

# **Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services**

## **A Report**

Mandated by Minnesota Session Laws, 2010, 1<sup>st</sup> Special Session, Chapter 1, Article 19, Section 4.

December 2010



Minnesota Department of **Human Services**

# **Legislative Report**

**Chemical and Mental Health Services Transformation Advisory Task Force:  
Recommendations on the Continuum of Services**

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

**Chemical and Mental Health Services Administration, Minnesota Department of Human  
Services**

**December 2010**

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# Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services

## Report to the 2010 Legislature

### TABLE OF CONTENTS

I.	Preface.....	Page 4
II.	Executive Summary.....	Page 7
II.	Introduction.....	Page 11
III.	Discussion.....	Page 12
IV.	Recommendations.....	Page 18
	• Levels of Care Workgroup Recommendations.....	Page 19
	• Neurocognitive Workgroup Recommendations.....	Page 33
	• Access of Care Workgroup Recommendations.....	Page 44
	• Housing with Services Workgroup Recommendations.....	Page 78
	• Transportation Workgroup Recommendations.....	Page 82
	• Dental Workgroup Recommendations.....	Page 94
	• Child and Adolescent Intensive Services Workgroup Rec.....	Page 100
	• Anoka Metro Regional Treatment Center Redesign Rec.....	Page 108
V.	Appendices.....	Page 110
	Appendices include (167 pages):	
	• June 8, 2010 Memo on the Overview and Timeline for CMHS Redesign Process	
	• June 9, 2010 Invitation to CMHS Transformation Advisory Task Force	
	• Selected text from Minnesota Laws 2010, 1 <sup>st</sup> Special Session, Chapter 1	
	• CMHS Transformation Advisory Task Force Member Director	
	• MHCP Enrollment of Clients Receiving Community Mental Health Services	
	• Background Materials Related to the Scope of the Population Served	
	• State Operated Services: Client/Patient Count by Care Center	
	• Scope of People Getting Public Mental Health Services in Minnesota	
	• Final Workgroup Report: Levels of Care	
	• Final Workgroup Report: Neurocognitive	
	• Final Workgroup Report: Access of Care	
	• Final Workgroup Report: Housing with Services	
	• Final Workgroup Report: Getting there with Dignity (Transportation)	
	• Final Workgroup Report: Dental	
	• Final Workgroup Report: Child and Adolescent Intensive Services	
	• Anoka Metro Regional Treatment Center Redesign Report	

## PREFACE

As required by state law, the following report conveys recommendations of the Chemical and Mental Health Services Transformation Advisory Task Force to the Commissioner of Human Services and the Minnesota Legislature.

Minnesota's fragile mental health care delivery system has only recently begun to improve with the critical investments of attention, public policy, and funding. The implementation of the recommendations of the Minnesota Mental Health Action Group (MMHAG) and the Intensive Needs Task Force (INTF) over the last five years have only begun to make momentum in addressing the complex needs of children and adults with mental illnesses and the affect their mental illness has on their family. MMHAG's work led the creation and adoption of a model benefit set in all of Minnesota's publicly funded health care programs and to improved funding for the mental health infrastructure – those basic services that are needed for the system to function adequately. Likewise, the INTF made significant strides at identifying ways for the system to improve so that the needs of those individuals who have the most intensive and complex mental health needs could be met.

Despite these improvements, the mental health system continues to be vulnerable to the environmental forces of our time. These forces include possible spending cuts, healthcare reform, and other public policy changes that will seem like solutions as the State of Minnesota grapples with solving a \$6.2 billion budget deficit during the 2011 Legislative Session. The 2010 Legislature established the Chemical and Mental Health Transformation Advisory Task Force to continue the transformation made to the system over the last several years and to improve services, close gaps, address barriers, promote cost efficiencies and support sustainable design. The attached report represents hundreds of hours of work by a wide-range of individuals all of whom intersect with Minnesota's mental health system.

As a recipient of this report, we encourage you to take the time to read this report in its entirety to understand the full range of potential solutions to the issues the system faces.

As we look to the 2011 legislative session, the task force members believe it is critical for the legislature to:

- **Maintain infrastructure investments** for respite care for children, crisis services for children and adults, school-based mental health services for children, culturally diverse services for children and adults, supportive housing for adults and families and evidence-based practices for children and adults.
- **Maintain funding and payment rates for existing mental health services** under Minnesota's health care programs and support practices that encourage tele-medicine and psychiatric consultation in particular due to the benefits this provides to the work force shortage issues and to the access to care issues that exist.
- **Maintain funding for the Adult Mental Health Initiative regions** so that they can continue to work to determine how, on an individual basis, people with the most intense needs are able to access services to keep them living in the community and can continue to fund essential services in their regions.

- **Promote and provide access to both early intervention and treatment** to prevent mental illness from becoming a disabling condition.
- **Commit to using a person-centered approach** to meeting more effectively the needs of people who have a mental illness along with other conditions and who (due to a lack of coordinated targeted services) utilize mainly high cost services such as hospitalization.
- **Maintain funding** for programs that support people with mental illnesses such as the subsidized housing and supported employment.
- **Support** creating **longer term intensive mental health treatment alternatives for children**, closer to their homes.
- Promote and support the development of **community partnerships** in the metro region and in greater Minnesota so that state provided services and high intensity hospital and residential services are **not provided in isolation** from other community-based services but rather are delivered effectively through **integrated service networks** across the state.
- Develop at least **one pilot initiative** in the metro region that will provide an array of services as an alternative to hospitalization at Anoka Metro Regional Treatment Center.

We believe by supporting these items, the State of Minnesota can continue the momentum achieved over the last decade and continue the necessary improvements in the fragile mental health delivery system. Lastly, it is imperative for everyone to understand that any change in the mental health system, whether positive transformative system redesign or potentially negative reduction of financial resources, have wide-spread systemic effects that extend beyond the immediate impact on families and individuals, including private providers and hospitals, county social services, law enforcement, jails and the Department of Corrections, public health, and housing. The Chemical and Mental Health Transformation Advisory Task Force formally requests that this be considered as decisions in the 2011 legislature are made.

Finally, we would like to express our sincere appreciation to the over 200 individuals who participated on the various work groups and all of the members of the task force for their time and efforts. We especially want to thank the consumers and family members who participated for sharing their critically important thoughts and experiences throughout this process.

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## I. EXECUTIVE SUMMARY

The Chemical and Mental Health Services (CMHS) Transformation Advisory Task was established to make recommendations to the Commissioner of the Minnesota Department of Human Services and to the Minnesota Legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, and specifically reduce cost and improve efficiency of services provided by the state through State Operated Services. The Task Force was convened in June 2010 and was made up of members representing consumers, family members, advocates, advocacy organizations; service providers and professional organizations; unions representing public employees; state and local government with administrative and policy responsibilities for these services; state legislators; and academic programs conducting research and preparing behavioral health professionals.

The Task Force met a total of ten times to hear presentations of recommendations from the following seven workgroups organized around key issues or service areas:

- 1) Levels of Care
- 2) Neurocognitive Services
- 3) Access of Care
- 4) Housing with Services
- 5) Getting there with Dignity (Transportation)
- 6) Dental Services
- 7) Children's Mental Health Intensive Services

Each work group was instructed to assess current needs and provide recommendations to the Task Force related to courses of action and on what role State Operated Services should serve in addressing these needs. Each work group then went on to provide recommendations and long range goals for the broader system of care. The Task Force members discussed and weighed the work of each work group and in some cases, instructed each work group to respond to specific questions and provide more information. Task Force members then voted on each of the recommendations using a web-based voting mechanism. It bears mentioning for the sake of clarity, that the Task Force did not study or make recommendations on the delivery of chemical health services, except as it relates to services for persons with co-occurring mental health and substance abuse disorders.

The taskforce considered and voted on over 120 recommendations. The results of the vote on those recommendations are presented in the body of this report. Those highlighted below in this executive summary were selected from among those actionable items with the broad support of the task force.

- **Levels of Care Workgroup** recommendations include:
  - Community capacity, both acute care and community-based services, must be developed and implemented before reducing capacity within the State Operated Services system.

- Service level agreements need to be developed between acute care and community based providers [governing the transition of shared clients between levels of care] and protocols established to monitor and evaluate said agreements.
- For the target population, a model of intensive case coordination should be developed and funded. This model has case coordinators as active members of the treatment team and not merely brokering services.
- **Neurocognitive Services Workgroup** recommendations include:
  - People should be empowered to direct their lives and the services they need to live where and how they want to live. In order to accomplish this it may be necessary to:
    - Work to relax categorical funding and eligibility structures;
    - Educate people about the services that are possible (not just those that currently exist or are readily available)
    - Allow people to have greater ability to control the resources allocated to them and have choice of who provides the services they receive
  - People should feel encouraged to consider employment and have meaningful jobs with support available as needed. In order to accomplish this it may be necessary to:
    - Make employment services available to all individuals interested in employment, regardless of their identified potential for work by professionals.
    - Encourage employers to consider creative options for employees, including telecommuting, flexible schedules, an array of employment options and focus on getting to know the person and their needs as an employee; and,
    - Minimize financial disincentives related to working.
- **Access of Care Workgroup** recommendations include:
  - Robust mobile adult and children’s crisis teams should be accessible across the state and should be able to provide services collaboratively with emergency departments, jails and detention centers.
  - Mobile Crisis Team Services should be reimbursable when provided in emergency departments, jails and detention centers.
  - Collaboration psychiatric consultation should exist from screening in a primary care to variety of community, chronic and acute care settings.
  - Collaborative psychiatric consultation should be available psychiatrist to psychiatrist to bridge continuity of service needs between acute and community-based levels of care.
  - Address the difficulty of recruiting or attracting mental health professionals who are willing to work on crisis teams.
  - Provide additional training to crisis teams that provide services to both children and adults to ensure that they understand the parent perspective.
- **Housing with Services Workgroup** recommendations include:
  - A statewide housing with services analysis is needed that examines on a regional basis
    - the availability of supportive and affordable housing;
    - the service availability;
    - needs of persons with a serious mental illness in the region; and
    - the community capacity to develop, fund, and manage housing with services.

- The Phase I Target Population should be individuals with serious mental illness and complex needs must meet the following diagnostic, service, and housing criteria:
  - mental health service Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) rating of 4 or 5; and
  - the individual does not meet medical necessity for inpatient hospitalization; and
  - has complex, or multiple, service and support needs that are essential to be met in order for the person to obtain and retain housing; and
  - the individual has a demonstrated history of being unable to retain housing; or
  - there is a documented history that makes the person ineligible for a housing subsidy, rental voucher, or unable to obtain affordable housing
  
- **Getting there with Dignity (Transportation) Workgroup** recommendations include:
  - All regions should establish a psychiatric responder round table which would promote collaboration between ambulance services, law enforcement, mental health mobile crisis intervention services and other transportation entities involved in the medical transportation of persons who need quick access to mental health treatment.
  - The role of the mobile crisis intervention team should be clarified to include assessing the individual’s need for emergency hospital services, acute care hospital treatment, crisis residential stabilization services, or Community Behavioral Health Hospital services and determine the most appropriate means of transportation to get the individual to the service.
  
- **Dental Services Workgroup** recommendations include:
  - Develop and implement a comprehensive assessment of dental needs in Minnesota utilizing a representative sample of the target populations, recognized oral health indicators and validated metrics.
  - Develop a comprehensive analysis of SOS clinics, including:
    - an analysis/assessment of clinics billing and reimbursement practices; business management practices and
    - develop plan for enhanced utilization of clinics with clear roles and functions along with an assessment of any additional equipment upgrades & staffing needs
  - Development and recognition of a clear role for SOS Clinics in serving the target populations
    - marketing of Clinics to providers, care coordinators and client communities regarding appropriate care coordination and referrals
    - development of partnership to serve as training sites and to recruit dental professionals
    - develop partnership with educational institutions for rotation of students/residents
  
- **Children’s Mental Health Intensive Services Workgroup** recommendations include:
  - **Public Safety Net:** the Child and Adolescent Intensive Services Workgroup believes the state has a responsibility to continue providing a “safety net” for this population and recommend that State Operated Services (SOS) continue to fulfill this obligation by maintaining its capacity to serve youth who require inpatient psychiatric care but whose treatment needs cannot be met in a community setting. However, maintaining this capacity does not necessarily mean providing services to these youth in a state-operated

facility. Alternative approaches to serving this population, such as contracting for psychiatric beds in community hospitals or supporting the development of psychiatric residential treatment facilities (PRTFs) should also be explored.

- **Supporting Families:** One of the most basic needs is for statewide dissemination of information for families about how to access services as early as they may have a concern. These materials could be customized locally to facilitate access to appropriate services, and could be distributed by family, advocacy and provider groups to assure a common knowledge base of available services. Additional suggestions for supporting families included
  - the development of parent-to-parent or other parent support groups in every county;
  - care coordination which crosses all systems touching the lives of children and families, perceived as broader in scope than current case management

The Task Force was also charged by the Minnesota Legislature to provide recommendations to the Commissioner and to the Minnesota Legislature on a redesign of the Anoka Metro Regional Treatment Center (AMRTC). In October 2010, the Task Force heard presentations from the Department on approaches to developing pilot models in partnership with counties and community providers Anoka Metro Regional Treatment Services. In order to achieve the legislatively mandated goal of the Task Force with regard to the AMRTC, the Department proposed releasing a formal Request for Proposal (RFP) on March 1, 2011 that will require response by May 1, 2011 to develop at least one pilot initiative in the metro region that will provide an array of services as an alternative to hospitalization at Anoka Metro Regional Treatment Center. The Task Force heard a proposal from State Operated Services to temporarily create a sub-acute service while the RFP process was underway. The Task Force responded with caution to this proposal, expressing that the expense of closing a unit and opening a new unit in another location may be prohibitive and did not fit the charge to the Advisory Task Force to provide recommendations that were “transformational” by addressing how State Operated Services fits into the a transformed broader system of care for adults with severe mental illness and complex needs in the metro region. In the end, the Task Force endorsed the following process for developing alternative services within the metro area:

- Staff of the Chemical and Mental Health Services Administration should meet with directors from the seven-county metropolitan area prior to January, 2011 to discuss an agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders.
- The process mutually agreed on above should be employed during January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members and advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a RFP to be developed by DHS. DHS will cover the cost of facilitator services to run and coordinate these meetings.
- DHS should issue an RFP consistent with recommendations of the CMHS Transformation Advisory Task Force, input from the local process outlined above and the requirements in

Laws of Minnesota 2010, First Special Session Chapter 1, Article 19 section 19 by March 1, 2011 with a projected due date of May 1, 2011 for local responses.

- The Chemical and Mental Health Services Transformational Advisory Task Force should appoint a subcommittee to evaluate and advise the Department's implementation of the recommendations above. Initially, and through the completion of the RFP process, the subcommittee will be composed of members who are representing advocacy organizations, consumers & family members, and the statutorily established advisory bodies for chemical and mental health services. The subcommittee will convene at least once to hear stakeholder presentations and advice on its task prior to the drafting of the RFP. In the event that the RFP process does not produce a plan for alternative services, the subcommittee will evaluate and advise any further action taken by DHS to plan and implement alternative services. The membership of the subcommittee overseeing the development and implementation of alternative services should expand once the RFP process is concluded to include key stakeholders initially excluded due to conflict of interest limitations.

## II. INTRODUCTION

As directed by the Laws of Minnesota 2010, First Special Session, Chapter 1, Article 19, Section 4, the Chemical and Mental Health Services (CMHS) Transformation Advisory Task Force was established to make recommendations to the commissioner of human services and the legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, reduce cost, and improve efficiency. (See Appendix III at the end of this report for specific legislative language.)

The 2010 Legislature established this task force in response to a 2009 Legislative report, [\*Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience & Recovery of the People\*](#), on the redesign of the public chemical and mental health system in Minnesota and its associated budget proposal and implementation plan. That report discussed the underutilization of the available beds within the State-Operated Community Behavioral Health Hospitals (CBHHs) and the inappropriate placement of persons with mental illness in inpatient hospital settings at the CBHHs and the Anoka Metro Regional Treatment Center. The report also discussed the process utilized to assess the needs and recommendations for system transformation obtained in community meetings held across the state and included input from nearly 1,000 Minnesotans representing those with most at stake in service delivery to people with mental illness— consumers, family members, advocates, county and tribal officials, community hospitals, community mental health providers, in addition to SOS employees and state legislators. The report resulted from a directive from the 2009 Legislature to transform services provided at the Anoka-Metro Regional Treatment Center and the Minnesota Extended Treatment Options.

### III. DISCUSSION

Between adjournment of the 2009 Legislature and the beginning of the 2010 Legislative Session, budget pressures for State Operated Services (SOS) and the rest of state government mounted and SOS identified that it needed to reduce its operating budget by \$17 million by the end of the biennium on June 30, 2011. The 2009 report was intended to be an immediate response to those budget pressures and the simultaneous need to transform the current publically-operated care delivery system. The report outlined a phased-in approach over a 15 month time period resulting in a reduction of full-time positions and the closing or transforming of several SOS services. The 2010 Legislature responded to the report and plan by creating the CMHS Transformation Advisory Task Force, by allowing certain SOS services to close or transition to another alternative, and by providing enough funds to delay the ultimate reduction of specific state-operated services.

Under the 2010 law that was passed, The CMHS Transformation Advisory Task Force was required to make recommendations to the commissioner and the legislature no later than December 15, 2010 on the following:

1. transformation needed to improve service delivery and provide a continuum of care, such as transition of current facilities, closure of current facilities, or the development of new models of care, including the redesign of the Anoka-Metro Regional Treatment Center;
2. gaps and barriers to accessing quality care, system inefficiencies, and cost pressures;
3. services that are best provided by the state and those that are best provided in the community;
4. an implementation plan to achieve integrated service delivery across the public, private, and nonprofit sectors;
5. an implementation plan to ensure that individuals with complex chemical and mental health needs receive the appropriate level of care to achieve recovery and wellness; and
6. financing mechanisms that include all possible revenue sources to maximize federal funding and promote cost efficiencies and sustainability.

The membership of the Task Force was composed of the following stakeholder groups:

1. Consumers and family members;
2. Advocacy organizations;
3. Service providers and professional organizations;
4. Unions representing public employees;
5. State and local government with administrative and policy responsibilities for these services;
6. State legislators; and
7. Academic programs conducting research and preparing behavioral health professionals.

Seven internal CMHS workgroups were identified to plan for system improvements and act as resources to the task force. These workgroups are:

1. Levels of Care;
2. Neuro-Cognitive Services;
3. Access to Care;
4. Housing with Services;
5. Transportation Services;
6. Dental Services; and

## 7. Child and Adolescent Intensive Services

These workgroups were charged with proposing an overarching model and framework for what will, once implemented, constitute the network of services to that the needs of the people around the state are uniformly fulfilled. These workgroups operated under the common principles of:

- The products of the workgroups need to be consistent with principles of Person-Centered Thinking, assuring attention to what is important to consumers.
- Recommendations should include evidence-based practices and best practices for adults (Trauma-Informed Care, Illness Management and Recovery, Assertive Community Treatment, Certified Peer Specialists, Integrated Dual Disorder Treatment, Supported Employment, Family Education and Support, Supported Housing, Supported Education, etc.) and Children and Adolescents (Cognitive Behavior Therapy, Positive Behavior Supports, Multi-Modal Approaches, Parent and Teacher PBS Training, Aggression Replacement Therapy, ABA, Trauma-focused CBT, etc.).
- Service design must be consistent with the expectation of recovery and resilience, and include family involvement when it works for the consumer.
- Recommendations should include the efficient and effective use of resources and sensitivity to local preferences.

Each workgroup also operated under a common set of parameters. These included:

- Each workgroup must identify or develop metrics to evaluate effectiveness of the group's recommendations.
- Workgroups should begin with the SOS redesign stakeholder input information and proposals from that process.
- Each workgroup's deliberation process needs to account for people with multiple and complex needs, including any combination of mental illness, intellectual disability, chronic medical conditions.
- The deliberation process needs to include all the state's residents, regardless of age, culture, or background.

From June 22, 2010 until December 6, 2010, the CMHS Transformation Advisory Task Force heard reports from the individual workgroups, discussed the findings and recommendations presented by the workgroups, requested additional work to be completed, drew conclusions from the results, and ultimately voted on the recommendations as presented in this report.

Besides the recommendations on the broader system, the Task Force was specifically charged by the Minnesota Legislature to provide recommendations to the Commissioner of Human Services and the Minnesota Legislature on a redesign of the Anoka Metro Regional Treatment Center. The process for achieving this goal, as presented by the CMHS Administration, was to proceed with issuing a Request for Information (RFI) in October 2010 as a step to initiate a process for the redesign of services at the Anoka Metro Regional Treatment Center. The stated purpose of the RFI was to "solicit recommendations and proposed models from potential responders to a Request for Proposals to serve approximately 100 adults who have multiple disabilities and multiple diagnoses with poorly managed chronic medical conditions and /or behavioral dysfunction and chronic functional deficits who have been treated by AMRTC or are at risk of

being committed to the commissioner of human services for treatment at AMRTC.” The objective of the RFI was “to begin the transition at AMRTC by reducing initial capacity at the facility by up to two units and to design the full array of quality mental health services from acute care to housing with supports in the community using, in part, staff from AMRTC who will continue to be state employees.” The RFI “envisioned that these networks with formalized service agreement will be a precursor to the Accountable Care Organization (ACO) proposed in the future under health care reform.”

The RFI, requested information from the seven counties served by the AMRTC and its array of service providers on:

- formal, collaborative models for delivering care;
- opportunities and challenges the models would present;
- requirements of resources, policy changes, and funding;
- the use of existing state staff to deliver services (*as prescribed by the law*); and
- the associated timeline for implementation.

While completely voluntary, participation in the RFI was considered a precursor to a future Request for Proposals (RFP) that the Administration proposed to initiate. According to the plan presented to the Task Force, the RFP would require the development of formalized, collaborative partnerships from providers that would cover the full service array from acute care settings to the wide range of community-based mental health services including housing with supports in order to meet the needs of the target population.

Within the RFI, responders were requested to address the following:

1. Indicate the specific community hospital(s) with acute psychiatric care units and the community-based providers that will establish the formalized partnerships and what enhanced or expanded services will be provided.
2. Indicate the proposed fiscal agent for the partnership.
3. Indicate how consumers, family members, advocates and other key stakeholders will be included in the planning, development, implementation and monitoring of new service models.
4. Indicate the mechanism(s) by which individuals are allowed to voluntarily participate in this pilot partnership alternative or choose to be served traditionally at AMRTC.
5. Indicate the proposed numbers and qualifications of state staff currently working as AMRTC that will be needed to support the partnership and proposed models and any training and potential administrative costs associated with incorporating additional staff into the service mix.
6. Indicate the methods by which quality monitoring and oversight will be implemented to evaluate the efficacy and cost-effectiveness of the proposed partnership and proposed new models.
7. Indicate a proposed timeline that addresses planning, development and implementation.
8. Indicate any supports, technical assistance and other additional resources that are needed to meet the proposed timeline for implementation scheduled to occur on or before January 1, 2012.

9. Indicate how any proposed partnerships or models will comply with existing statutory or other legal requirements, including any requirements related to state employment or if any changes in current law would be necessary to effectuate the proposed partnerships or models.

Responses to the RFI were requested to be received by 4:00pm (CST) on November 17, 2010.

The seven-county metropolitan region initially responded to the RFI by submitting a series of questions and the Department of Human Services replied by provided responses on October 29, 2010. (Questions and Responses can be found in appendix II of this report.) Concurrently, the Counties submitted a letter dated October 29, 2010 (see appendix III) unanimously affirming that:

- “Support of the objective of transitioning citizens out of AMRTC and back into the community. However, each county needs additional information regarding its citizens placed at AMRTC to determine what level of supports would be needed to accomplish this;
- Individuals in question have significant multiple disabilities, diagnoses, and upon transition would continue to be at very high risk for re-commitment to the Commissioner;
- A willingness to consider multi-county models to accomplish the objective;
- Confirmation that a significant waiting list at AMRTC compromises the availability of needed services;
- Appreciation that responses to the RFI are voluntary in nature; and
- Agreement that responses should detail a full service array.

Despite these points, the Counties urged the “Department not to move hastily to downsize the AMRTC without adequate planning...” and that “the Metro Counties do not want to see our residents disproportionately experience poverty and homelessness due to failures of the service delivery system.”

