rates of vacancies existed for bachelor's level mental health practitioners and mental health rehabilitation workers with short time frames (1-3 months) to recruit.

- Thirty eight (38) percent of responders indicated that shortages had a highly negative impact on services with medical management having the greatest impact.
- The lack of qualified applicants and salary/benefits were identified as the top two reasons for vacancies across all programs.
- Public program reimbursements were seen as a barrier for workforce capacity
- Scope of practice issues are linked to funding of training programs. Highly specialized training is required yet those programs are in short supply and not funded adequately. This has a particularly negative impact in rural areas of the state.
- Changes in licensure standards will create more shortages in the next 3-4 years.
- Language assistance and information for staff on culturally appropriate care would be most helpful in providing culturally appropriate services
- Agencies are using many strategies to address vacancies. Flexible work schedules, salary adjustments and advancement opportunities were identified as the most important.

### **C. Recommendations**

The following recommendations are based on the subcommittee findings and survey results and are divided into the areas of regulatory/policy changes, reimbursement, and training.

#### **Regulatory/Policy**

- Review Minnesota's interpretation of the federal definition of what constitutes psychiatric rehabilitation services for assertive community treatment, adult rehabilitation mental health services, intensive residential treatment and day treatment. The current service restrictions are not reflective of the level of functional impairment or the array of services needed. If necessary, propose federal changes to this definition.
- Foster increased use of advanced practice nurses and physician assistants (more flexibility in practice, training incentives and par reimbursement).
- Align all prescribers with accountability to the same authority—the Board of Medical Practice.
- Allow for undergraduate supervised field experience to count towards the requirement of supervised hours to achieve practitioner and professional level status. Allow years of supervised experience to count for licensure. Give more weight to field experience in the area of mental health professional licensure.
- Make licensed professional clinical counselors (LPCC) a reimbursable mental health professional.
- Clarify licensing requirements and future of LPC and LPCC licensing.
- Allow individuals who hold a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university to be classified immediately as a mental health practitioner. Practitioners can provide a range of community-based services under the supervision of a mental health professional. The current requirement

places the individual as a mental health rehabilitation worker with less pay, less responsibility and increased supervisory requirements.

- Align definitions of a mental health professional/practitioner, licensure requirements, and scope of practice across related statutes.
- Support assertive community treatment teams in hiring master's level clinicians to provide therapy.
- Expand loan forgiveness programs to more agencies.
- Reduce regulation –decrease paperwork requirements for writing individual treatment plans, diagnostic assessments and the completion of other required work.
- Create uniform credentialing processes across health plans. Credential the agency, not the individual. This may need to be addressed with accrediting agencies. Insurance companies could then accept Rule 29 agencies as providers.
- Revise Rule 36 crisis staffing requirements for all staff.
- Remove AA requirement for mental health rehabilitation worker (MHRW) candidates who work day hours and allow the hours earned from one of the behavioral sciences or related fields from an accredited college or university to count toward MHRW
- Reduce 2000 hours enhanced supervisory requirement for mental health rehabilitation workers who have worked in mental health field—allow enhanced supervision to take place once hired.
- Author legislation with variance to expand US born mental health workers licensure requirements where language spoken at home is not English and clients are also non-English speaking.

## **Reimbursement**

- Level Medical Assistance reimbursement for community Mental Health Centers and all other nonprofit providers.
- Allow physician assistants, clinical nurse specialists and nurse practitioners the same reimbursement for medication management as a psychiatrist.
- Increase reimbursement for public programs (both facility and professional).
- Promote tele-psychiatry and collaborative care models in Minnesota to more efficiently use our work force resources.

## **Training**

- Provide additional professional development training or training grants for local agencies.
- Teach evidence- based practices in training programs. One option would be to incorporate the DHS Adult Mental Health Division's "Mental Health Core Training Videos" in the MNSCU and University systems. The videos are interactive training opportunities offered to practicing professionals and organizations.
- Teach practical diagnostic, treatment and documentation skills. Currently people are completely unprepared for being a full time therapist. Work with mental health agencies to understand how this could be done and recommend course work.
- Recruit more actual practitioners for mental health training programs.
- Offer classes for social work and chemical dependency counselors at tribal colleges.
- Provide better training in registered nurse programs on mental illness.

- Stop offering or assure applicability of academic degrees/certifications/licensure that are not recognized by Minnesota Medical Assistance (e.g. LPC/LPCC).
- Recruit more advanced practice registered nurses into mental health.

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