As a result of this caution, the Metro Counties agreed “that to produce a thoughtful, comprehensive, multi-county response to *the* RFI with merely 28 business days from publication to due date is unrealistic, for the following reasons:

- The RFI essentially asked counties to accomplish the next step in de-institutionalizing people with serious and persistent mental illness. This is a major systems transition. The scope of work encompassed in the RFI was daunting and cannot be adequately assessed in the time frames provided. Simply put, if the answer to moving more people out of AMRTC was so straightforward that Counties could provide it to you in 28 days, those counties would have accomplished it already.
- The RFI asks the Counties to identify how consumers, family members, advocates, and other key stakeholders will be included in the planning, development, implementation, and monitoring of new service models. Ideally, those individuals should be involved from the very beginning – the RFI stage – but this time frame did not realistically allow for more than their token involvement.
- The RFI further required identification of the mechanism(s) by which individuals can choose to receive service at AMRTC over whatever model(s) developed. There are many problems with being able to respond to this item within the time frame provided. First of all, such a mechanism may actually require a change in the Commitment Act, which of course cannot

be accomplished by November 17. In addition, it will likely require the creation or identification of risk protocols that are currently not in use. Again, this task is not likely to be complete by November.

- The RFI requested that Counties indicate specifically the numbers and qualifications of state staff required to effectuate the model. This strikes us as an extremely detailed question to respond to within the first four weeks of planning for a major system transition.”

The Counties furthered that, “beyond the low quality submissions DHS would likely receive in such an abbreviated time frame, it simply may not be logistically realistic for county governments to process a response so quickly. County Boards of Commissioners typically require policy discussion and subsequent board approval in order for local social service agencies to submit RFI responses, a process which is not possible given the time required to complete the response drafting. In addition, it is possible county attorneys will advise us not to respond as multi-county entities without the existence of an underlying legal framework, such as a Joint Powers Agreement.”

In response to the receipt of this letter, the Department responded with a letter dated November 3, 2010 (see Appendix IV). The letter indicated that the RFI was to “solicit suggestions, potential proposals and any recommendations that would assist the department with issuing a RFP that incorporated ideas at the local level.” Responding to the Counties concerns about level of response necessary and the Counties inability to respond in a thorough fashion by the specified timeframes, the Department outlined the following alternative approach:

- “1. Staff of the Chemical and Mental Health Services Administration will meet with directors from the seven-county metropolitan area in December 2010 to discuss a less formalized and mutually agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders;
2. Meetings would be convened in January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members and advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a RFP to developed by DHS. DHS would be willing to consider covering the cost of facilitator services to run and coordinate these meetings.
3. DHS will issue a RFP on March 1, 2011 with a projected due date of May 1, 2011 for submission.”

The letter also indicated that “because the last legislative session included budget savings that must be realized by State Operated Services, the department will likely need to proceed with some temporary changes at AMRTC to meet the budget pressures being encountered. It is the department’s intent that any changes be temporary in nature until a workable design is developed and implemented in 2011.”

In addition to this activity, on November 22, 2010, State Operated Services presented the CMHS Transformation Advisory Task Force with a temporary plan to re-design and move two units out of AMRTC until a more permanent solution identified through the RFP process could be initiated.

The patients served at Anoka have multiple diagnosis and multiple disabilities. They present complex cases and have co-occurring disorders. Of the total population served at Anoka, approximately 70% have a psychotic disorder, 25% have a bipolar disorder, 18% have major depressive disorder, 75% have a substance use disorder and 30% have a personality disorder.

As has been stated previously, approximately 30-40 patients being served at AMRTC are being served at a hospital level of care which is a higher level of care than the individuals need. This number has been consistent for two years.

It is believed this population could be moved from Anoka to a lesser level of care that would serve as an Intensive Residential Treatment Service (IRTS) plus or a “sub-acute” level of care to better meet their needs in a more appropriate setting. While respecting the timelines of the metro-wide RFP process that was presented to the Task Force, SOS felt that it needed to respond to current budget pressures and the inappropriate utilization of 30-40 beds.

The temporary proposal submitted by SOS was to convert the vacant Bloomington unit to a sub-acute unit by May 2011. In addition, SOS would open a second sub-acute unit on the Anoka Campus and relocate it to a yet to be determined community site by July 2011. Both of these sites would then need to be integrated with the existing primary care and behavioral health care community structures.

The Taskforce expressed concerns with this temporary proposal. Taskforce members indicated that they were concerned that care coordination and service delivery would not be improved and that the timeline was aggressive. Specific concerns expressed by persons who utilize CMHS services included a request to improve communication regarding discharge planning with them to avoid stress caused by the unknown. In addition, the Task Force expressed concerns pertaining to the lack of adequate time needed to assess service delivery in the metropolitan region, the needs of the persons receiving services at AMRTC, and the best methods for improving service delivery for these persons, including additional redesign of the system needed to support these individuals.

Greater detail of the process proposed by the Department to redesign services delivery for persons served by the Anoka Metro Regional Treatment Center are specified within the *Chemical and Mental Health Services Transformation Advisory Task Force: Anoka Metro Regional Treatment Center Redesign*, an appendix to this report.

Task Force members emphasized that the ongoing redesigned chemical and mental health system make the following improvements:

1. Is person-centered with an individual plan for each person;
2. Is integrated into the health care system;
3. Identifies the highest users of the public health care system and designs appropriate interventions;
4. Improves communication on services that are efficient and effective;
5. Covers the entire life span of a person;
6. Is committed to improving access and sharing risk;
7. Adopts a new method of transporting persons; and

8. Adopts current new and best practices, such as health care homes, etc. as it is designed.

#### IV. RECOMMENDATIONS

The individual CMHS workgroups identified earlier in this report presented a series of recommendations to the CMHS Transformation Advisory Task Force for their consideration. After hearing the recommendations, the Task Force instructed each workgroup to respond to specific questions and provide more information at consecutive meetings. Task Force members then utilized an electronic survey tool to vote on each recommendation. Those recommendations and the resulting votes are presented in this section.

##### **Recommendation Options Included:**

1= I **strongly support** this recommendation and think it should have a high priority.

2= I **support** this recommendation.

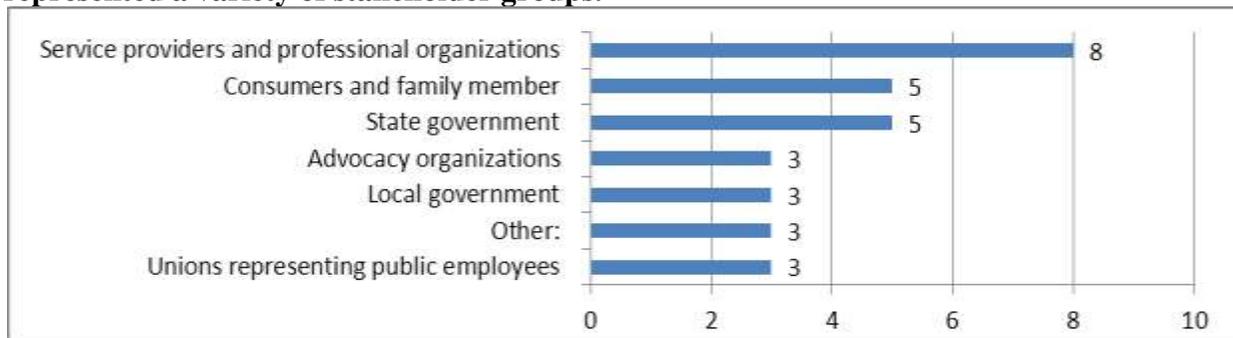
3= I can support this recommendation, but with **some ambivalence**.

4= I generally support this recommendation, but want to voice the following **concerns** or caveats

5= I **do not support** this recommendation

##### **Respondents**

**The total respondents for all survey questions=30, unless otherwise noted. Respondents represented a variety of stakeholder groups.**

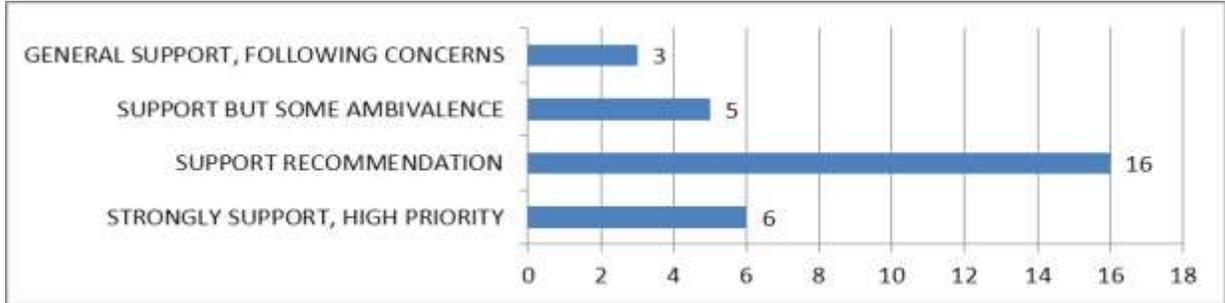


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## Levels of Care Workgroup Recommendations:

### RECOMMENDATION

- The transformation is based upon defining practical regions and empowering the relevant agencies, facilities and providers to perform and be responsible for necessary tasks to meet the needs of clients in that region. Identical expectations and standards need to be upheld regarding consumer choice, access, quality and consumer satisfaction, flow and cost metrics. The Adult Mental Health Initiative regions are a reasonable starting point for these discussions.



### Groups with concerns or who do not support recommendation:

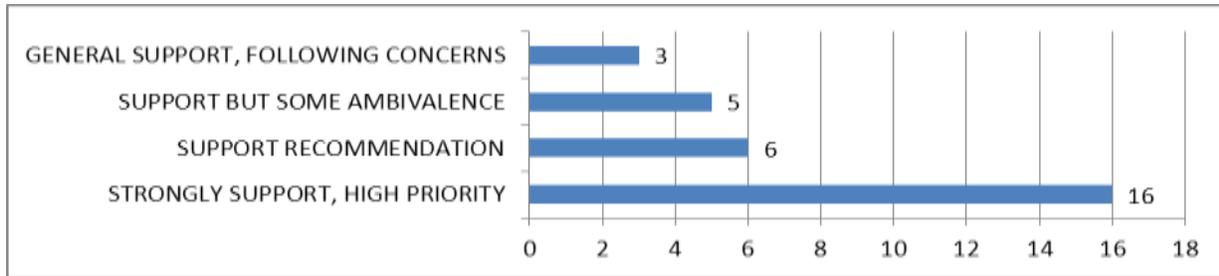
	Frequency	Percent
Advocacy organizations	1	33.3
Local government	2	66.7

### Comments/Concerns/ Reasons for not supporting recommendation:

- The state needs to assure that appropriate facilities actually exist within a reasonable distance of everywhere in the state before making this a mandate.
- My one concern is that in pursuing this, the ability to have "identical" capabilities will be compromised with the pressures of the Stats, local, and private partnerships that need to occur to make this more viable.
- Some initiatives work better than others, and some understand better the "identical expectations" for consumer choice. How will the identical expectations be achieved? Also, why not have the initiatives function in conjunction with their LACs?
- I'm concerned about shifting responsibilities to the AMHI's with no guarantee of stable funding. If the funding diminishes who becomes responsible for those services? I agree with the theory of doing things regionally, as long as they are adequately, financially supported.

**RECOMMENDATION**

- It is recommended that traditional boundaries of county lines and host county concurrence rules not drive or be a barrier to access.



**Groups with concerns or who do not support recommendation:**

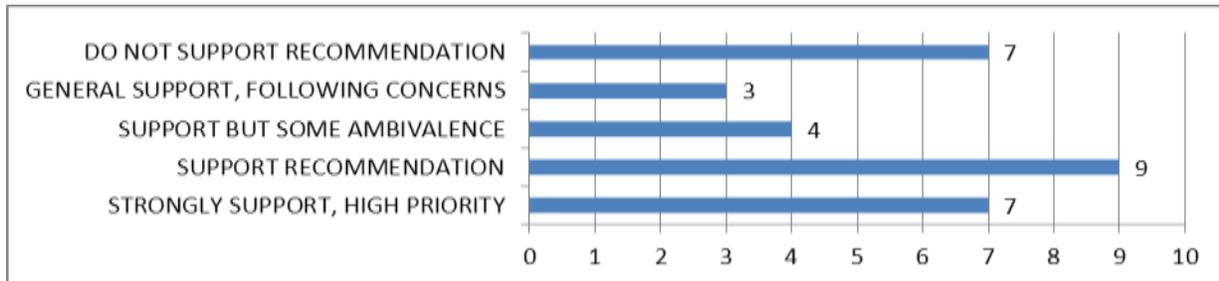
	Frequency	Percent
Local government	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Great idea for clients, but some existing laws making counties the designated payers for mental health services for their residents may need to be changed. Otherwise counties may be financially responsible for services over which they have no control.
- DHS will have to develop rules on how disputes might be handled between counties with regard to a client availing themselves of the services of the ACO in another county; particularly if that client loses eligibility for Medicaid/health insurance and falls into an uncompensated care. The county of social service responsibility generally pays for community based treatment services for those individuals without medical insurance from their specific Mental Health Grant allocation.
- We request the consideration of the utilization of in-network providers be included in looking at service options to avoid an increase in out-of-network costs for health plans.
- This has been a consistent problem for consumers and the more services are Medicaided the more this county turf stuff needs to go.
- This needs to be defined more before ever attempted as the boundaries are complex and different for every program.

## RECOMMENDATION

- Shared decision making responsibility, accountability and risk across the acute care and community based mental health system must be an expectation. DHS, in partnership with other key decision makers, need to address the barriers that current tort laws create in this area and work with others on tort reform.



### Groups with concerns or who do not support recommendation:

	Frequency	Percent
Advocacy organizations	1	10.0
Consumers and family member	2	20.0
Local government	1	10.0
Other:	1	10.0
Service providers and professional organizations	1	10.0
State government	1	10.0
Unions representing public employees	3	30.0
Total	10	100.0

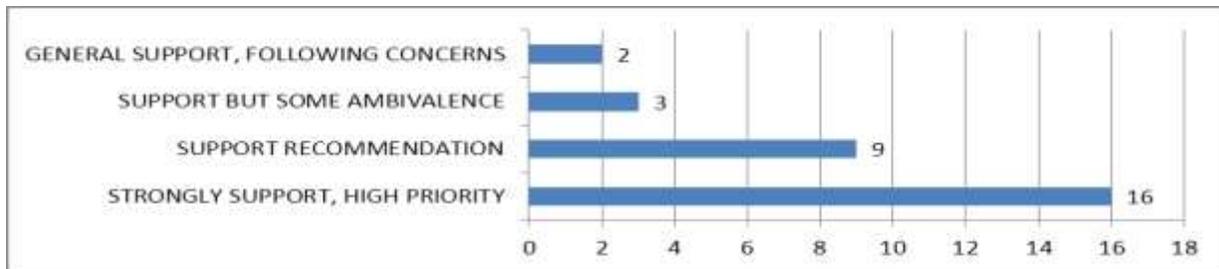
### Comments/Concerns/ Reasons for not supporting recommendation:

- Don't support tort reform.
- What do we mean by tort?
- Tort reform should not be linked immediately to these piloting efforts. The results of the pilots should be evaluated for success. Individuals should have an enhanced quality of life under these pilots and should have extended community tenure outside of an involuntary status before tort reform is contemplated.
- Did we change the tort verbage to something else?
- Hopefully preaching to the choir when I state my hope that the consumer's choice is a prime consideration as is reasonable and safe, (least restrictive setting capable of meeting the person's needs and those of the larger community).
- Tort laws are only one of several issues to address. Statutory tort limits are in statute for state and local government entities, plus a few "instrumentalities of local government". Perhaps, contracted providers who operate within a defined framework could be included in this category. See: M.S. 466.01 etc.
- Tort laws are only one of several issues to address. Statutory tort limits are in statute for state and local government entities, plus a few "instrumentalities of local government". Perhaps, contracted providers who operate within a defined framework could be included in this category. See: M.S. 466.01 etc.
- Did we talk about this?

- I believe at the last meeting 11/22 the discussion was to change "tort reform" to indicate the group's wishes for liability risk-sharing through more creative insurance pooling or other insurance constructs. If the tort reform language is removed, I am a 1 on this!

**RECOMMENDATION**

- Flexibility of funding to address the range of client needs has been proven to be highly effective as a tool to assure community tenure; it should be a key component of services to the target group.



**Groups with concerns or who do not support recommendation:**

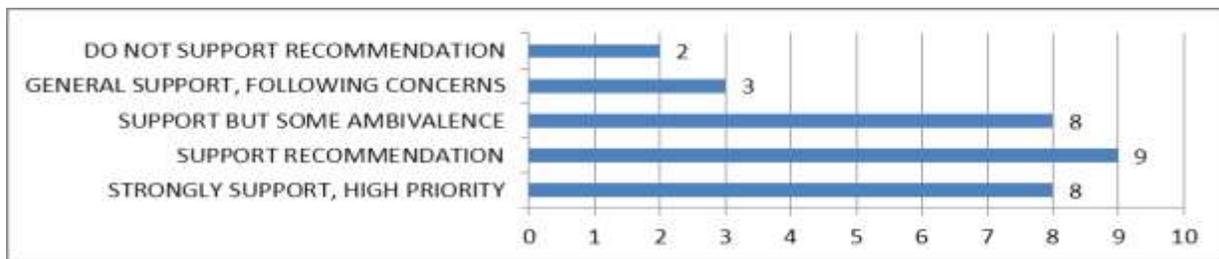
	Frequency	Percent
Other:	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- There needs to be a full partnership with DSD and Continuing care is addressing funding options, (Medicaid) as well as eventual cooperative efforts with the Corrections department.
- We would ask that health plans be included in the process of adding additional services to maintain a person in the community to allow for input on prior authorizations, payment options and adding additional medically necessary services.

**RECOMMENDATION**

- Two pilots, as described under transitional services, using the current service capacity, should be created this year to test the model. Additions to or changes in pre-existing services that are reimbursable under the Minnesota Health Care Programs will require state plan changes and federal Center for Medicare and Medicaid Services (CMS) approval as well as funds for additional state match. DHS Health Care Administration will need to be involved in these discussions.



**Groups with concerns or who do not support recommendation:**

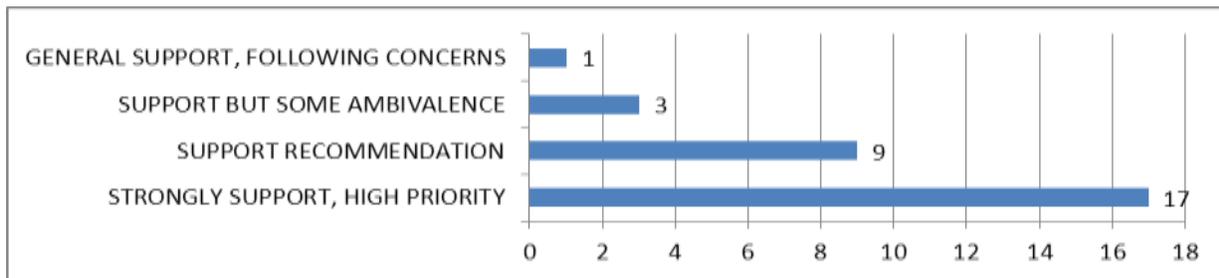
	Frequency	Percent
Local government	1	20.0
Other:	1	20.0
Unions representing public employees	3	60.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- DHS must provide leadership at the asst commissioners' level. This must be a priority for the whole department. Internal barrier busting may be key to the pilot's success
- We request that Managed Care Health plans be included in these discussions as well if they will be asked to expand current services.
- I think we should just go with the Bloomington site to start.
- I don't think we can assume that pilots will need CMS approval--it all depends on how the funding for the pilots is shaped. IT would be better to avoid the need for CMS approval if possible so we can get started in a more timely way.
- Are these at Anoka or where?
- Transitional pilots are a good idea, but that cannot be the end point. Obviously, pilots will have to wait until 2011.

**RECOMMENDATION**

- Community capacity, both acute care and community-based services, must be developed and implemented before reducing capacity within the State Operated Services system.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	100.0

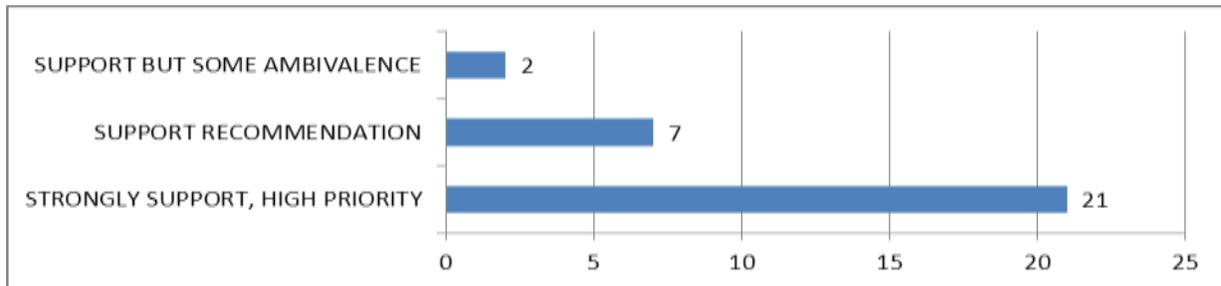
**Comments/Concerns/ Reasons for not supporting recommendation:**

- I would say that community capacity has already been developed and to a large degree is funded in the MA forecast. However, there are gaps in MA coverage and rates for some key services may be too low to assure safety-net functions will occur.
- With specialization of certain CBHH's, how does that affect capacity for the remaining CMS certified, general CBHH's? That needs to be assessed for those local partners and for the State.

- You have it turned around. Again, more people are served in the community than in State Operated Services.

**RECOMMENDATION**

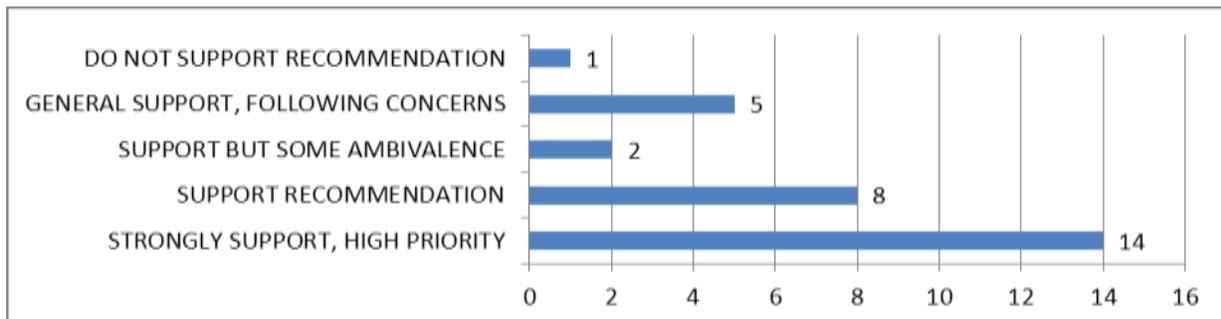
- Given that the target population are the most clinically complex group of individuals who can exhibit the highest acuity treatment needs, services must be designed to address each individual’s clinical picture- one size does not fit all.



**Groups with concerns or who do not support recommendation:**  
NONE

**RECOMMENDATION**

- Staff must be skilled and clinically competent to provide transitional and long term supports and services and must be cognizant of the role of natural supports. Services in both acute care and community-based settings must be either dual disorder competent or dual disorder enhanced, given the high percentage of individuals who have both a mental illness and substance use disorder. In addition, there is an important role for the use of Certified Peer Specialists in providing on-going supports and services. Adequate resources (both human and fiscal) are needed to develop and implement a set of standards and to train and provide consultation to settings as they use these standards. Training alone does not effect change.



**Groups with concerns or who do not support recommendation:**

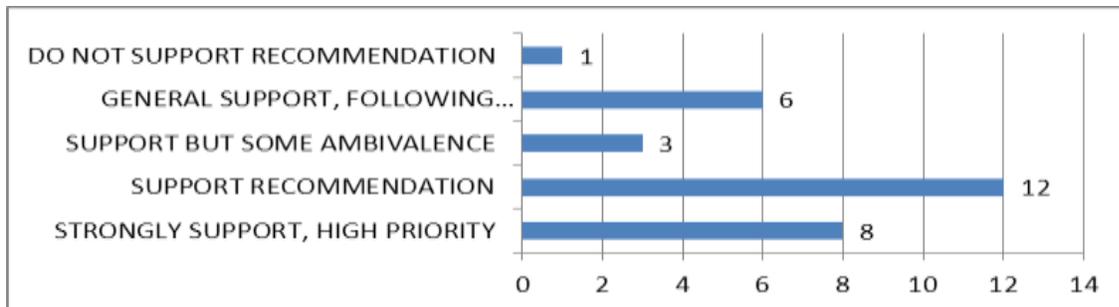
	Frequency	Percent
Advocacy organizations	1	16.7
Local government	1	16.7
Other:	1	16.7
Unions representing public employees	3	50.0
Total	6	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- The MI/CD issues described above do not take into account brain injury. Treatment modalities and clinical skills toward such must be a given. Traditional insight based programs do not meet the needs of most persons living with the effects of these diagnosis.
- Would the current rates apply to Certified Peer Specialists or would there be a different payment structure based on the different need?
- The fiscal part I like, the peer support is probably O.K., but shouldn't we look in side our own house first?
- This is good theory, however I would not want this done only to maintain current staffing patterns in SOS facilities. All State facilities need to be looked at to achieve their optimal functioning while keeping fiscal constraints in mind
- Agree but must train current staff to be able to do this role

**RECOMMENDATION**

- Intermediate services may be necessary but there should be a specified sunset date to assure that a rigid lock step model of service delivery is not created. Continuous reassessments of client needs and desires should drive their next level of care, structure and services. The capacity of each resource should be adjusted to meet the demand.



**Groups with concerns or who do not support recommendation:**

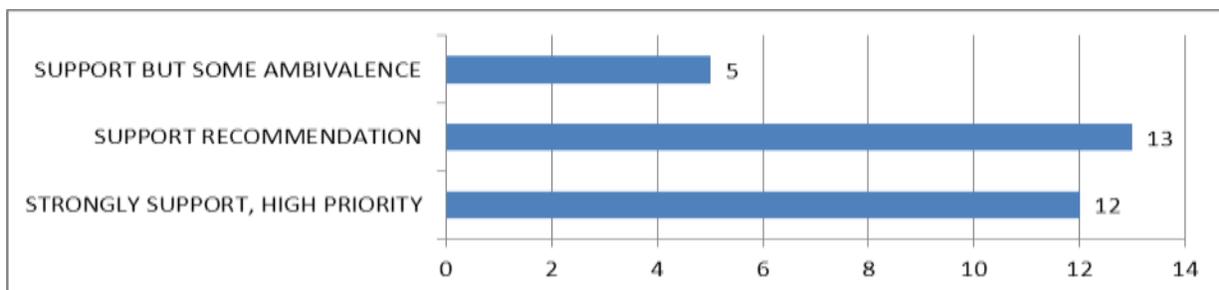
	Frequency	Percent
Advocacy organizations	1	14.3
Local government	1	14.3
Other:	1	14.3
Service providers and professional organizations	1	14.3
Unions representing public employees	3	42.9
Total	7	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Regular re-evaluation is needed, but too-frequent re-evaluations are costly and time-consuming. Some DD clients' conditions don't change much from year to year.
- Graduated progress.
- We would not want to just shift the backlog to another site....we need flexible services; however, there are some patients currently at AMRTC who could be moved to an intensely supervised setting.
- We would support a re-evaluation of current services to determine if they are appropriate, adequate and medically necessary or if the client's service needs require adjustment. Regular review of the current services would be a built in component.
- Doesn't a specified sunset date provide for the lock step model?
- I am concerned that a specific sunset date might also be rigid. If you build it they will come, so making sure the next level is there for folks will enable people to vote their choices with their feet and leave those intermediate settings.
- Way too focused on step down types of approaches instead of providing the needed services to people where they live. This interruption will just lead to people losing their housing.
- The sunset date is rigid and locks in a time.
- I think the needs should be based on client needs, not system needs, so that no hard and fast sunset dates can be implemented, because it is the individual continuum of care that is needed.

**RECOMMENDATION**

- Service level agreements need to be developed between acute care and community based providers and protocols established to monitor and evaluate said agreements.



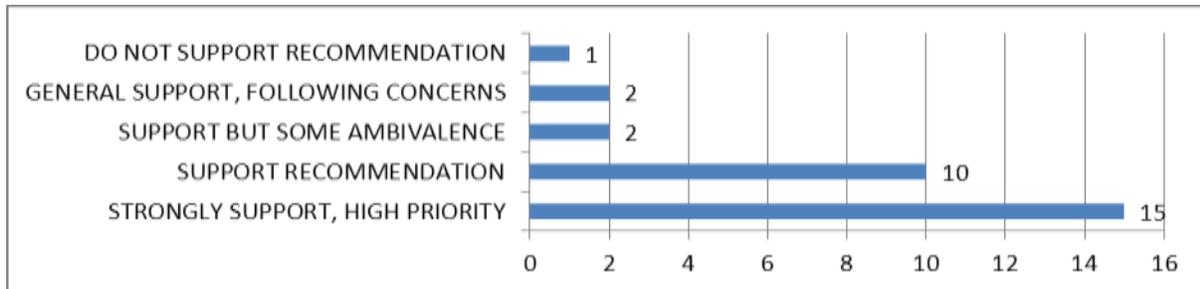
**Groups with concerns or who do not support recommendation:**  
NONE

**Comments/Concerns/ Reasons for not supporting recommendation:**

- If practice agreements are in place, it will facilitate transitions, and reduce the burden on broker-style case management.
- Among those agreements need to be a clear understanding between both parties about the level of care the community entity can and will serve so the client is not moved from place to place if their behaviors are very difficult.

**RECOMMENDATION**

- For the target population, a model of intensive case coordination should be developed and funded. This model has case coordinators as active members of the treatment team and not merely brokering services.



**Groups with concerns or who do not support recommendation:**

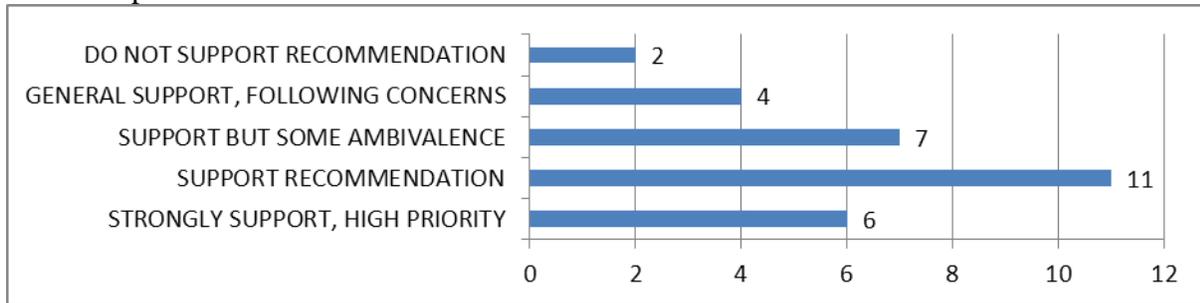
	Frequency	Percent
Other:	1	33.3
State government	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- See above comment on practice agreements that embed care management into a team that facilitates transitions to the right combination of services and supports.
- The definition and roles of intensive care coordinator, the current care coordinator and a mental health targeted case manager will need to be clearly defined to avoid duplication of services and/or billing.
- Would THIS require CMS approval?
- It would seem appropriate to look to the counties and see if there is a way to combine this with Rule 79 since those are already partially funded. I believe with adequate funding, counties are well positioned to enhance the basic services they already provide.

**RECOMMENDATION**

- A Utilization Review system should be developed to eliminate ineffective services and to right size under-utilized services with the goal of assuring return on investments as we expand/create services for a new model.



**Groups with concerns or who do not support recommendation:**

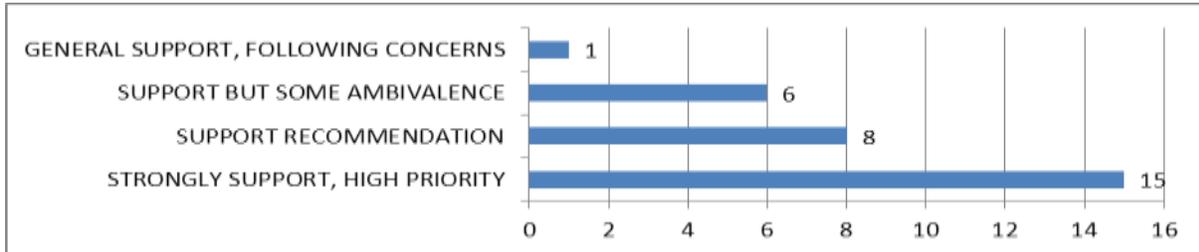
	Frequency	Percent
Consumers and family member	1	16.7
Other:	2	33.3
Service providers and professional organizations	2	33.3
Unions representing public employees	1	16.7
Total	6	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Waste of money.
- Current systems should be evaluate within the context of their current role, staffing resources, general resource allocation and funding; provide the needed resoureces/funding to meet the expanded service model and then evaluated for effectiveness.
- I am concerned that a Utilization Review system seems counter to a patient-centered approach. What has a favorable outcome for one person, might not work for someone else. If this new model is going to be patient-centered, what if a particular service that really helps me doesn't help many other people. Won't I still end up needing to conform to fit the system.
- Agree, but must include MTM as a service to be included in the review and recommendations (based on the states ROI of this pharmacy service)
- Lots of variation in UR functions...Whatever is done in this area should comply with Federal Parity legislation (non-quantitative limitations). I would prefer balancing the UR function with active monitoring of utilization, real-time feedback, and working with system on quality improvement and care management. This would be better than "captain may I..." or a simple yes/no function related to payment and prior authorization. A strong UR role has a rotten history in the behavioral health field.
- Health plans should be involved in the utilization review process for their members
- In order for this to work properly the protocols/results/data generated by the UR system would need to be available to EVERYONE or it can be end up being used primarily as a cost cutting mechanism.

**RECOMMENDATION**

- Given that our approach is to be client centered and recovery oriented, the transformed system needs to meet the consumer where he or she is (readiness to change); and when appropriate, consider a harm reduction approach and focus on increasing community tenure as a goal instead of decreased re-admissions.



**Groups with concerns or who do not support recommendation:**

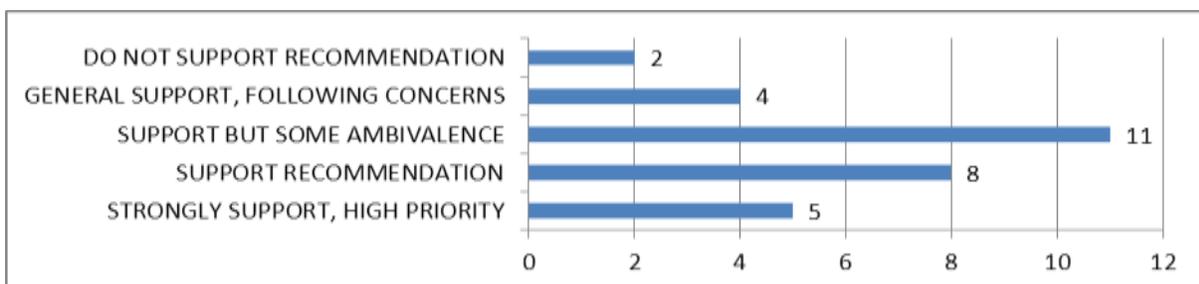
	Frequency	Percent
Other:	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- "Recovery oriented" is a wonderful descriptor, and it is important to also remember that persons with moderate to severe brain injuries recovery is measured by a return to a "new normal".
- Tiered payment structures would be most appropriate for consumers who are not fully engaged with receiving services or consumers whose need for intensive services is diminishing.
- Absolutely!! Meeting a person where she is not the same as "readiness to change" which I don't think is a helpful criterion.

**RECOMMENDATION**

- Level 1 hospitals need to be reimbursed at a rate higher than the other levels acknowledging the additional services and staffing requirements needed to provide more intensive services in secure units for patients with higher acuity and more complex care needs. This could be done through state grants/subsidy dollars commensurate with the increased expense/resources needed to provide such services. Addressing these funding mechanisms will require negotiations with CMS, DHS Health Care Administration, and the hospitals themselves.



**Groups with concerns or who do not support recommendation:**

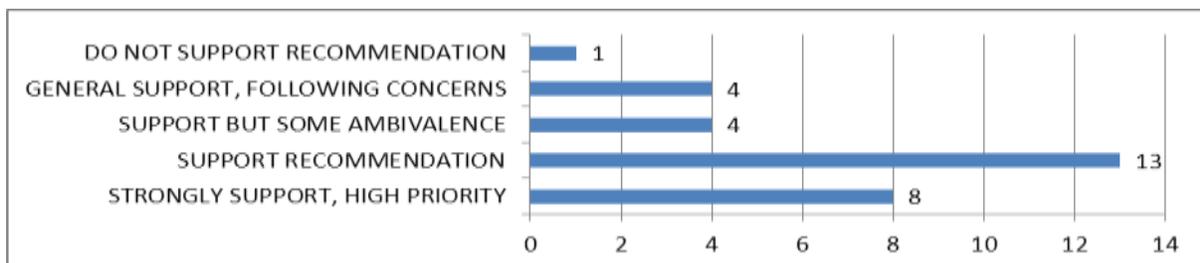
	Frequency	Percent
Advocacy organizations	1	16.7
Consumers and family member	2	33.3
Other:	1	16.7
Service providers and professional organizations	2	33.3
Total	6	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I agree with the statement but only if the hospital is held to an outcome that supports the person served ability to maintain community tenure upon discharge.
- We need to have a better understanding of this increased cost.
- Agree that providers need incentives to offer a service. However, I'd also likes to see performance metrics tied to that (for example, perhaps penalties for readmissions within 60 days of discharge into community)
- If the protocols that determine who goes where referred to earlier are adhered to this is a good idea.
- I'm not so sure about implementing the tiered level approach. It seems to be a way of justifying increased expenses and staffing--or off-setting uncompensated care for uninsured/under-insured with limited # day's coverage. The current rate setting methods should be able to pick up the relative cost-based increases for most DRG based stays. The state grant approach has worked well in several rural areas of MN for uninsured or situations in which insurance covers a limited number of days. It can give consumer a choice of staying in community hospital vs. civil commitment as a gateway to continued treatment.
- If Managed care Organizations will be asked to contribute to the payment of these, we request that we be included in the negotiations.
- How will we make sure that people who don't need this level are not placed in this level by providers as a way to generate more hospital dollars?
- At this time we cannot provide more funding for the highest costing service.
- I am not convinced of the need for and the role of level 1 hospital.

**RECOMMENDATION**

- Determination of how and in what manner the levels of hospital care resourcing should be examined at a regional level based on the region's current service array and in collaboration with local entities.



**Groups with concerns or who do not support recommendation:**

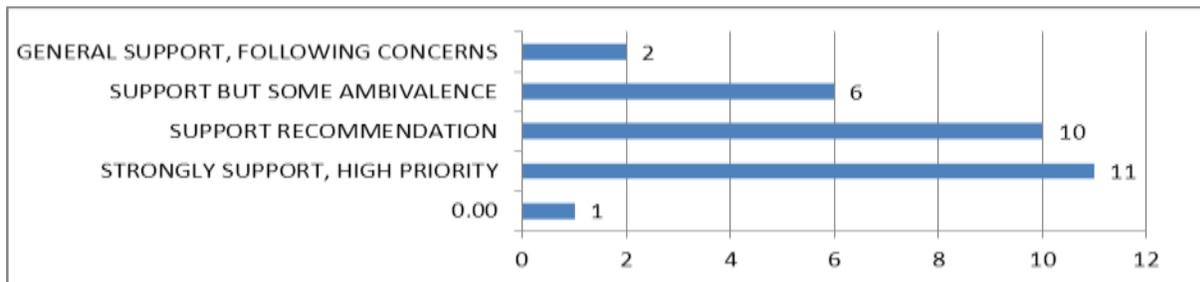
	Frequency	Percent
Advocacy organizations	1	20.0
Consumers and family member	1	20.0
Other:	1	20.0
Service providers and professional organizations	1	20.0
State government	1	20.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Managed Care Organizations would request to be involved in these discussions.
- The hospitals themselves should drive this discussion and the discussion should take place in collaboration with the regions.

**RECOMMENDATION**

- The triage process is a key asset to utilizing this proposed network of psychiatric inpatient services. We recommend that the ACCESS work group address the need for highly trained and experienced psychiatric providers to be responsible for the triage process.



**Groups with concerns or who do not support recommendation:**

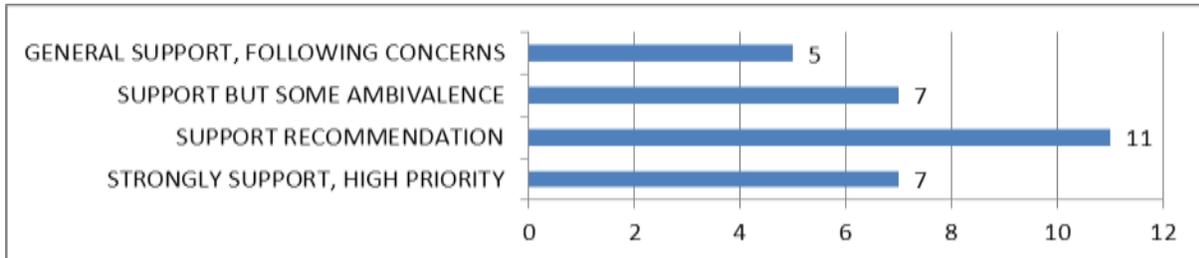
	Frequency	Percent
Local government	1	50.0
Other:	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Psychiatric providers are not available 24/7 in all parts of the state, unless telemedicine becomes universally accessible in all hospital emergency rooms.
- Including access to neuro-psychiatrists.
- We would request a definition of triage. If there will be a billable assessment, we would request that we be allowed to give input into establishing the triage process.

**RECOMMENDATION**

- A methodology needs to be developed that allows for the movement of patients from one setting to another based on the clinical complexity of the individual and an agreed upon mechanism for timely transfers. This could be accomplished through the use of service agreements or formalized partnerships.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	20.0
Consumers and family member	1	20.0
Other:	1	20.0
Unions representing public employees	2	40.0
Total	5	100.0

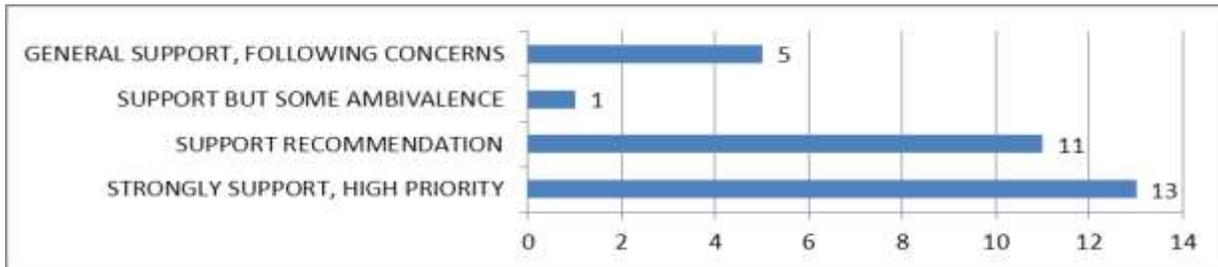
**Comments/Concerns/ Reasons for not supporting recommendation:**

- I think that the word, Respectful, needs to be in there, too.
- We would agree with this if the health plans would be required to pay for transportation tied to medical necessity.
- Would this be part and parcel in the RFP?
- And where does the notion of consumer choice fit into these service agreements between providers?
- Again, concerned about people moving to levels of care instead of figuring out how to provide intensive services where people live

## Neuro-cognitive Work Group Recommendations

### RECOMMENDATION

- People are empowered to direct their lives and the services they need to live where and how they want to live
- Steps to Success
- a) Services are not tied to funding or disability group
  - b) People have the opportunity to be educated about services that are possible (not just those that currently exist or are readily available)
  - c) People have the choice of who provides the services they receive
  - d) People are allowed the dignity of risk and the right to fail
  - e) Services such as personal care attendant (PCA) or independent living skills (ILS) are not tied to housing so that consumers do not have to find a new housing provider if they no longer need or want those services
  - f) People have the opportunity to control the resources allocated to them for services and supports



### Groups with concerns or who do not support recommendation:

	Frequency	Percent
Local government	2	40.0
Other:	1	20.0
Service providers and professional organizations	1	20.0
State government	1	20.0
Total	5	100.0

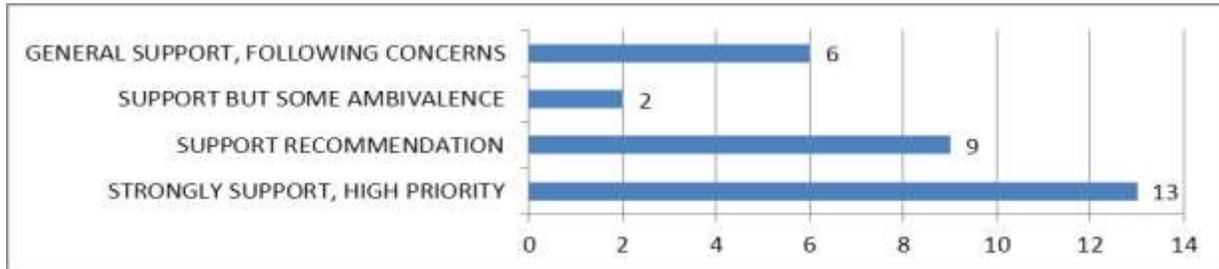
### Comments/Concerns/ Reasons for not supporting recommendation:

- Great goal, but full array of services are not yet available everywhere.
- I generally support this except if the community desired is an unhealthy environment for getting psychologically stable. Example- some parents or significant others that may live in that community may be the ones that trigger the mental relapses by not helping them make good choices or sabotage to enable them.
- With the obvious caveat that they are not a harm to themselves or others and that their choices don't knowingly lead to higher costs of care to taxpayers when other good choices are available at a lower cost and equal clinical outcomes
- Although this may be the ideal, in practice, a person's history and risk factors significantly limits their options for housing and sometimes, services.

- There needs to be some further definition of this, what if where and how they want to live is unsafe or inappropriate?

**RECOMMENDATION**

- People have their choice of living arrangement in the community with neighbors and roommates (if they want them) of their choice  
Steps to Success:
  - a) Supportive services are available within the community including respite for the family and competent direct support workers
  - b) State, county and city policies support development of appropriate services and housing options
  - c) Caregivers and service coordinators are trained in supporting individuals in selecting appropriate housing, appropriate housing services, and developing housing situations that meet their needs and desires
  - d) Policy revisions support funding such as GRH and other Housing Grant funds to be funneled to benefit individuals rather than providers. Funding supports individuals to live independently in non-group situations
  - e) Guarantors are available to co-sign rental agreements
  - f) Financial Institutions are available to provide lending services
  - g) Somebody is identified as responsible for developing the necessary options
  - h) There is funding and appropriate options to meet individual needs



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	2	33.3
Other:	1	16.7
Service providers and professional organizations	2	33.3
State government	1	16.7
Total	6	100.0

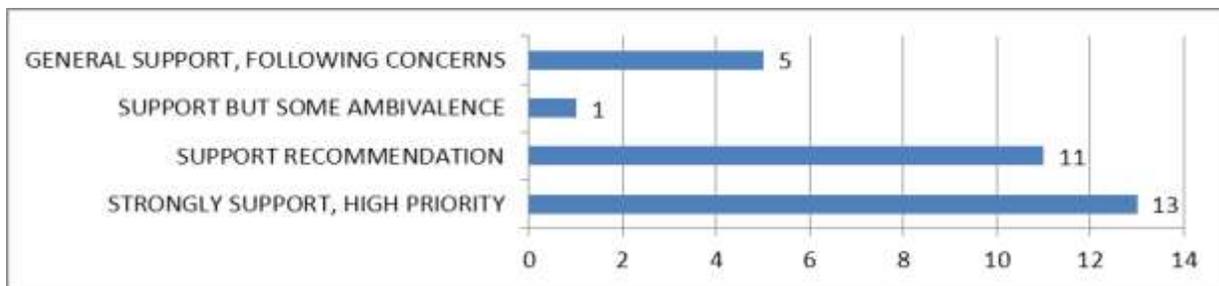
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Great goal, but full array of housing options are not available everywhere. I support working toward making more options available, but we cannot mandate until the options actually exist.
- Again if this is a contraindication of them getting psychologically stable then I am not for this.

- With the obvious caveat that they are not a harm to themselves or others and that their choices don't knowingly lead to higher costs of care to taxpayers when other good choices are available at a lower cost and equal clinical outcomes
- Again, financial constraints and a fragile medical condition will limit the services for a consumer.
- And how does this principle fit with previously mentioned agreements made between providers for movement of individuals between them?
- Same as above, very vague and idealistic, put the reality and context with it
- With the current state of community supports and projected funding issues, I have problems with goal statements that are too unrealistic.

**RECOMMENDATION**

- People have relationships and connections to people they like and with whom they want to be connected  
Steps to Success:
  - a) Relationships skills are a required component of professional care giving roles;
  - b) Training opportunities are made available for all interested persons;
  - c) Specific training is made available regarding the particular needs of the person with neurocognitive needs, e.g. Individual Treatment Plan; and
  - d) Funding streams are flexible and cover access to relationship skill building training in creative ways across a variety of venues (link to education, training, stigma & awareness)
    - Online training
    - Support group
    - Continuing education/adult education
    - Art and literature
    - Movies and television.



**Groups with concerns or who do not support recommendation:**

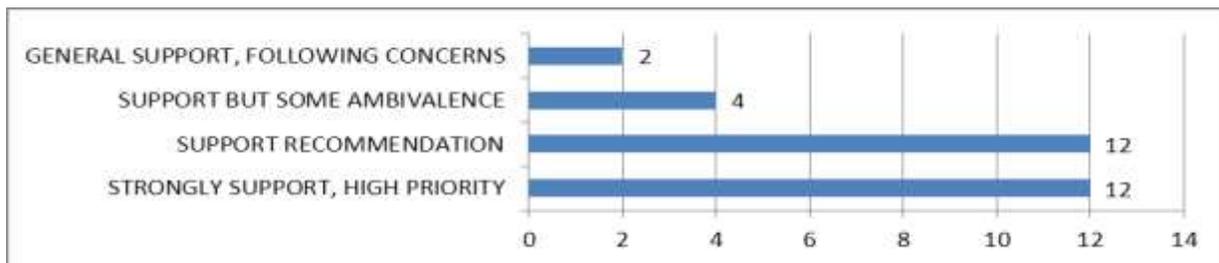
	Frequency	Percent
Local government	2	40.0
Service providers and professional organizations	2	40.0
State government	1	20.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Great goal, but must be moderated by reality.
- Unless this is contraindicated in making them mentally stable.
- I don't understand the recommendation. It seems like a statement.
- Same as other 2
- The same concern as Q21

**RECOMMENDATION**

- Families feel supported both as individual family members and as a family unit
- Steps to Success:
- a) Family members are able to balance support and caregiving of individuals with neurocognitive disorders while living their own meaningful lives, including holding jobs, maintaining relationships, attending school, etc.
  - b) Families have freedom of movement with access to services without geographic limitations
  - c) Families are involved when and to the extent that works for the person
  - d) Many families play a vital role in helping to identify the individual’s past goals and preferences and are advocates in de-stigmatizing their disability. Families are recognized and supported by the service system for their own needs, choices, and wishes
  - e) Families have access to the same opportunities in the community as families without special needs family members
  - f) Families feel supported both as individual family members and as a family unit
  - g) People with neurocognitive disabilities lead meaningful lives in the community when families feel supported both as individual family members and as a family unit



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	1	50.0
Service providers and professional organizations	1	50.0
Total	2	100.0

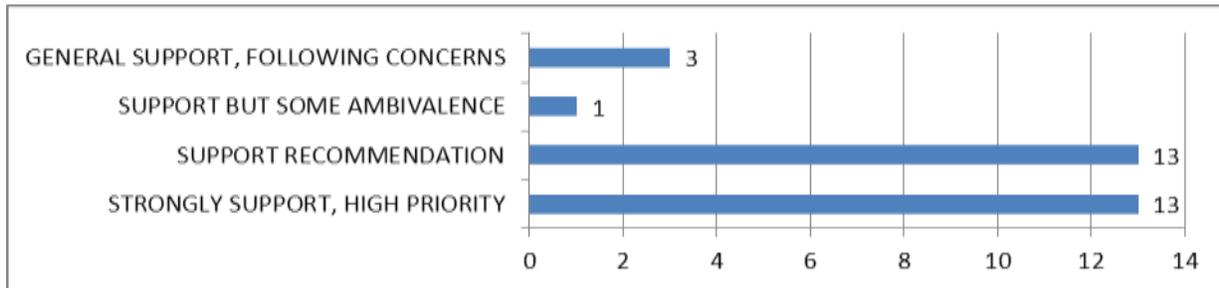
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Great goal, but state/counties/agencies do not control ALL family dynamics.
- If the adult person is in agreement; sometimes a person served wants privacy during treatment.
- I don't understand the recommendation. It seems like a statement.

- Families may not feel supported if what the consumer wants is different than what the family wants, but that is the reality of real recovery. This would be a lower priority than supporting the choices of the individual and this distinction needs to be made. Families are important, but are not equal to the consumer in this process.

**RECOMMENDATION**

- People have support coordinators who know and understand them and their unique situation and advocate effectively for them based on taking the necessary time to learn their personal story  
Steps to Success:
  - a) Flexible service with caseloads that allow intensive work and assures that support coordinators know and understand the people they are assigned to support
  - b) Support coordination is available to all populations so persons who are older or have disabilities can obtain assistance via one-stop-shopping versus having to navigate/negotiate on their own various complex program service models
  - c) Support coordinators are certified by demonstrating competency before being enrolled as a provider
  - d) People have the choice of support coordinators
  - e) Support coordination includes a range of services and intensity based on the individual needs of the person, from very frequent visits/interactions to less frequent visits
  - f) Support coordinator caseloads are flexible and not tied to a program but designed to meet the needs of individuals they serve
  - g) People have highly trained staff who they choose to provide their support that are energetic, positive, motivated and who communicate hope



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	1	33.3
Other:	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

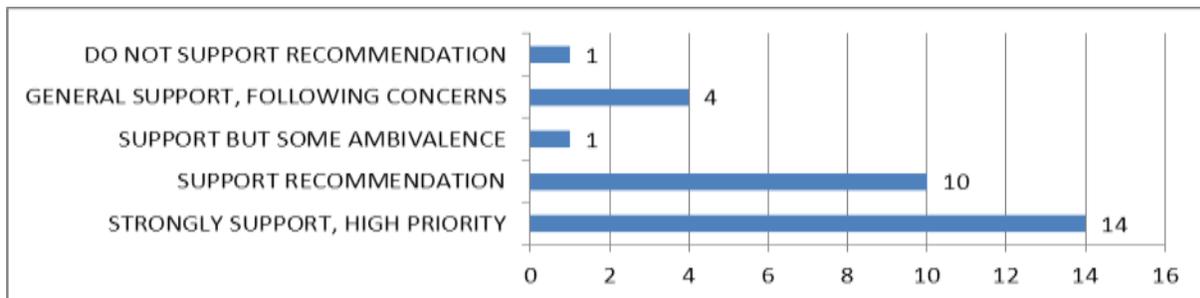
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Sounds great!
- What's the difference between this and the care coordinators mentioned earlier? Costs a lot of \$.

- Where will these support coordinators come from and how will they be funded?
- The definition of support coordinators is unknown.

**RECOMMENDATION**

- People have highly trained staff who they choose to provide their support that are energetic, positive, and motivated
- Steps to Success
- a) Professional-level training of staff is readily available and supported
  - b) Direct support staff are trained, competent and certified
  - c) People who conduct assessments also provide training and technical assistance to customers of their evaluations
  - d) Specialty services by neuropsychologists are accessible by programs and clinics that see large volumes of individuals with neurocognitive disability to appropriately inform and guide services and supports



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	2	40.0
Other:	1	20.0
Unions representing public employees	2	40.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

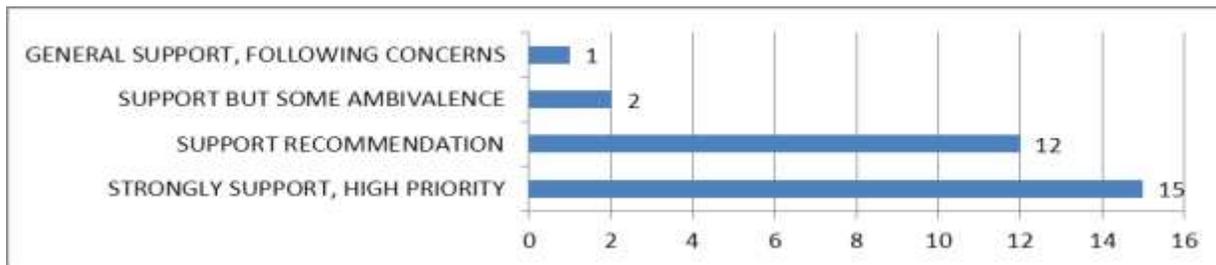
- Unfortunately, not all staff are highly trained and energetic, positive and motivated, but this is a great goal.
- Totally arbitrary. Says nothing.
- How would this work with collective bargaining agreements?
- Again, funding and process?
- How far does this go and terms of do they get to fire or layoff qualified employees

**RECOMMENDATION**

- There are processes in place to identify persons with neurocognitive disability who need this service

Steps to Success

- a) Annual training requirements for psychologists or other qualified individuals to assess for neurocognitive impairments and resulting functional impairment
- b) Universities are required to include coursework and professional training for all students going into health care fields in order to broaden the network of professionals qualified to assist in the identification process
- c) Standardized screening for brain injury is universal and funded
- d) Mandatory education and training of a wide range of health and human service, criminal justice, and education professionals to assist with early identification. Persons with undiagnosed neurocognitive impairments are likely to be seen in health care and other settings where professionals are in a position to assist with identification and make referrals for further assessment.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Other:	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

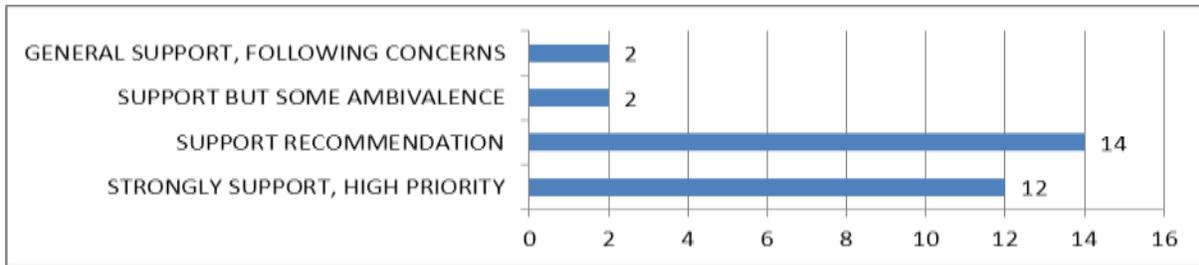
- Just a principle
- While also understanding and looking for dual diagnosis or more

**RECOMMENDATION**

- There is a prompt response to identifying and supporting individuals with neurocognitive disability who represent emerging populations

Steps to Success

- a) Partnerships created between DHS, refugee resettlement organizations, county planners, state demographer, and both traditional and nontraditional community providers to report on new populations either anticipated or emerging
- b) Development of a process by which to engage new populations in identifying their experience with and perspective on individuals with neurocognitive disorders
- c) There are strategies for learning about cultural perspectives on disability while also informing new populations about support and services for those individuals and their families in a culturally sensitive manner and understanding potential services that could be developed



**Groups with concerns or who do not support recommendation:**

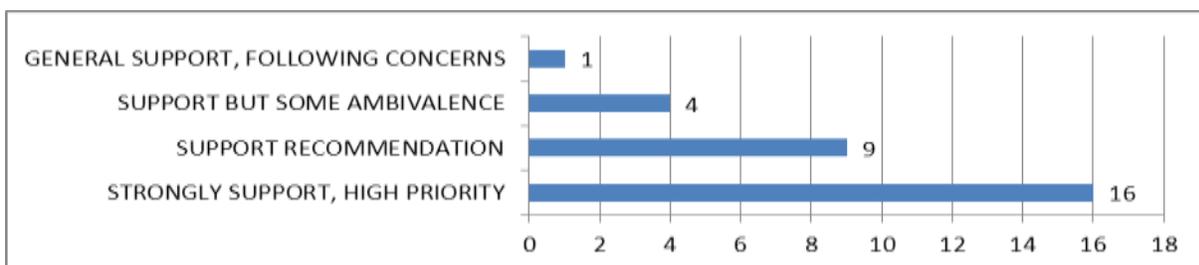
	Frequency	Percent
Other:	1	50.0
State government	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Just a principle.
- It is still unclear to me exactly what this recommendation means. This recommendation is still too vague in order to support it strongly.

**RECOMMENDATION**

- People are encouraged to consider employment and have meaningful jobs with support available as needed  
Steps to Success
  - a) Employment services are provided to all individuals interested in employment, regardless of their identified potential for work by professionals.
  - b) Employers consider creative options for employees, including telecommuting, flexible schedules, an array of employment options and focus on getting to know the person and their needs as an employee.
  - c) Benefits analysis and counseling result in no financial disincentives related to working for individuals receiving neurocognitive services.
  - d) Retirement or not being employed should be an option for individuals if they choose.
  - e) Working is an option for all individuals if they have an interest. Both paid supports and related family communicate hope and positive impact related to work and availability or benefits analysis to guide informed choice.



**Groups with concerns or who do not support recommendation:**

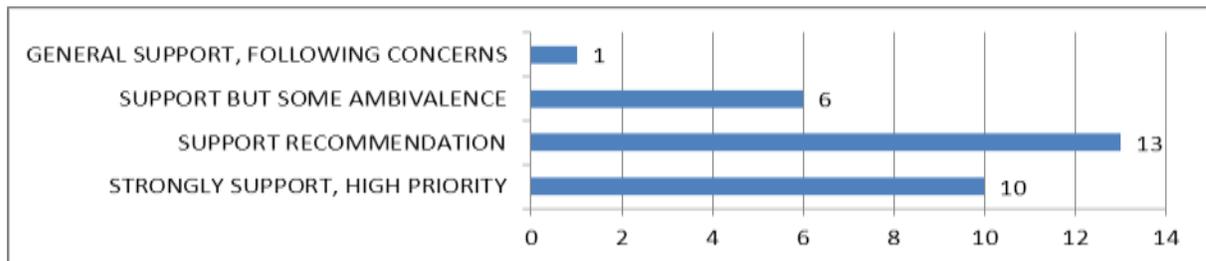
	Frequency	Percent
Local government	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Clients must take personal responsibility to cooperate with their rehabilitation programs for this to be effective. Also: DT&H programs around the state are NOT consistently reimbursed for serving clients with similar needs. The historic reimbursement formula needs upgrading. Annual increases should be flat, instead of percentage-based, to prevent reimbursement discrepancies from growing wider.
- As long as the encouragement does not seem like a demand for the person to be employed.

**RECOMMENDATION**

- There is a high level of public education and awareness about the identification and prevention of neurocognitive disabilities and how to support individuals with those disabilities  
Steps to Success
  - a) A website with information about neurocognitive issues and services is created which is user-friendly. It appeals to many different age groups and is in multiple languages
  - b) Public service announcements appear on television and on the internet
  - c) Department of Education creates mandatory curriculum on neurocognitive issues benefiting from partnership with MN Department of Health who have already developed a brain injury educator’s manual and teacher competencies
  - d) Stigma is eradicated.



**Groups with concerns or who do not support recommendation:**

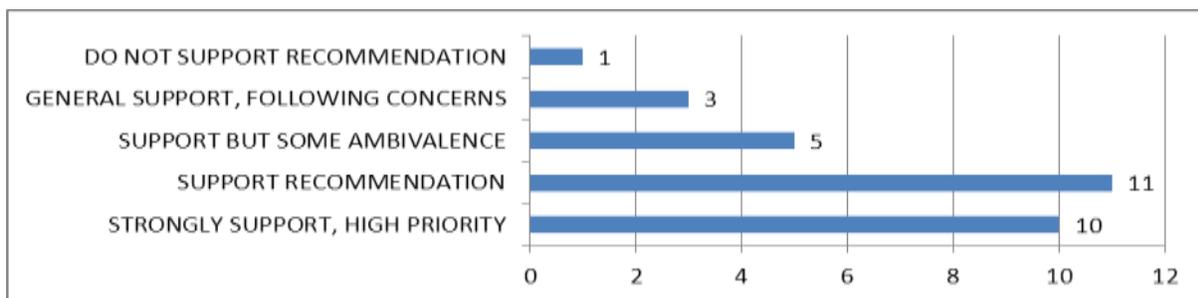
	Frequency	Percent
Other:	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- How? TV ads? \$\$\$\$
- That the system has a responsibility to educate the wider public on the efficacy of the services made available by their tax dollar.

## RECOMMENDATION

- There is technology that works for people  
Steps to Success
  - a) Procedures for funding and policy are able to keep up with new technology
  - b) Individual services are not tied to any funding or disability group
  - c) Individuals have opportunities to be educated about possible options for the use of technology (not just those currently available or used)
  - d) People have resources available to assure their needs are met
  - e) Technology is a tool to help create and support flexible, comprehensive, etc. services for those we serve
  - f) People identify technology that enables them to live independently longer



### Groups with concerns or who do not support recommendation:

	Frequency	Percent
Other:	1	25.0
Service providers and professional organizations	1	25.0
Unions representing public employees	2	50.0
Total	4	100.0

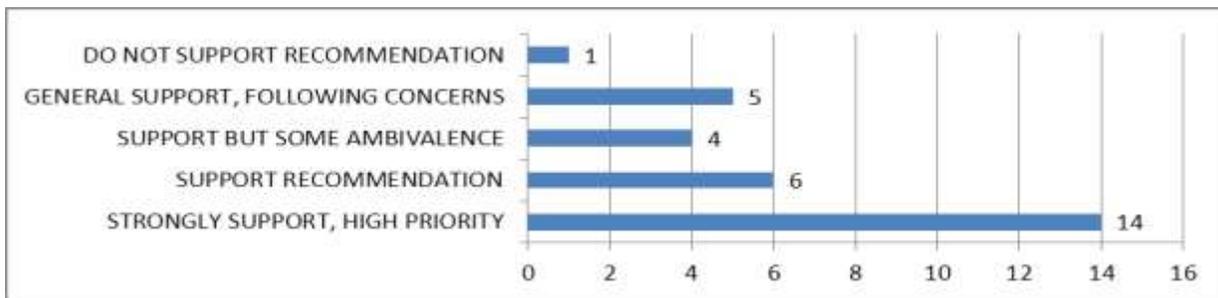
### Comments/Concerns/ Reasons for not supporting recommendation:

- Just a principle.
- I don't understand the recommendation. It seems like a statement.
- While not impinging on the rights of others they may live with, and that they have the ability to change as the situation warrants.
- Is there, or is this where we want to go?
- And it's important to get the MA funding for the technology if it supports that person's independence and functioning.
- Technology is a gadget.

## RECOMMENDATION

- The needs for safety for the individual, supports, staff, and for public safety are addressed everywhere  
Steps to Success
  - a) A plan is developed to educate communities on people with neurocognitive needs and the benefits of community integration for these individuals and the community

- b) Individuals are provided access to proactive resources to assist in identifying and addressing neurocognitive needs and community integration
- c) Communities develop plans to address safe and accessible living communities for individuals with neurocognitive challenges.
- d) Families and caregivers are provided support and education in understanding and responding to persons' needs
- e) Trauma debriefing services are available for persons served and their supports
- f) Training such as Crisis Intervention Training (CIT) is provided to all Public Safety Officers, ambulance response agencies, and hospital first line providers
- g) For services that already include CIT, services are enhanced with more intensive training in understanding behavior common to persons with neurocognitive needs and how to work effectively with people through more nimble crisis response teams



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	16.7
Local government	2	33.3
Other:	1	16.7
State government	1	16.7
Unions representing public employees	1	16.7
Total	6	100.0

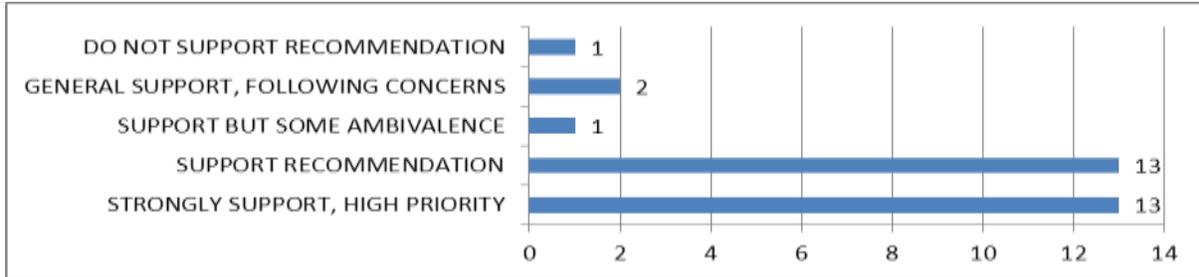
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Greater independence means there may be additional risk. Small group homes mean fewer staff on duty at any given point in time, compared to common staffing at intermediate care and larger facilities. Also, consumer-directed caregivers may lack the supervisory oversight of agency-assigned caregivers.
- Just a principle.
- While I support this, the way it is worded leave me feeling it conveys that persons with mental illness are dangerous.
- I am not sure what this one really means or entails.
- definition of who, when, where, how
- safety wouldn't be my highest priority, not sure of the context here
- Safety is not job 1. Fear of injury is prevalent.

## Access of Care Workgroup Recommendations

### RECOMMENDATION

- Credentialed psychiatric LIP’s can be reached in 60-120 minutes.



### Groups with concerns or who do not support recommendation:

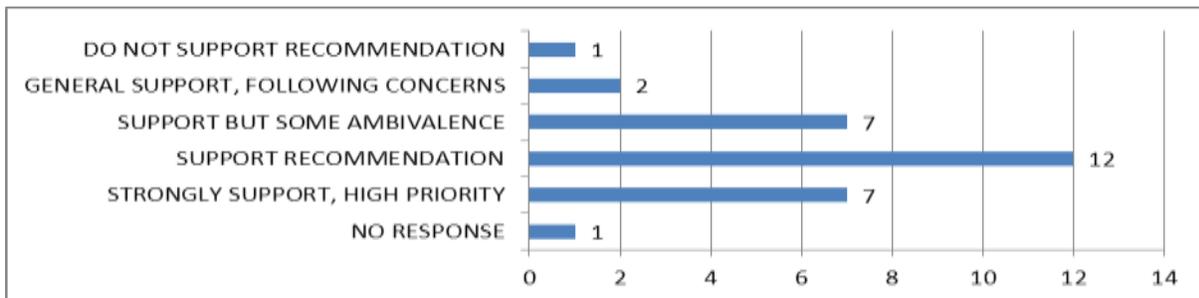
	Frequency	Percent
Local government	1	33.3
Unions representing public employees	2	66.7
Total	2	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

- Great goal, but not sure if this is possible yet statewide.
- For crisis services or urgent or emergency.
- Would this be done through Initiative, if so define funding.
- or sooner
- Not true at all. Not fast enough in an emergency. If a goal, then 2.

### RECOMMENDATION

- There is a web-based system in place to record system utilization that allows us to measure use of service and response time to each call. As part of this system there is also a location for providers of the service to provide feedback on utilization of the system. Data is initially analyzed daily, weekly and monthly. Reports and analysis are on the web-based system for users to evaluate.



**Groups with concerns or who do not support recommendation:**

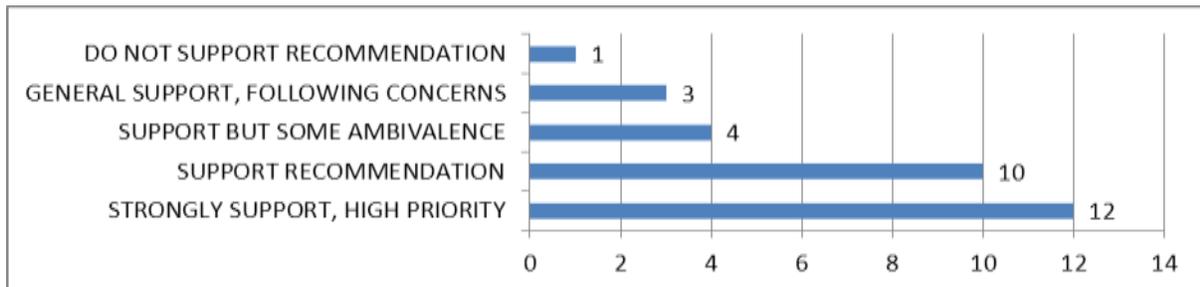
	Frequency	Percent
Other:	1	33.3
Unions representing public employees	2	66.7
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I can't recall, but is this going to be made public as part of a provider report card at some point in the future?
- Lots of detail in this proposal that would need to be operational. Sometimes, there is lots of administrative hassle just to get the tracking system in place vs. doing the direct services. So, ease of use and usefulness of the system to improve access and quality is key.
- Would health plans be expected to submit data and develop reports to support this system? Would health plans need to develop an infrastructure to support this expectation?
- How much time will be spent on analyzing vs. actual treatment.
- Why just limit the feedback to providers?
- utilization reports are important, but not the highest priority
- Not anywhere close to reality. If a goal, then 3.

**RECOMMENDATION**

- In each jail and detention center there is a phone number that when dialed provides individuals access to live or tele-presence psychiatric services.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	25.0
Local government	1	25.0
Other:	1	25.0
Unions representing public employees	1	25.0
Total	4	100.0

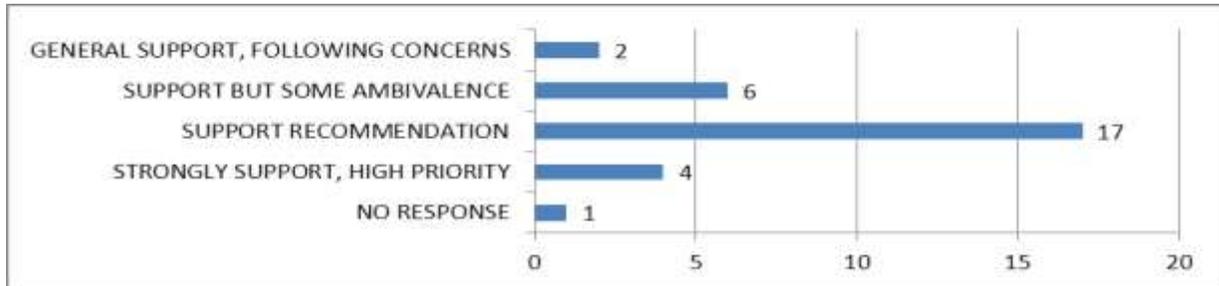
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Great goal, but not sure if this is--or could become--a reality yet statewide.
- What will trigger the ability to access this line?

- Nice idea. Lots of things would need to be worked out to make this happen.
- Cost, details, is this being done elsewhere and if so how?
- But not necessarily to the state but to a local number and local resources.
- I presume this is untrue. If a goal, then 2.

**RECOMMENDATION**

- A registry has been established that denotes what services each jail or detention center have. A regional system is in place to fill in the gaps. The registry questionnaire has been of assistance in organizing the registry process.



**Groups with concerns or who do not support recommendation:**

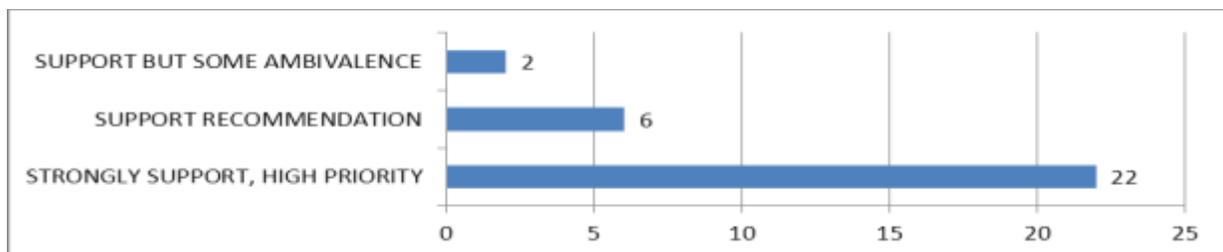
	Frequency	Percent
Local government	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Is this a recommendation or a statement?
- How will this registry be effective as the individual has no choice as to where they are incarcerated?
- Process?
- What happens if the location doesn't have what is needed is the transportation going to be required to go somewhere else

**RECOMMENDATION**

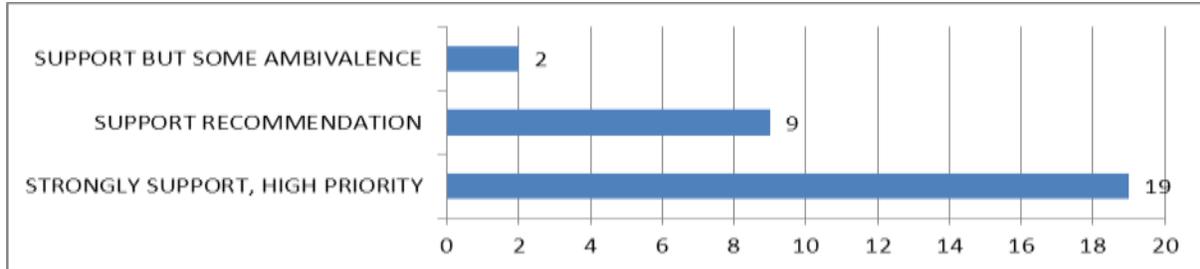
- Robust mobile adult and children’s crisis teams are accessible across the state.



**Groups with concerns or who do not support recommendation:  
NONE**

**RECOMMENDATION**

- There is a mobile crisis center in every region which is available/accessible to work with adults and children and provides, and upon request, collaborates with Emergency Departments, Jails and Detention Centers in the provision of crisis services. Data Source: CMHSA Divisions

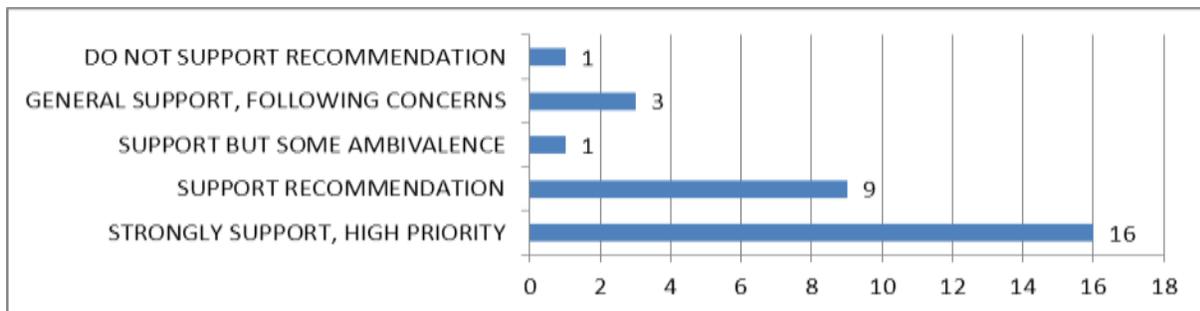


**Groups with concerns or who do not support recommendation:**

- "Center" concept probably would need to be defined....are we talking about a "crisis stabilization residential center"...eg. like Bridge House in Duluth or Diane Aherns in St. Paul, or Woodland Centers in Wilmar and others? or are we talking about the mobile crisis capability?

**RECOMMENDATION**

- Mobile Crisis Team Services are reimbursable when provided in ER's, Jails and Detention Centers.



**Groups with concerns or who do not support recommendation:**

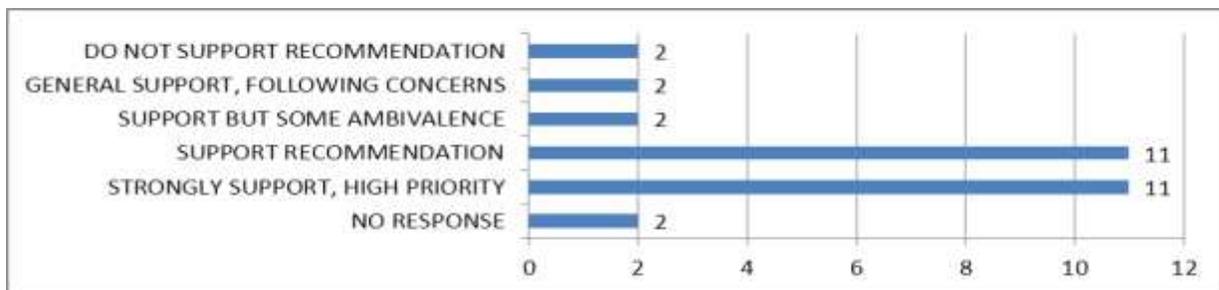
	Frequency	Percent
Advocacy organizations	1	25.0
Consumers and family member	1	25.0
Other:	1	25.0
State government	1	25.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Are there other locations where the service should be available but isn't reimbursable today (such as a less intensive hospital in out-state MN)?
- Are they reimbursable when in the community? If not that should be included
- We would agree that Mobile Crisis Teams be reimbursed for ERs but not for jails and detention centers.
- well, yes but we know it can't be MA

**RECOMMENDATION**

- A periodic assessment with Mobile Crisis Team Service Providers indicates that this group of service providers is being paid for their services in ER's, Jails and Detention Centers.



**Groups with concerns or who do not support recommendation:**

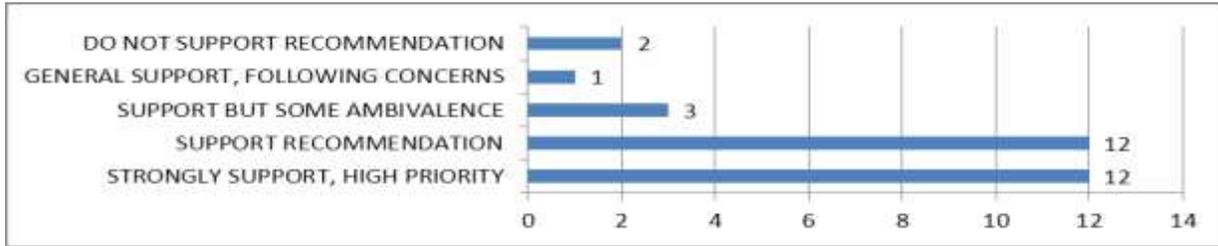
	Frequency	Percent
Advocacy organizations	1	25.0
Consumers and family member	1	25.0
Local government	1	25.0
Other:	1	25.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Not sure who is the payer? If State-Operated Services, using \$ saved from closing RTCs, I support.
- is this a recommendation?
- There may be issues related to claiming Medicaid Federal match for jail or other services administered by Corrections.... there are creative ways to address part of this (Oklahoma example).
- Use of Mobile Crisis Teams would be utilized for ERs only.
- this wasn't what we recommended, I don't think you measure access by payment

**RECOMMENDATION**

- Shared care odels that exist across the state have psychiatric collaboration.



**Groups with concerns or who do not support recommendation:**

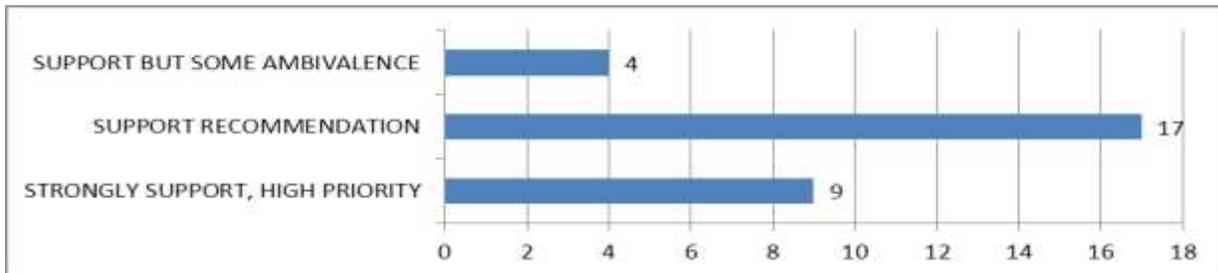
	Frequency	Percent
Consumers and family member	1	33.3
Service providers and professional organizations	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- is this a recommendation?
- I would suggest that this is a two-way street--mental health shares with primary care....primary care shares with MH.
- If psychiatric consultation is needed for patient care. If an APRN is all that is necessary, I see no reason that a psychiatric collaboration be required. This sounds like a turf protection rather than a patient safety issue.
- Are we mandating treatment plans?

**RECOMMENDATION**

- Shared care is defined, definition written and consultation services are available upon request. Uses web-based system defined earlier.



**Groups with concerns or who do not support recommendation:**

NONE

**Comments:**

- Just a principle.

- Consumers utilizing a web based system, especially when having a mental health crisis will likely not occur.

**RECOMMENDATION**

- People have confidence with the rapid access response process and it is tried and true.



**Groups with concerns or who do not support recommendation:**

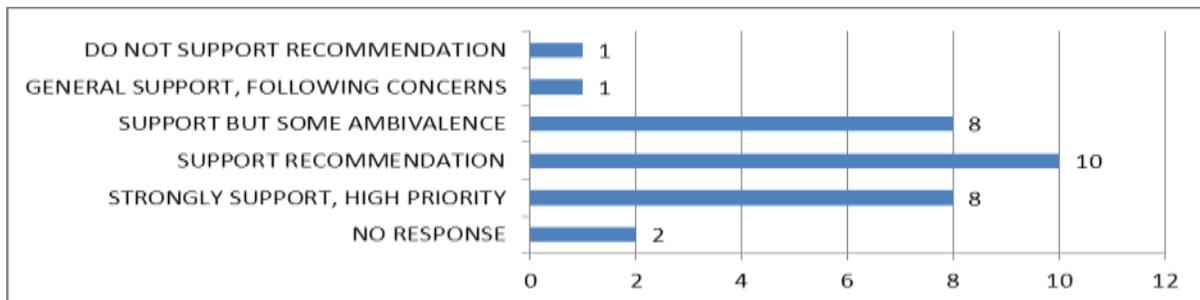
	Frequency	Percent
Local government	1	20.0
Other:	1	20.0
Unions representing public employees	3	60.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Needs to be tested before rolling out statewide.
- is this a recommendation
- Is this true everywhere?
- If there are tried and true than would give a 1 or 2
- Don't think it is at all universal. If this is a goal, then 3.

**RECOMMENDATION**

- Web based feedback has been shared, self-correcting module has addressed issues, feedback substantiates it is used and provider and user satisfaction with the system is evident.



**Groups with concerns or who do not support recommendation:**

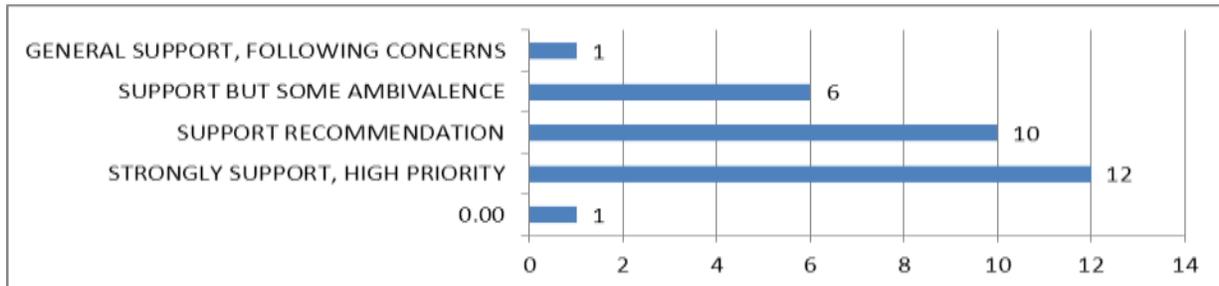
	Frequency	Percent
Unions representing public employees	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Is this a recommendation?
- Will this include the person receiving services opinion as well as those close to that person?
- Is there enough evidence of this? Or are we offering this as a recommendation?
- Details, payment sources??
- The Web is not a substitute for face to face care, verbal dialogue, and personal assessment.

**RECOMMENDATION**

- Rapid access model is regionalized, with written regional plans that demonstrate regional linkages, etc. in the event of significant crisis or disasters. Plans incorporate collaboration with other regional health care partners (plan has mutual aide tied into the plan and is linked with county emergency disaster response team).



**Groups with concerns or who do not support recommendation:**

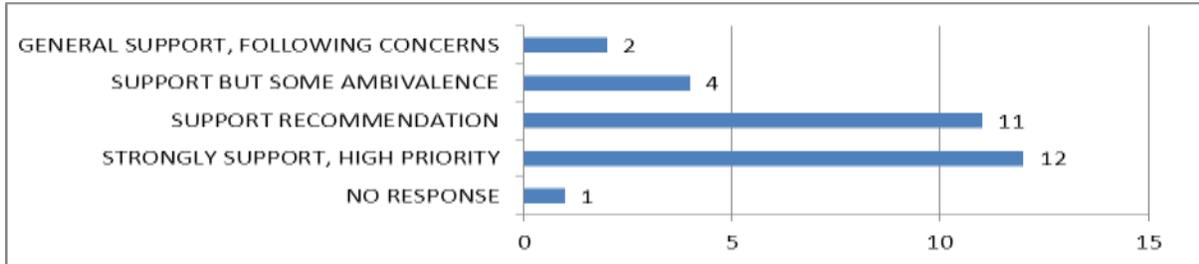
	Frequency	Percent
Unions representing public employees	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Is this a will be not an is?
- Make sure consumers are involved in the development of these regional plans
- Again, I voice my concern that we not shift things and remove the funding, thus cost shifting to the initiative and/or counties without planful deliberation and conversation with those pay sources

**RECOMMENDATION**

- Plan is written and functional model exists within each region of the state.



**Groups with concerns or who do not support recommendation:**

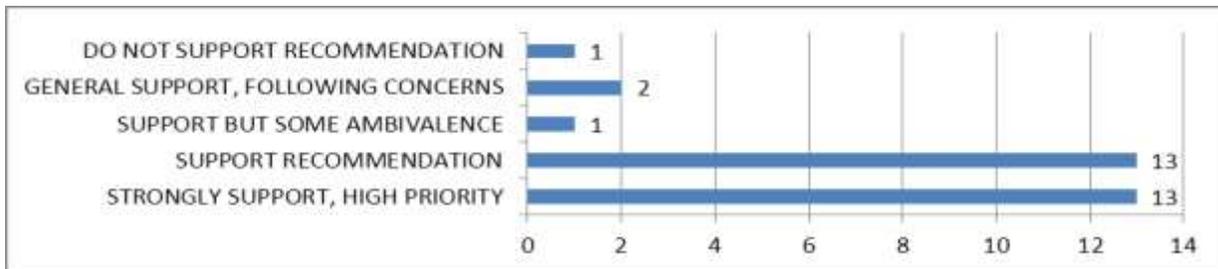
	Frequency	Percent
Unions representing public employees	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- With several of these, they are out as statements of current practice versus something that we should move toward

**RECOMMENDATION**

- There are formal and ceremonial relationships between tribal independent nations and the state around rapid access to psychiatry.



**Groups with concerns or who do not support recommendation:**

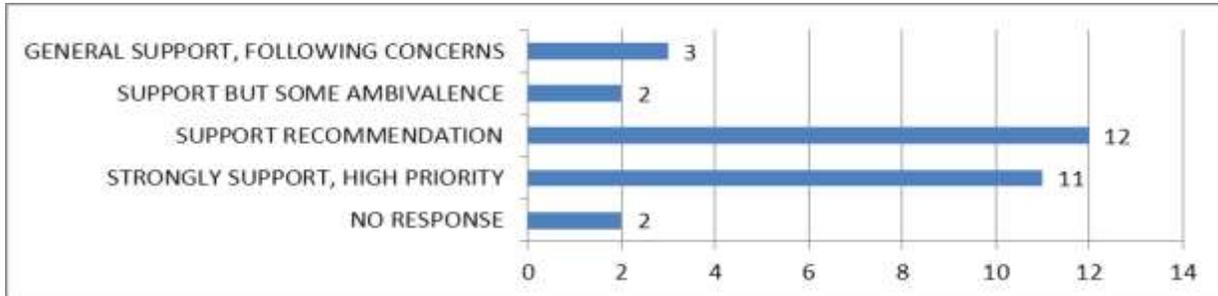
	Frequency	Percent
Advocacy organizations	1	33.3
Unions representing public employees	2	66.7
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- why the state? Why not the communities or counties that they are in?

**RECOMMENDATION**

- Regional plans demonstrate tribal involvement in their development. Agreements between independent nations and the state have been formally and ceremonially executed and are in action.



**Groups with concerns or who do not support recommendation:**

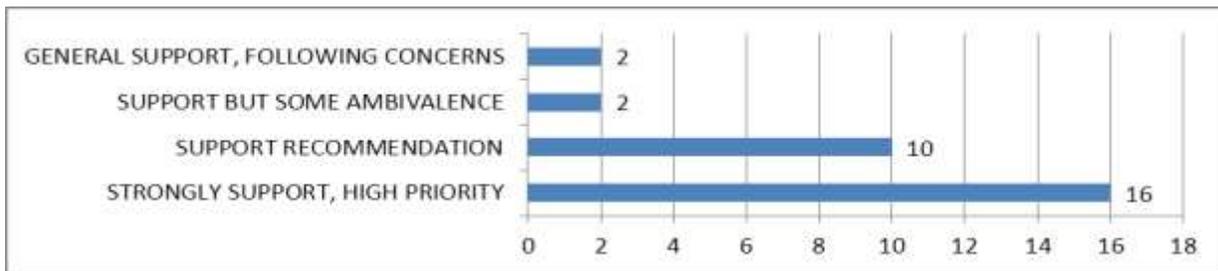
	Frequency	Percent
Advocacy organizations	1	33.3
Unions representing public employees	2	66.7
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- is this a recommendation?
- Tribal involvement wording may reflect an unintended tendency toward imposing it upon them. The use of the term "initiated" may speak to a stronger intent to partner.

**RECOMMENDATION**

- Rapid Access Service is global (meaning across the State of Minnesota with equal access to this service regardless of where the person lives, Metro or Greater Minnesota).



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Unions representing public employees	2	100.0

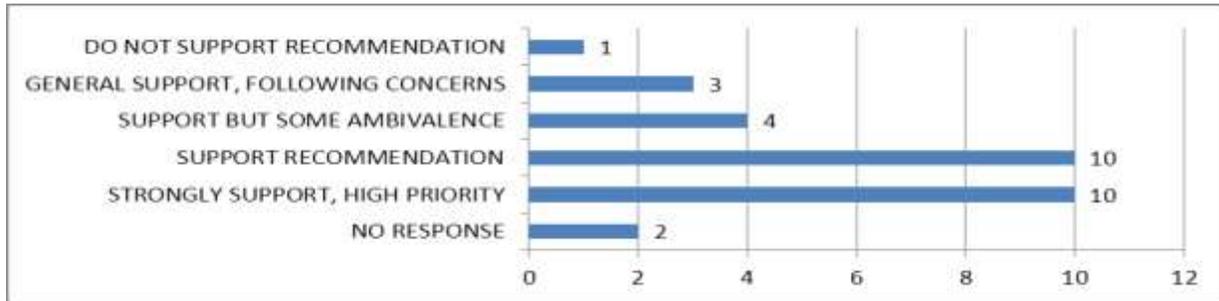
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Is this a recommendation?

- does it also mean global regardless of your insurance coverage? It should.
- Absolutely would want but haven't gotten there replace is with will be

**RECOMMENDATION**

- Web-based data hits demonstrate access is equal and available.



**Groups with concerns or who do not support recommendation:**

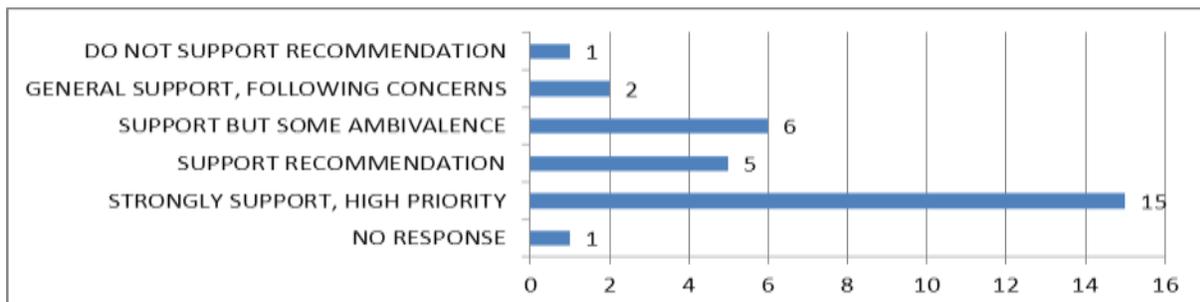
	Frequency	Percent
Service providers and professional organizations	1	25.0
Unions representing public employees	3	75.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Is this a recommendation?
- I don't think I understand about the web-based component. However, data demonstrating equal access is good.
- See 43 and 44
- See previous
- What is a data hit?

**RECOMMENDATION**

- Common language and assessment tool exists to access the need for urgent or emergent behavioral health care.



**Groups with concerns or who do not support recommendation:**

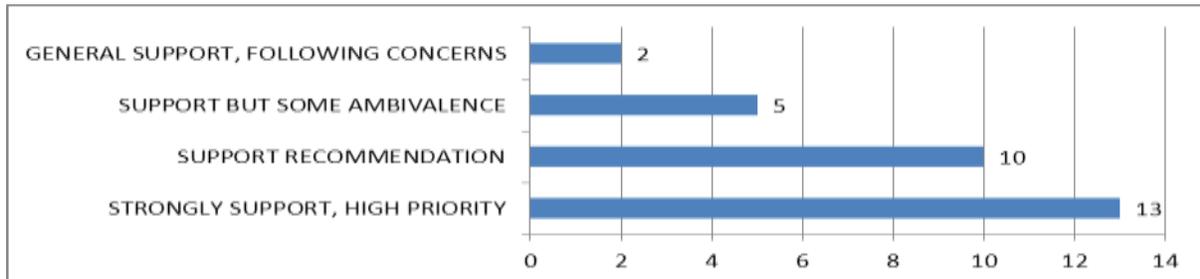
	Frequency	Percent
State government	1	33.3
Unions representing public employees	2	66.7
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I think these are important but the process should not be so rigid that there is not room for the individual who assessed the person to use some professional judgment.
- Assessment protocol might be better. I am not aware of any one "tool" available that would have the sensitivity specific for this purpose. There certainly are tools that might be useful, but these would be part of a protocol and process.
- I am concerned about who chooses the tool and what and who is responsible for changing this tool if there are problems with it. would it also apply to the tribes?
- see previous
- I do not think the practice of mental health nursing and medicine can be reduced to a "tool".

**RECOMMENDATION**

- There are ongoing communication, education and evaluation plans in place which have been implemented around the Rapid Access Service.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Other:	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

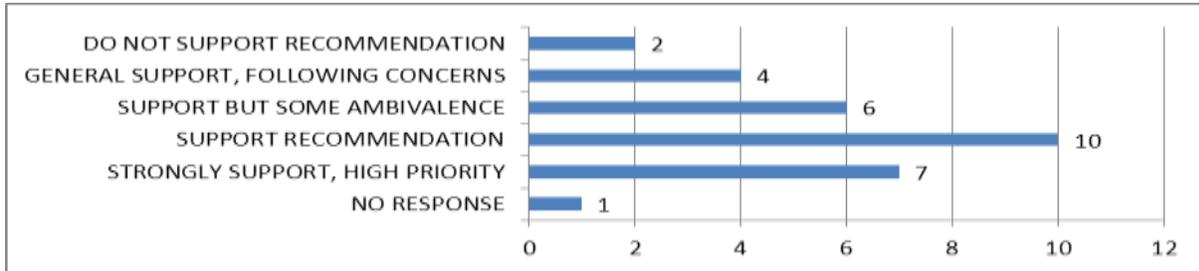
**Comments/Concerns/ Reasons for not supporting recommendation:**

- is this a recommendation
- See previous comments

**RECOMMENDATION**

- Global screening, triage and psychiatric consultation should be common practice for mental health services.

*NOTE: Survey language included multiple recommendations listed as “Global screening, triage and psychiatric consultation should be common practice for mental health services. Around SOS, there would be a platform for the regional planning for this service. Participation may vary from region to region from no involvement to significant involvement which would be determined in the regional planning process.” Comments and scoring may reflect both recommendations.*



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	2	33.3
Local government	1	16.7
Service providers and professional organizations	1	16.7
State government	1	16.7
Unions representing public employees	1	16.7
Total	6	100.0

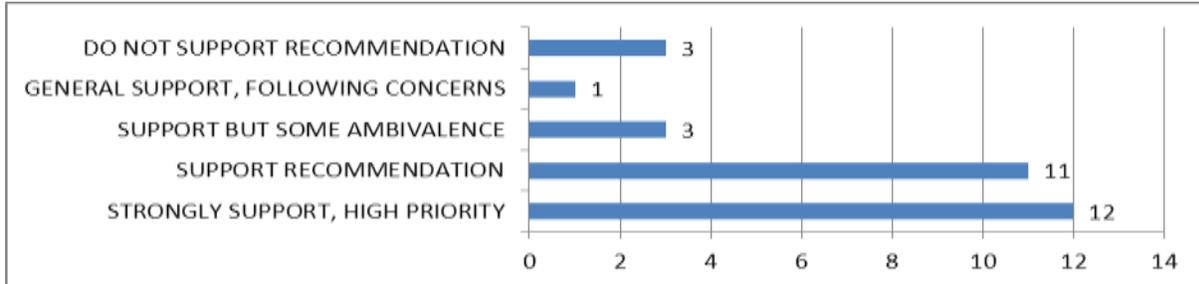
**Comments/Concerns/ Reasons for not supporting recommendation:**

- SOS may be the platform but they should not control the process of planning or service delivery. They may be an essential resource in greater Mn but not a significant player in the Metro Area/urban/suburban environs.
- The planning process referred to per region should not be relegated to what is currently available.
- Consumers and families must be an equal partner in the regional planning.
- Caution: It doesn't justify SOS jumping into a new line of business or redesign just because a component of the ideal system is currently unavailable or does not reach into a particular city/town. With a little juggling of resources, community providers with some support from counties, state, and health plans could and would develop most services necessary for most clients/consumers.
- a region with no involvement??
- NOT SOS, it is not the "star" or point person in each region
- This idea could be put into a requirement of health insurance plans in Minnesota. That's a Commerce function. Why burden DHS?
- For SPMI clients, this may be reasonable, but a better model may be multidisciplinary treatment planning. It is completely unrealistic to assume that every mental health patient

will have psychiatric consultation. The screening, triage, consult is a systems model, not a patient care model.

**RECOMMENDATION**

- Collaborative partnerships and relationships are the primary goal.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Other:	1	25.0
Unions representing public employees	3	75.0
Total	4	100.0

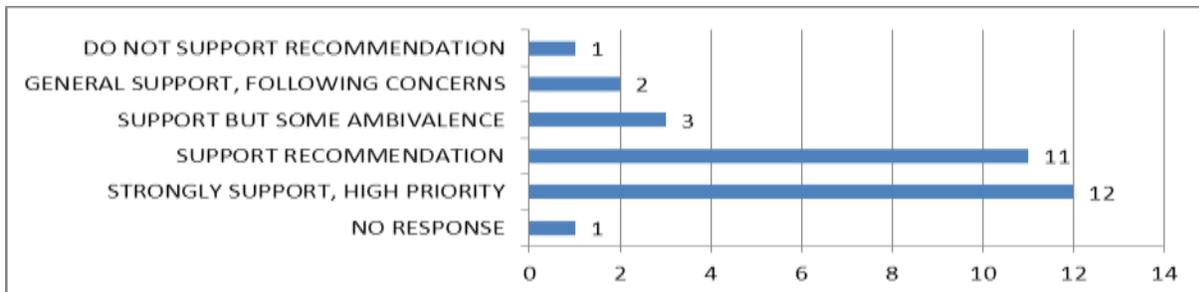
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Just a principle.
- Is this a recommendation?
- Primary goal is excellent, consumer-friendly services that achieve practical outcomes while being good stewards of limited resources. Partnerships are a means to that end.
- I have not been given any evidence that partnerships, especially public/private ones are or will become viable.
- Who will these be with and what impact on current State employees
- Partnerships imply money. Are local hospitals going to give DHS money to care for MI and D, or Sex Offenders, or Criminal DD? Certainly no one thinks that the underfunded Department of Human Services is going to give money away.

**Psychiatric Collaboration**

**RECOMMENDATION**

- Collaboration should also include education provided by the consulting psychiatrist.



**Groups with concerns or who do not support recommendation:**

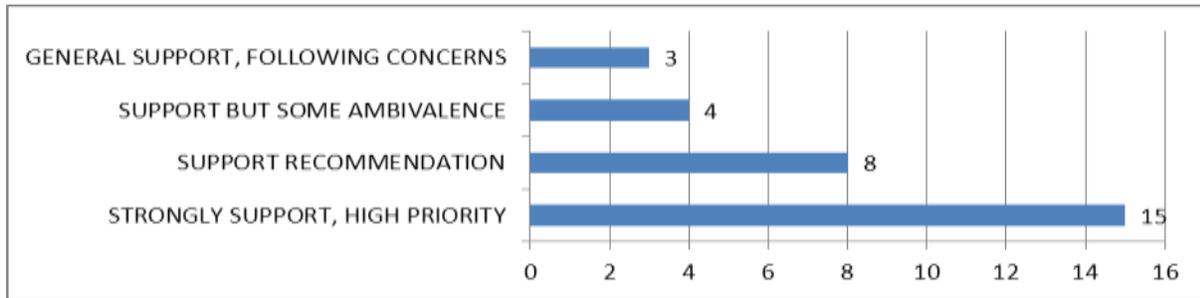
	Frequency	Percent
Other:	1	33.3
Service providers and professional organizations	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Not enough time - too variable.
- And education provided to the consulting psychiatrist. Psychiatrists do not know everything. Learning goes several ways. This is not a hierarchical system, or shouldn't be.
- A Psychiatrist is going to educate? We don't have enough psychiatrists to staff DHS, DOC, and the Veteran's Homes. Education is not the proper role at this time for a limited resource like a psychiatrist.

**RECOMMENDATION**

- Psychiatrists provide consultation services for any patient referred from the identified providers (add possibly schools, law enforcement and jails).



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Other:	1	33.3
Service providers and professional organizations	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

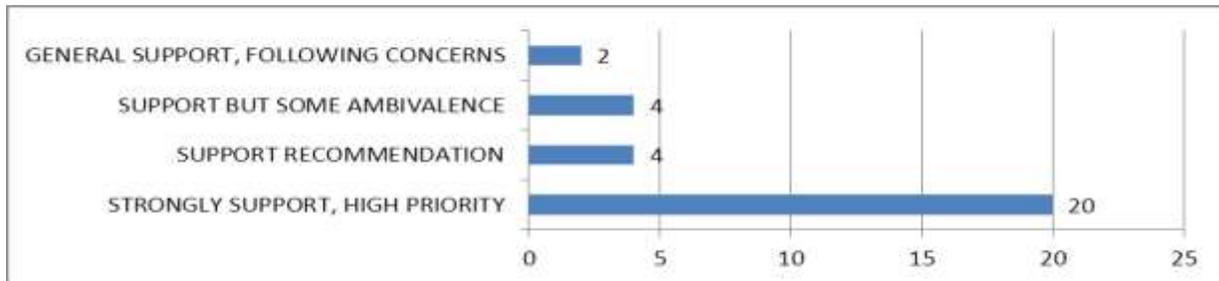
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Mental Health Professionals not just psychiatrists
- Time and money an issue.
- Nice goal, but we have very limited psychiatry....I am concerned that going too far in this direction could short-change psychiatry direct care duties. It's a matter of degree.
- How would an individual or family member initiate this referral if their school or clinic failed to take their concerns seriously? We know this happens.
- I am concerned about how realistic this is in terms of workforce issues.

- DHS Psychiatrists, who are permanent employees and not locums, largely do not exist. A consultation means that money is given. Are the "identified providers" going to pay the DHS Psychiatrists?

**RECOMMENDATION**

- Collaborative care should be available psychiatrist to psychiatrist to bridge continuity of service and further service needs.



**Groups with concerns or who do not support recommendation:**

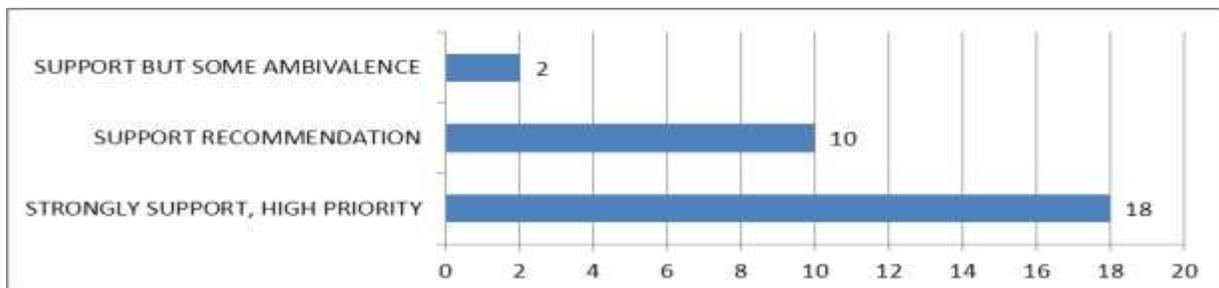
	Frequency	Percent
Service providers and professional organizations	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- It could also use collaboration with the pharmacists in SOS and a community based MTM pharmacist or the SOS MTM pharmacist should remain in place to help with continuity of service
- Doesn't always need to be MD to MD, but the idea of direct relationships between treating providers or between hospital and clinic is good. If psychiatrist is part of a team, some communication could be with other aspects of the team.
- Is this a presumption of collaboration from DHS to the private sector and vice versa? I doubt that Mayo or Fairview or Allina or any of the other systems would want their MDs providing unreimbursed care or liable to the lawsuits that might result.

**RECOMMENDATION**

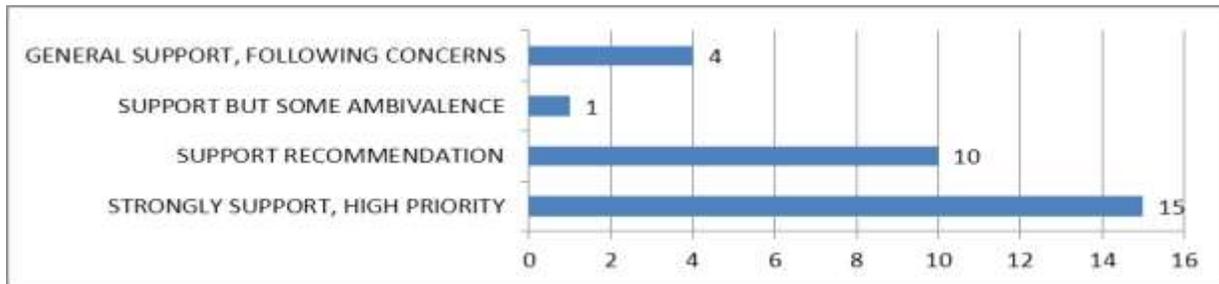
- Collaboration should exist from screening in a primary care setting to chronic and acute care in a variety of community settings.



**Groups with concerns or who do not support recommendation:**  
NONE

**RECOMMENDATION**

- Collaboration should intervene “upstream” to prevent the need for more expensive services.



**Groups with concerns or who do not support recommendation:**

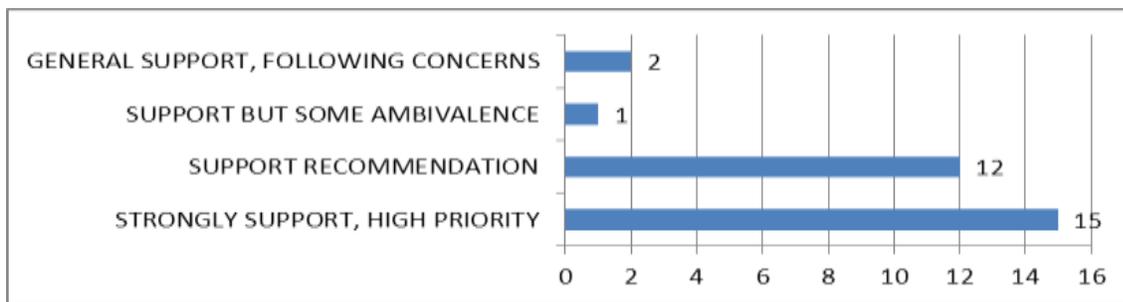
	Frequency	Percent
Consumers and family member	1	25.0
State government	1	25.0
Unions representing public employees	2	50.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- To a lay person this terminology is hard to understand
- upstream must be defined
- Unclear exactly what this means but I believe that collaboration must occur and every phase of the process and has to be built into the culture and expectations of any new system. There has to be a reasonable way to compensate for collaboration time.
- Would there be a danger of placing a client in a lower level of care than as actually needed?
- Don't know what "upstream" means.

**RECOMMENDATION**

- Existing examples of good collaboration should be used as role models.



**Groups with concerns or who do not support recommendation:**

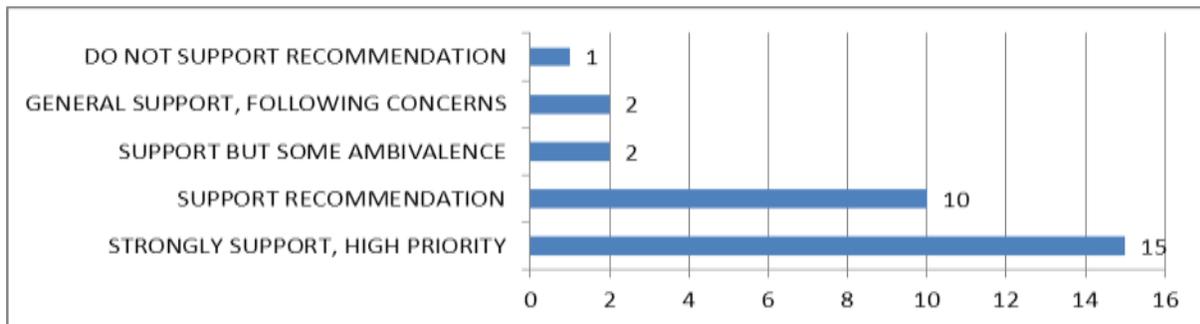
	Frequency	Percent
State government	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- The state should survey providers for examples of good collaboration amongst all of its healthcare professionals providing services
- Our current processes are hit and miss depending on the members of the group. We should not be locked to something existing but also consider new and innovative ideas
- What models?

**RECOMMENDATION**

- Integrating mental health care and primary care in service delivery and payment is a must to sustain any level of collaboration.



**Groups with concerns or who do not support recommendation:**

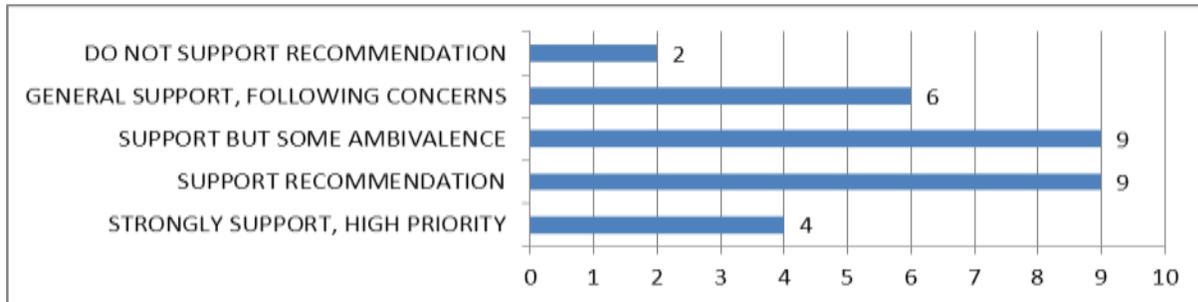
	Frequency	Percent
Advocacy organizations	1	33.3
Local government	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- The settings for this should be varied. Primary Care services could be available within Rule 29 Clinics and CSPs. One model of service delivery does not fit every consumer’s needs.
- Cooperative use of Medicaid funds with other departments is a must. Ultimately the use of COR, and CFR needs to be explored as well as TCM.
- Integration is the highest level of collaboration. There are shades of gray...shared care, practice agreements, co-location, referral protocols based on triage assessment.
- Is this question saying the DHS must pay?

## RECOMMENDATION

- Video technology is highly regarded as the solution.



### Groups with concerns or who do not support recommendation:

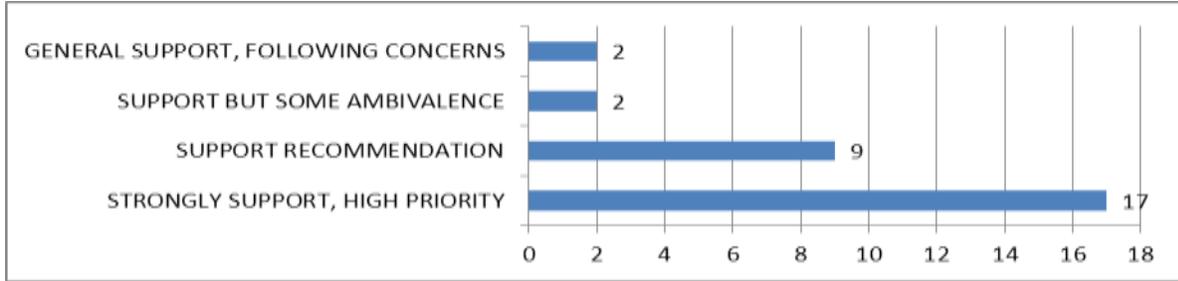
	Frequency	Percent
Advocacy organizations	1	12.5
Consumers and family member	1	12.5
Other:	1	12.5
Service providers and professional organizations	2	25.0
State government	1	12.5
Unions representing public employees	2	25.0
Total	8	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

- It is JUST NOT THE SAME as having a psychiatrist right in the room. I think it is disrespectful. It is difficult to get an accurate assessment of patient. It also seems like psychiatrists are gradually putting themselves out of business.
- as one of the solutions, not THE solution. But there should be ways to encourage the video model
- Please refer to the extensive work done by the "Monitoring Technology Workgroup" put together
- face to face is the best and is a vision for the future but video technology is an important tool given the current workforce shortage in the mental health field in MN. This however should not replace a goal to recruit more psychiatrists to practice in MN.
- This should not be the ideal but available when there are no other options.
- Video technology is regarded as part of the solution?
- Should that be "a" instead of "the" solution?
- It is one solution but not the solution. It can play a limited role. Sometimes its role is overestimated.
- Video technology is okay in a plane over the Atlantic Ocean, when no other option is available.

**RECOMMENDATION**

- Collaboration should be available in local community settings that tend to be the first point of contact.



**Groups with concerns or who do not support recommendation:**

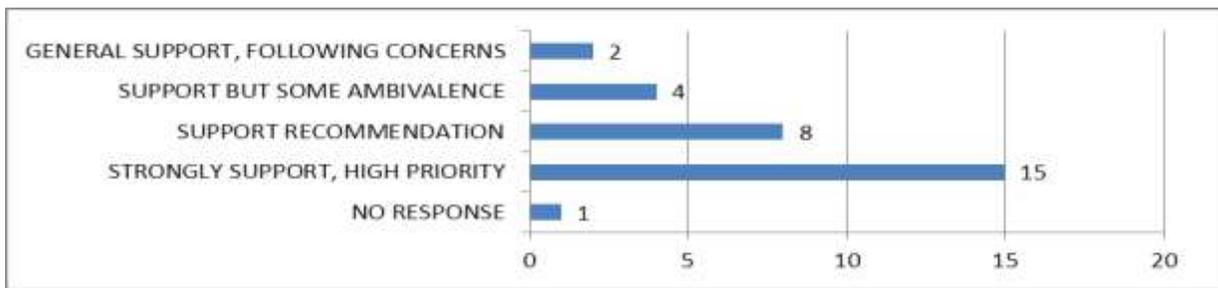
	Frequency	Percent
Local government	1	50.0
Service providers and professional organizations	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- There is a risk that these services may become too medically based in hospitals and primary care settings. We need to strike a balance of control between community based mental health services and medically provided services
- First point of contact is a direct care provider....collaboration can supplement and strengthen the clinical tools available to them.

**RECOMMENDATION**

- Consultation and collaboration need to be based on local client need and local resources.



**Groups with concerns or who do not support recommendation:**

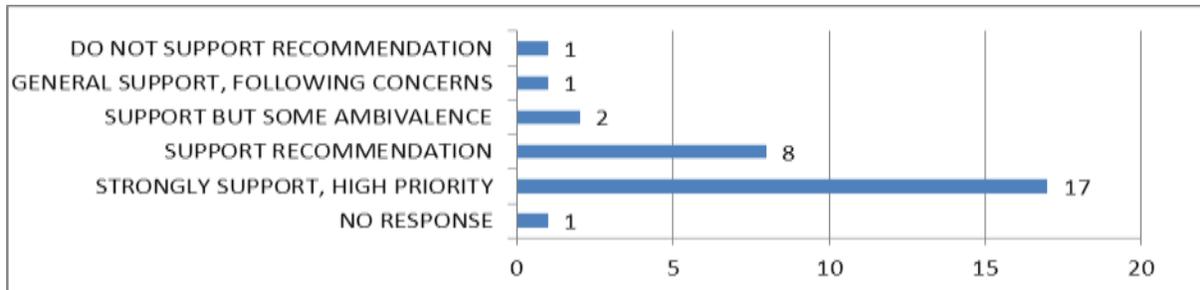
	Frequency	Percent
Advocacy organizations	1	50.0
State government	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- This however cannot negate the fact that critical services must be accessible across the state.
- If local resources don't adequately support this collaboration then the answer is not "you don't have to do this" as this language would indicate, but rather "we'll help you get the necessary resources".

**RECOMMENDATION**

- Service should be available at all levels of care from screening to acute care.



**Groups with concerns or who do not support recommendation:**

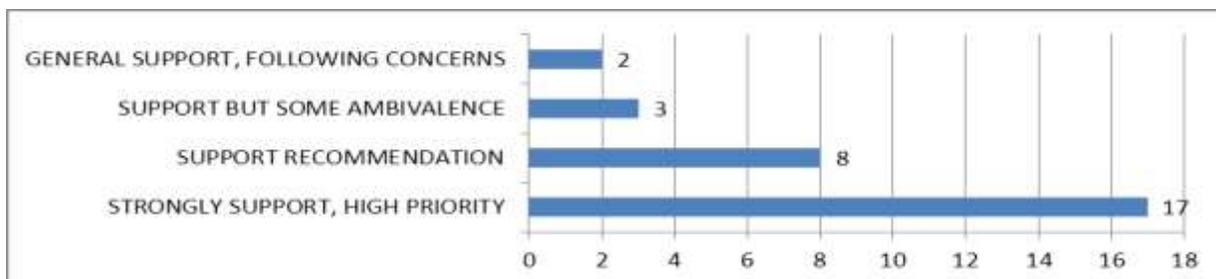
	Frequency	Percent
Local government	1	50.0
State government	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Of course, but not all levels of care are accessible yet everywhere in the state.
- I believe that this recommendation is for consultative services to be available at all levels of services including screening in primary care, however, this can be provided by another type of mental health professional and not always needing to be provided by psychiatrists. I can support this recommendation if it is indicating that the consultative services at the screening level can be provided by a broader array of professionals.

**RECOMMENDATION**

- The model needs to be financially sustainable for all providers who are involved in collaborative consultation.



**Groups with concerns or who do not support recommendation:**

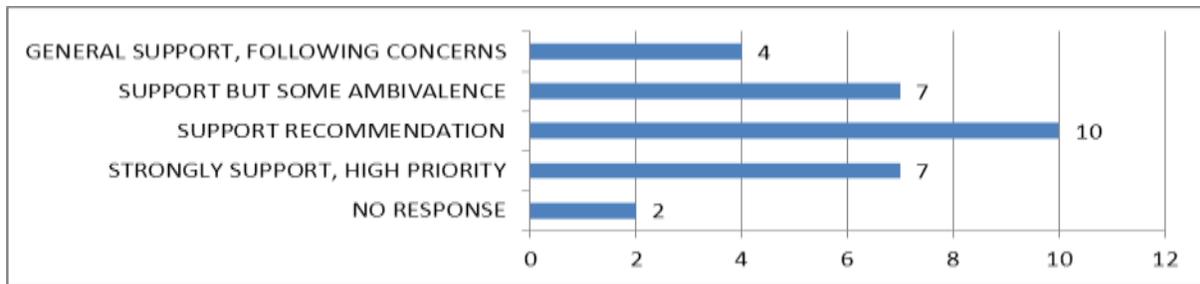
	Frequency	Percent
Local government	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Of course, but this is a BIG problem to solve. What is sustainable for one provider may not be sustainable for all, and MA and Medicare reimbursements in rural MN are low compared to the metro.
- I think this is impossible.

**RECOMMENDATION**

- A tracking matrix will be used to track: number of requests for psychiatric consultation and/or collaboration; number of people who get response to their requests; the type of consultation/collaboration (local or state); the time it took to access psychiatric collaboration/consultation; demographics. All participating resources will track this information.



**Groups with concerns or who do not support recommendation:**

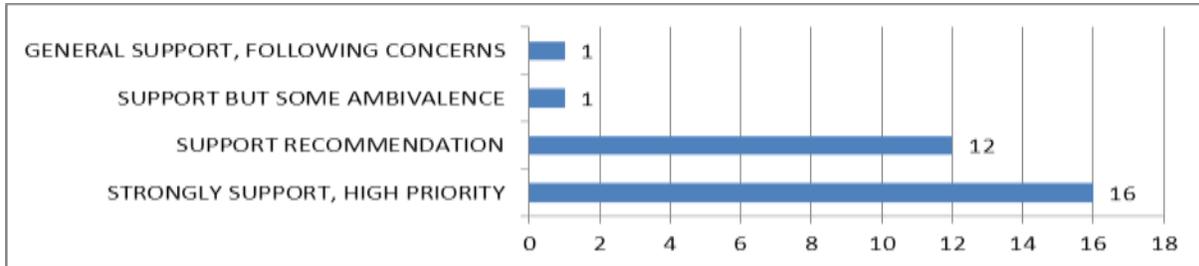
	Frequency	Percent
Advocacy organizations	1	25.0
Other:	1	25.0
Service providers and professional organizations	2	50.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Too much built into this recommendation. It could be a boondoggle of data collection, depending on model and set-up. However, I am supportive of using some sort of patient registry for case-specific clinical purposes...a database to track client progress and communicate among multiple providers. I see this as primarily a clinical tool rather than an accountability function.
- What are the expectations from the health plans to assist in the implementations of this goal? Who develops the tracking method and could there be input into this process?
- Don't see how we can add on to what people are already doing
- Make it simple so it does not interfere with care.

**RECOMMENDATION**

- Address the difficulty of recruiting or attracting mental health professionals who are willing to work on crisis teams.



**Groups with concerns or who do not support recommendation:**

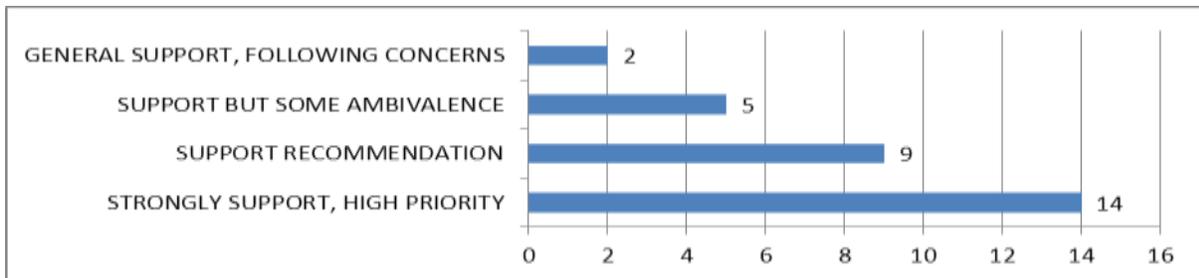
	Frequency	Percent
Advocacy organizations	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- As well as neuro-cognitive deficits.

**RECOMMENDATION**

- Develop a joint privacy release between the MN Dept. of Education and DHS so that families can provide advance approval for their children to receive crisis services in the schools.



**Groups with concerns or who do not support recommendation:**

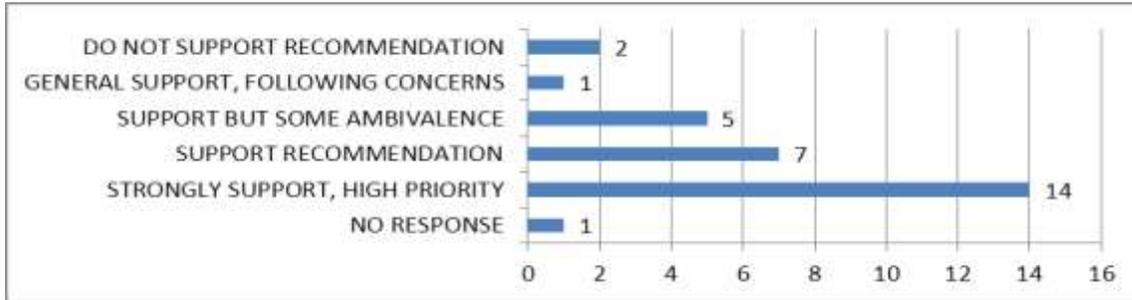
	Frequency	Percent
Advocacy organizations	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Child protection considerations
- would like more explanation as to what the barrier is here. HIPAA would seem to allow this--is it something in IDEA?

**RECOMMENDATION**

- Strengthen current law regarding the use of peer specialists on crisis teams.



**Groups with concerns or who do not support recommendation:**

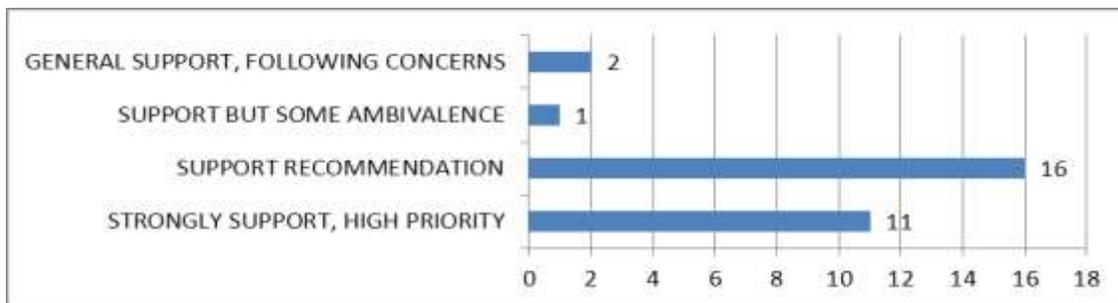
	Frequency	Percent
Other:	1	33.3
Unions representing public employees	2	66.7
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- If peer specialists would be utilized on crisis teams, there would need to be intensive training to define their roles and ensure that their safety and those of the other members as well as the person in crisis will be maintained.
- What would constitute a peer specialist?
- What are the skills and duties required of a Peer Specialist that are not already performed by State employees?

**RECOMMENDATION**

- Create a list of essential elements that should be used in any assessment tools used for adults.



**Groups with concerns or who do not support recommendation:**

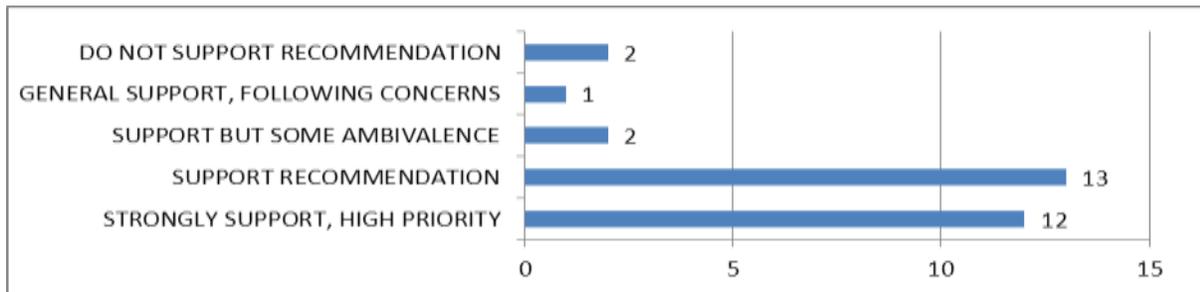
	Frequency	Percent
Local government	1	50.0
Service providers and professional organizations	1	50.0
Total	2	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- As well as neuro-cognitive deficits.
- Prior to that look at the assessment tools we already use and streamline what we use. do we need so many different tools, it becomes very time intensive
- My concern is that "essential" will be translated into required or outcome measurement tools. Clinicians must be given space to customize assessment tools to the given situation and patient. Otherwise, why use a clinician--just give patients a test.

**RECOMMENDATION**

- Create and use a client satisfaction tool.



**Groups with concerns or who do not support recommendation:**

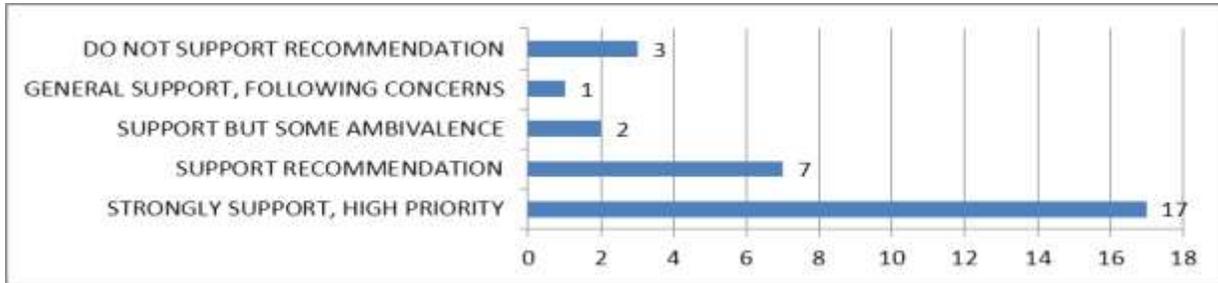
	Frequency	Percent
Advocacy organizations	1	33.3
Other:	1	33.3
Unions representing public employees	1	33.3
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Reliable tool won't work. Will have small and un-representative [*sample of ?*] respondents.
- Satisfaction surveys tell one how pleased the person is at that moment in time. Outcome measures and the individuals attainment of previously stated goals is a more telling measure.
- Client satisfaction can be happiness with hot food and not if they are getting the lowest dose of meds.

**RECOMMENDATION**

- Clarify that crisis teams can go into emergency departments and distribute model and existing agreements.



**Groups with concerns or who do not support recommendation:**

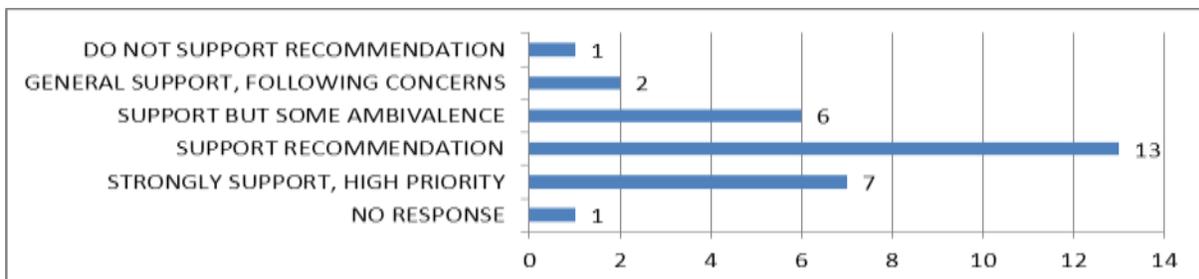
	Frequency	Percent
Other:	1	25.0
Service providers and professional organizations	1	25.0
State government	1	25.0
Unions representing public employees	1	25.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- this is confusing wording
- I continue to have concerns regarding this issue depending on the skill, expertise and functional level of the individual crisis teams.
- This recommendation is vague and needs clarification before we can support it.
- Crisis teams should be able to go into an ER only if the facility has credentialed the crisis team. All crisis teams should apply for credentialing at the hospitals in their area. We should work toward having all of these teams credentialed, however credentialing is required by hospital accreditation bodies and must occur.
- I doubt an ER would let non-system employees perform work.

**RECOMMENDATION**

- Support adding funds so all teams can have health care navigators and create a list of key elements of a health care navigator.



**Groups with concerns or who do not support recommendation:**

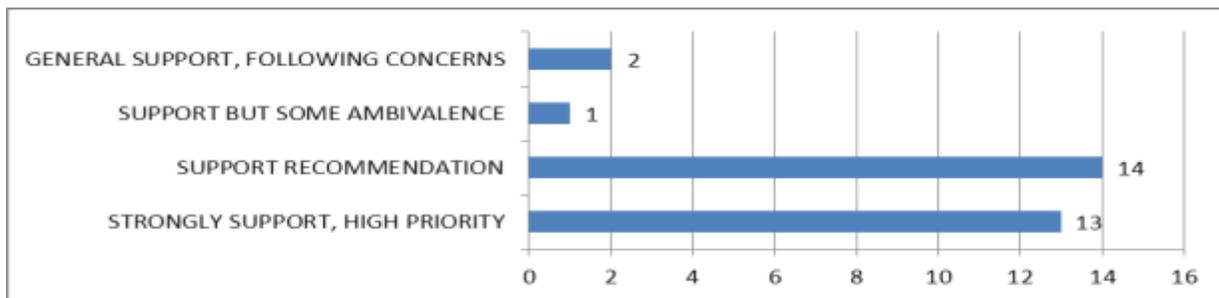
	Frequency	Percent
Advocacy organizations	1	33.3
Unions representing public employees	2	66.7
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Include the need for all departments at DHS to cooperate with the development of funding options.
- Not necessary for each crisis event...however, linkages to the primary care/medical/surgical system is very important. Navigators are one way to move in that direction.
- I do not recall discussing healthcare navigators.
- How does this fit with the intensive case management services mentioned earlier?
- I do not know what skills or duties a health care navigator would perform that State employees do not already do.

**RECOMMENDATION**

- Identify clearly the lack of or barriers to accessing specific services post-crisis.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Service providers and professional organizations	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

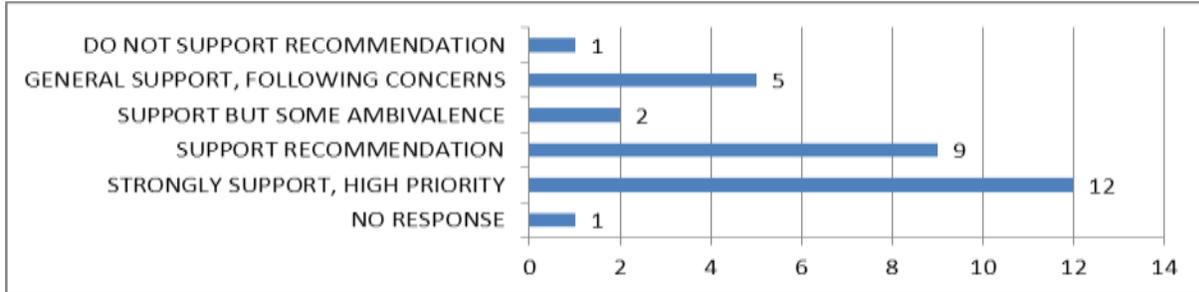
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Lack of barriers or barriers.
- How?

- Who is identifying the barriers and for whom are they doing this? Is this a study? Is this a navigator clearing the way so there are no impediments to service? How will they do that?

**RECOMMENDATION**

- Create a separate funding stream to pay for crisis/respice beds for children.



**Groups with concerns or who do not support recommendation:**

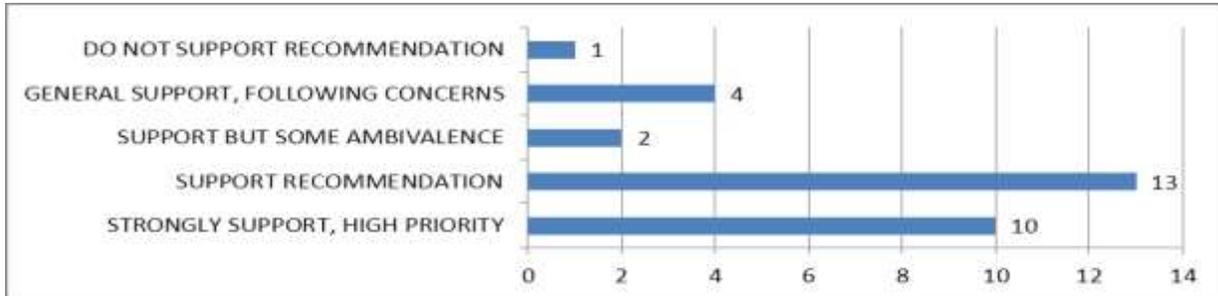
	Frequency	Percent
Advocacy organizations	2	33.3
Local government	1	16.7
Other:	1	16.7
State government	1	16.7
Unions representing public employees	1	16.7
Total	6	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- YES. But current shortage of crisis children's facilities especially in rural areas or for youth with multiple, complex diagnoses or very young children.
- Include the need for all departments at DHS to cooperate with the development of funding options.
- I support this but the funds must be restricted so they may not be used unless it is truly a mental health qualified provider and specifically excludes the use of DOC licensed programs for these children.
- Crisis beds are already available, Please add in the justification for needing a separate funding stream.
- We would be better served to create a funding stream for crisis and respice that supports the individual's need regardless of their age. What purpose is served here by having a separate funding stream for kids?? Families of adults need respice too.
- As long as not at the cost of other needed funding

**RECOMMENDATION**

- Develop more crisis beds for adults in key regions of the state and look at creating a state funding “pool” in order to address the problem of crisis beds not being able to be used by people outside the county they are located in.



**Groups with concerns or who do not support recommendation:**

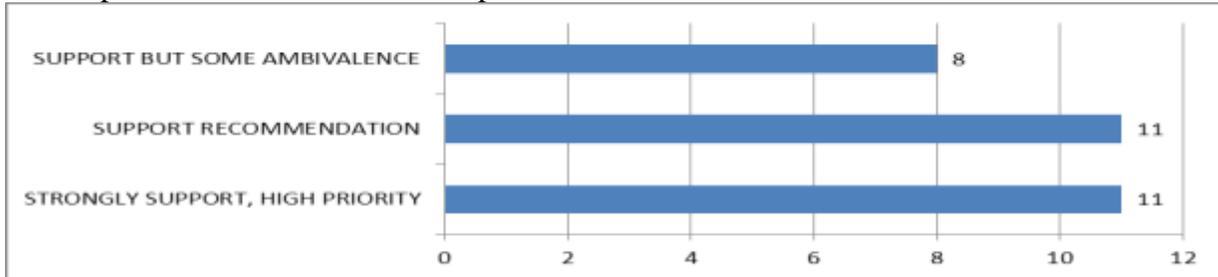
	Frequency	Percent
Advocacy organizations	1	25.0
Service providers and professional organizations	2	50.0
State government	1	25.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I do not believe the information provided supports this global of a statement. Often times it is a respite bed that is needed and not a crisis bed.
- Include the need for all departments at DHS to cooperate with the development of funding options.
- I believe we need more crisis beds that are actually available when the person is in need but I believe that any solution must address host county concurrence which is a form of discrimination against individuals who do not reside in that county.
- why just adults?
- If this will facilitate use for patients in crisis, I would support it. However, I would not want this to allow counties to get off of the hook. They should be responsible for paying for a crisis bed, even if it is not located in their county.
- Is this a first come, first served system or an only in my back yard system?

**RECOMMENDATION**

- Include in the definition of crisis services and plans the need to prevent future problems/crisis and action steps.



**Groups with concerns or who do not support recommendation:**

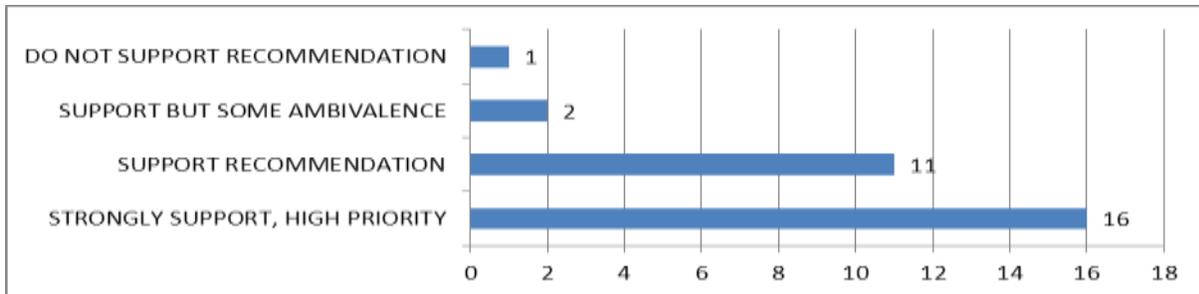
NONE

**Comments:**

- Duration is too short; community access/resources too limited to require the crisis service plan to direct future action steps. This should be more of a shared care review and planning step.
- It is a good idea that should be incorporated into the sequence of crisis response; however, I'm not sure that that is the responsibility of the crisis team...rather, it might be done as part of the services following crisis intervention.

**RECOMMENDATION**

- Firmly state that the values on which crisis services are based are: strengths based, recovery oriented and person centered services that are culturally appropriate, foster hope, encourage the development of natural supports and foster/support individual choice.



**Groups with concerns or who do not support recommendation:**

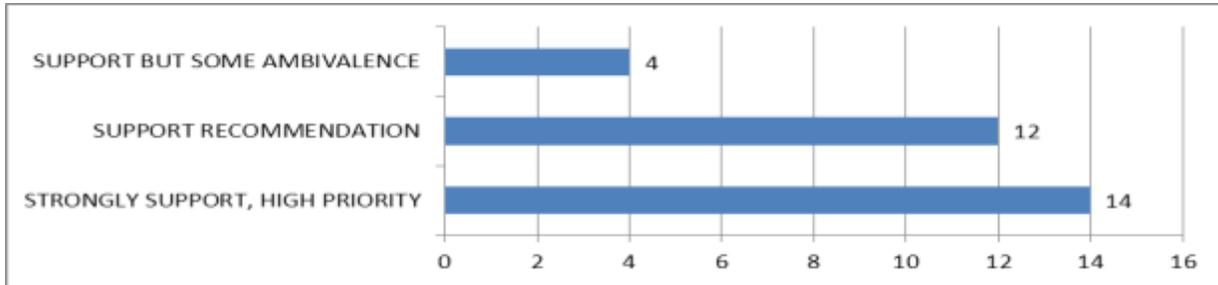
	Frequency	Percent
Consumers and family member	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Yes. we will need to off-set a culture that could view crisis services as a function of public safety...police...or courts.

**RECOMMENDATION**

- Provide additional training to teams that provide services to both children and adults to ensure that they understand the parent perspective.



**Groups with concerns or who do not support recommendation:**

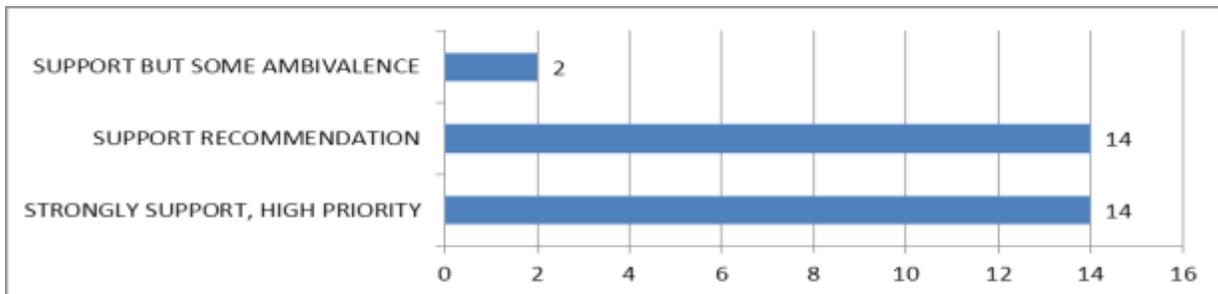
NONE

**Comments:**

- Provide additional training to ensure that teams and parents understand the consumer's perspective.

**RECOMMENDATION**

- Define integrated, collaboration, consultation and coordinated.



**Groups with concerns or who do not support recommendation:**

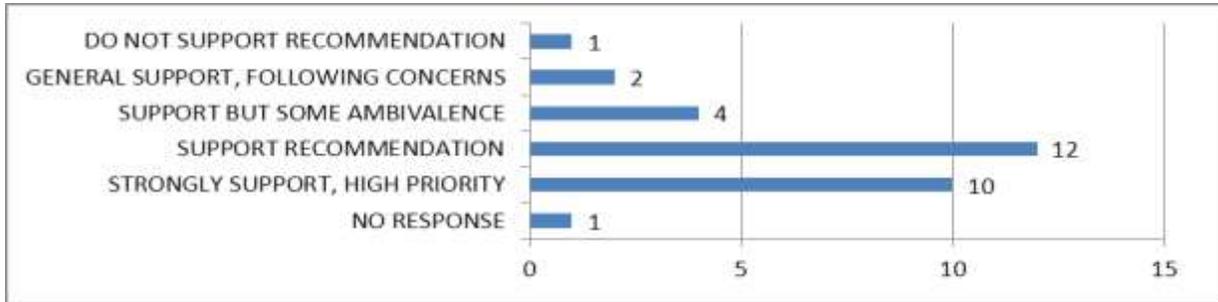
NONE

**Comments:**

- And the associated payment models for which types of providers.

**RECOMMENDATION**

- Collect information from all teams, regardless of grant funding and change the reporting forms slightly so that the same or equivalent data is collected for both children and adults.



**Groups with concerns or who do not support recommendation:**

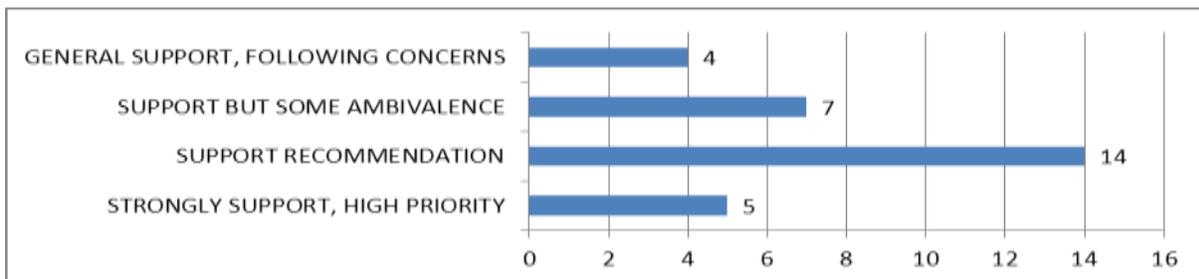
	Frequency	Percent
Other:	2	66.7
Service providers and professional organizations	1	33.3
Total	3	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Too many apples to oranges.
- Would there be a cost to upgrade our technology and create an automatic process to gather this information?
- Carefully consider how much data you need and will actually use. Do not burden providers. Every question or form the provider must complete is lost care to patients.

**RECOMMENDATION**

- Look at conducting follow-up surveys six months or a year later.



**Groups with concerns or who do not support recommendation:**

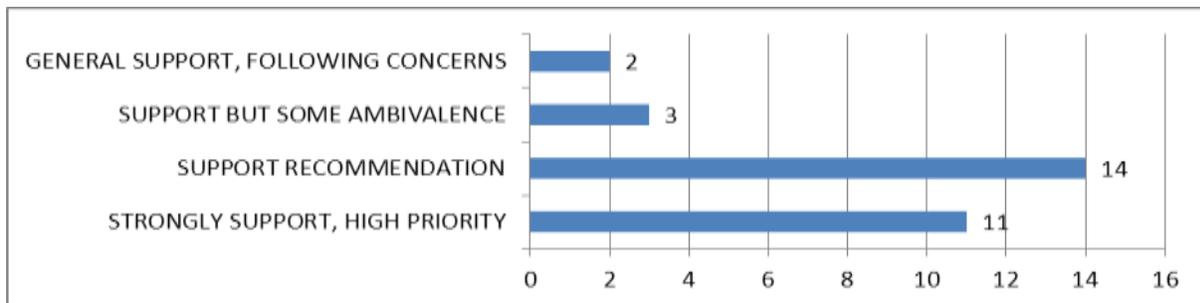
	Frequency	Percent
Advocacy organizations	1	25.0
Other:	1	25.0
Service providers and professional organizations	1	25.0
Unions representing public employees	1	25.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- This is more meaningful if the survey includes primary barriers to community tenure that go beyond MH status changes; and include issues of housing stability, employment, level of poverty, and social isolation.
- Don't understand reference.
- Need further clarification of who would do these and how would it work? What would the validity for these surveys look like and how would DHS track those with multiple visits.
- For crisis services?
- I know there isn't money to do this now

**RECOMMENDATION**

- Address the need for emergency and non-emergency transportation.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Other:	1	50.0
State government	1	50.0
Total	2	100.0

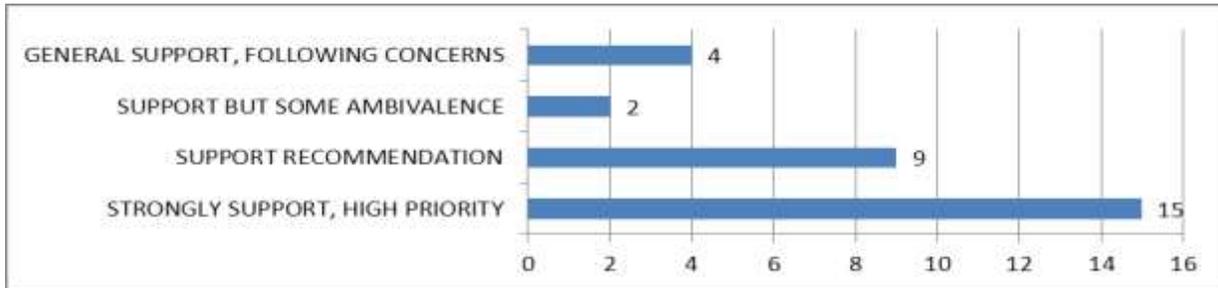
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Can only support if the transportation does not rely upon local law enforcement which causes trauma to clients.
- Health plans should be included in this discussion as transportation can be a very frequently utilized benefit.
- Vitally important

- How? At who's cost?

**RECOMMENDATION**

- Ensure a steady continued funding stream to pay for the infrastructure costs and the costs of uninsured and underinsured individuals.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	1	25.0
Other:	1	25.0
State government	1	25.0
Unions representing public employees	1	25.0
Total	4	100.0

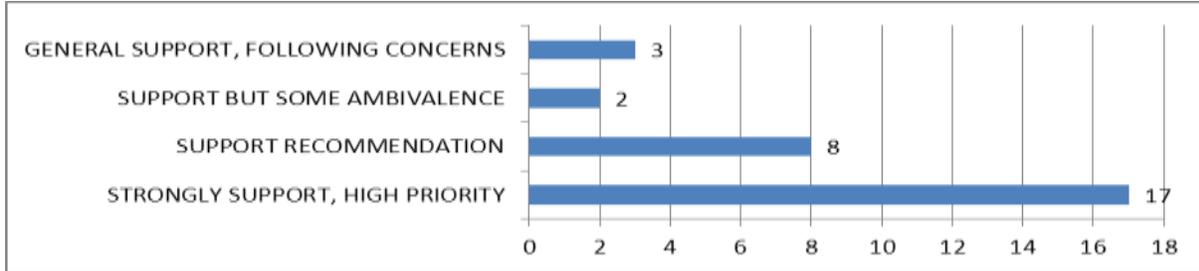
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Include the need for all departments at DHS to cooperate with the development of funding options.
- Must be sustainable into the future so as not to be subjected rapid ups and downs.
- How would this be funded and how would costs be contained?
- essential to making such a system work. Should be like ambulances--perform the service first and worry about payment second.
- How? Who will pay for it?
- At the cost of what other area that needs funding?

## Housing with Services Workgroup Recommendations

### RECOMMENDATION

- A statewide housing with services analysis is needed that examines on a regional basis
  - a) the availability of supportive and affordable housing;
  - b) the service availability;
  - c) needs of persons with a serious mental illness in the region; and
  - d) the community capacity to develop, fund, and manage housing with services.



### Groups with concerns or who do not support recommendation:

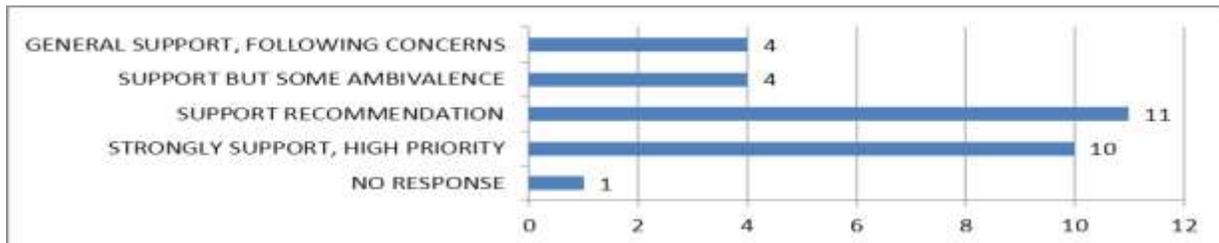
	Frequency	Percent
Advocacy organizations	1	33.3
Local government	1	33.3
Service providers and professional organizations	1	33.3
Total	3	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

- This seems like a duplicate effort. Rather than to continue to evaluate need, I would like to see resources go directly towards housing subsidies.
- Include neuro-cognitive deficits
- So much of this seems to depend on the Section 8 and federal housing programs, it seems that they need to be engaged in this process with us.
- While an analysis may be helpful to document each community's unique needs, the pressing need is for housing with services, not further analysis. Perhaps the creation of some services could begin in concert with the initiation of analysis, based upon previous analyses.

**RECOMMENDATION**

- In planning and developing permanent supportive housing in Minnesota, the Chemical and Mental Health Services administration will use the SAMHSA toolkit and advise its usage by local mental health authorities, tribes, provider administrators and program leaders.



**Groups with concerns or who do not support recommendation:**

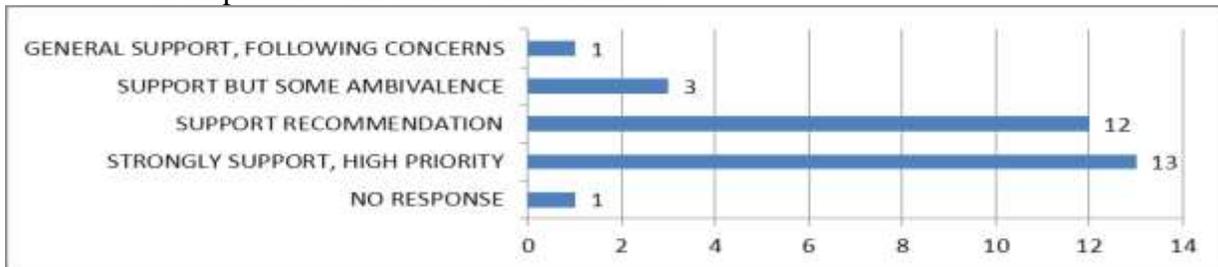
	Frequency	Percent
Advocacy organizations	1	25.0
Service providers and professional organizations	3	75.0
Total	4	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I hesitate on this as I have not had the benefit of reading the toolkit or its applicability to MN housing related needs.
- Explain the kit to lay persons
- Include neuro-cog deficits
- I may have missed something but the SAMHSA material looked too philosophical to be a true "toolkit" for action.
- What is meant by advise? The SAMHSA toolkit needs to be used in flexible way that responds to community needs.

**RECOMMENDATION**

- That the affordable and supportive housing need is too important for the basic health and welfare of persons with serious mental illness to end with this Phase I report and that in order to be effective the discussion must continue into Phase II
  - a. with a review of the housing with services analysis of the housing needs of persons with serious mental illness; and
  - b. the development of a comprehensive strategic plan for addressing the housing needs of all persons with serious mental illness



**Groups with concerns or who do not support recommendation:**

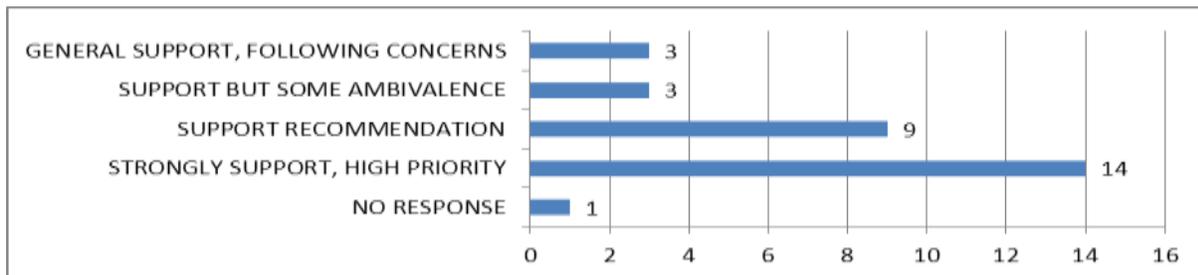
	Frequency	Percent
Advocacy organizations	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I'm ambivalent as I remain uncertain about the need for a review/analysis. Again I believe the data is already available.
- Is Phase I and II a defined process?
- Include neuro-cog deficits
- This is such a basic and important need, the planning and research needs to go to the next level.
- Housing with supports is probably the highest need, and requires the most immediate investment of time and resources.

## RECOMMENDATION

- The Phase I Target Population should be individuals with serious mental illness and complex needs must meet the following diagnostic, service, and housing criteria:
  - a. mental health service Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) rating of 4 or 5; and
  - b. the individual does not meet medical necessity for inpatient hospitalization; and
  - c. has complex, or multiple, service and support needs that are essential to be met in order for the person to obtain and retain housing; and
  - d. the individual has a demonstrated history of being unable to retain housing; or
  - e. there is a documented history that makes the person ineligible for a housing subsidy, rental voucher, or unable to obtain affordable housing



### Groups with concerns or who do not support recommendation:

	Frequency	Percent
Advocacy organizations	1	33.3
Consumers and family member	1	33.3
Other:	1	33.3
Total	3	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

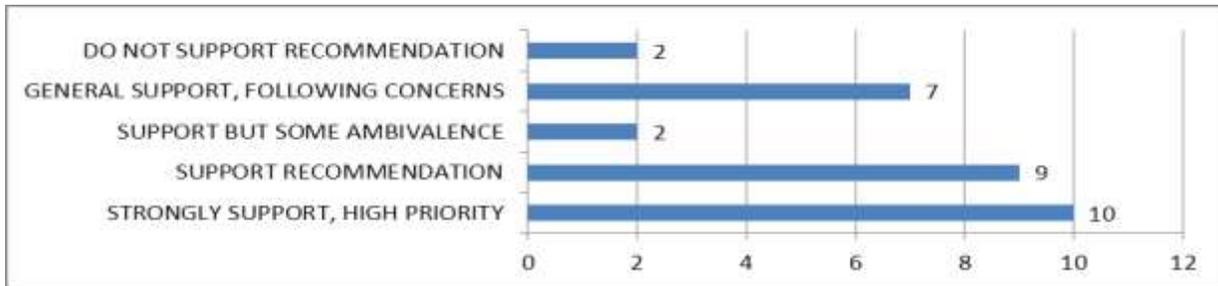
- May never get through Phase 1.
- Include neuro-cog deficits
- I think this might be different Metro vs. rural. In Metro, I see some advantage of addressing the housing plus service needs of some of the easier consumers/patients. This could relieve pressure on AMRTC and community hospitals. Some of the most very difficult consumers might be appropriate for AMRTC, but shortening the length of stay could achieve increased capacity or downsizing.
- This does not seem like the same explanation that the group came up with. I believe there was a phrase changed. Instead of; "and" c. has complex, or multiple, etc. I believe we had used the word "may".
- Is a lower priority.

## Transportation Workgroup Recommendations

### RECOMMENDATION

- Regarding transportation provided by law enforcement: In an effort to make transportation by law enforcement more effective and less traumatic to individuals experiencing a mental health crisis, it is important that a mental health component be added. It is recommended that MS § 253B.10, subd 2 be expanded to include: “Whenever possible, a peace officer who provides the transportation **should have mental health crisis intervention training or seek the assistance of a mental health crisis intervention practitioner or professional** shall not be in uniform and shall not use a vehicle visibly marked as a police vehicle.”

The state should develop CIT training which is continuously available across Minnesota, to psychiatric responders.



### Groups with concerns or who do not support recommendation:

	Frequency	Percent
Advocacy organizations	1	11.1
Local government	3	33.3
Other:	1	11.1
Service providers and professional organizations	1	11.1
State government	1	11.1
Unions representing public employees	2	22.2
Total	9	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

- Great goal, but cannot be mandated until such CIT-Trained staff are available and reality of shortage of unmarked vehicles in rural areas is addressed. State services should pay for this. Not clear whether county social services or county law enforcement is responsible for arranging for this transport. This needs clarification and funding; otherwise sheriffs will oppose.
- If all persons are treated with respect and dignity, I am uncertain as to why this medical condition would be treated any differently than any other medical condition requiring law enforcement involvement.
- Police Departments have their own rules of operations and mandates and are not under the jurisdiction of the Department of Human Services. The recommendation over reaches by stating that they cannot be in uniform or drive unmarked cars.

- Include neuro-cog deficits
- I still believe that transportation issues should not be handled by law enforcement. I support this recommendation as a bridge to a completely different system. Any new system must however include the CIT training.
- The ideal for the peace officer would be for them not to be in uniform or in a police vehicle but this might not always be practical
- Seems to be in conflict with providing alternatives to LE.
- Essential!!
- This would potentially create a huge cost to Greater Minnesota and be burdensome

**RECOMMENDATION**

- Regarding emergency medical (ambulance) transportation:
  - a) Should not be used when less restrictive approaches to psychiatric transportation are available;
  - b) Is best used when there is an identifiable medical need;
  - c) EMT and Paramedics should receive adequate training and orientation related to addressing the needs of individuals who are experiencing an acute psychiatric emergency, or have the immediate availability of someone qualified to provide mobile MH crisis intervention.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	2	50.0
Other:	1	25.0
Service providers and professional organizations	1	25.0
Total	4	100.0

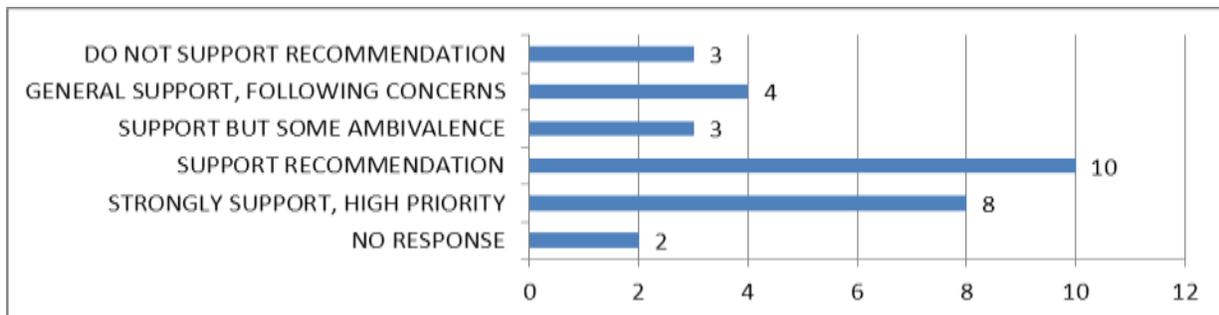
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Our community experience is that these professionals provide care with respect and dignity. The very nature of their work places them in an emerging need environment. The severity of psychosis is often what results in the transportation management issues; the EMT professional has the connection to the hospital physician and ability to treat on premise and while in transport. I would like to have seen a survey of EMT and Paramedics to see what they would identify as most helpful to them. The mobile crisis teams call upon the police and EMTs when the needs for safety and security are greater than the crisis worker can provide.

- In addition to defining medical need, safety should be criteria as well. Persons who are actively a danger to themselves and others may need ambulance transportation
- Does everyone know what an EMT is?
- Less restrictive options are not currently available for those with medical needs or where there are concerns for safety of the consumer or the transporter. How frequently would this service be utilized and is there enough of a demand to develop a different transportation service to meet this specific need?
- This should be a regional discussion based on resources and needs, not dictated in statute without a great deal more research.

**RECOMMENDATION**

- Regarding the development of a less costly, more appropriate “middle tier” option: The state and counties should pursue the development of Special Psychiatric transportation as an effective and cost-saving alternative.
  - a) collaboration should occur with MCOs serving public pay clients and commercial plans to make this service available to their recipients
  - b) courts and counties should consider this option in lieu of using law enforcement when transporting to court hearings
  - c) the state should allow Crisis Intervention Practitioners and Professionals to authorize the special psychiatric transportation services and an additional attendant if needed; and,
  - d) In order to allow for the evaluation and consideration of various approaches to this service, the state should fund a handful of demonstration projects to be designed and implemented by Adult Mental Health Initiatives.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	14.3
Local government	2	28.6
Other:	2	28.6
Service providers and professional organizations	1	14.3
Unions representing public employees	1	14.3
Total	7	100.0

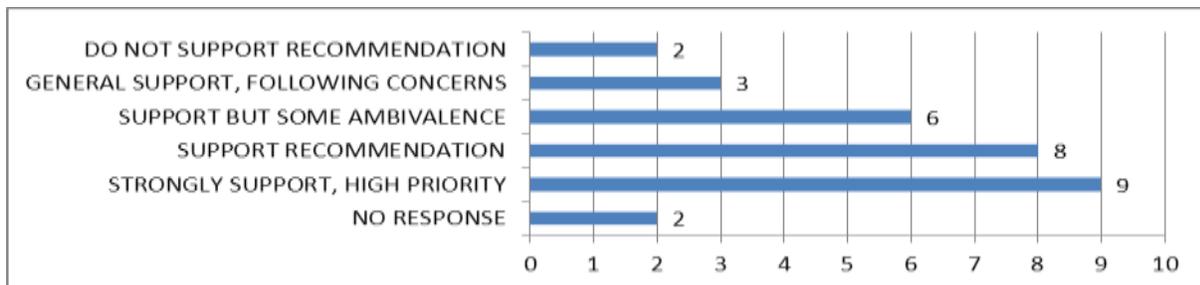
**Comments/Concerns/ Reasons for not supporting recommendation:**

- Demonstration projects should be developed by regional entities who agree to work together.

- Unrealistic.
- A fully funded pilot should be tried first to see if this is even doable. This cannot be passed on to the courts and counties to negotiate on their own; it is an unfunded mandate for both entities. This is a very large expansion of the role of Crisis Intervention teams.
- Include neuro-cog deficits
- "Middle tier" options would need to be clearly defined and health plans would be responsible for transportation that is medically necessary to a medical appointment, not for court hearings.
- This needs to be a conversation had at the local and regional level as resources and funding streams vary by region, based on the needs in that area.
- DHS could have positions to transfer patients. DHS staff are trained professionals. DHS does not provide this service, because it is not funded to do so.
- I cannot support this if it is suggesting that a mental health practitioner is placing a transportation hold on the patient. They do not have the training to do so.

**RECOMMENDATION**

- Regarding the potential role of crisis workers as “health officers” under the commitment act: The recommended change to the Civil Commitment Act is to amend MS § 253B.02, subd. 9 to read:
  - Subd. 9. Health officer. "Health officer" means a licensed physician, licensed psychologist, licensed social worker, registered nurse working in an emergency room of a hospital, or psychiatric or public health nurse as defined in section 145A.02, subdivision 18, or an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3, or a Mental Health Practitioner or Mental Health Professional providing Mental Health Mobile Crisis Intervention Services as described as 256B.0624 and formally designated members of a prepetition screening unit established by section 253B.07.*



**Groups with concerns or who do not support recommendation:**

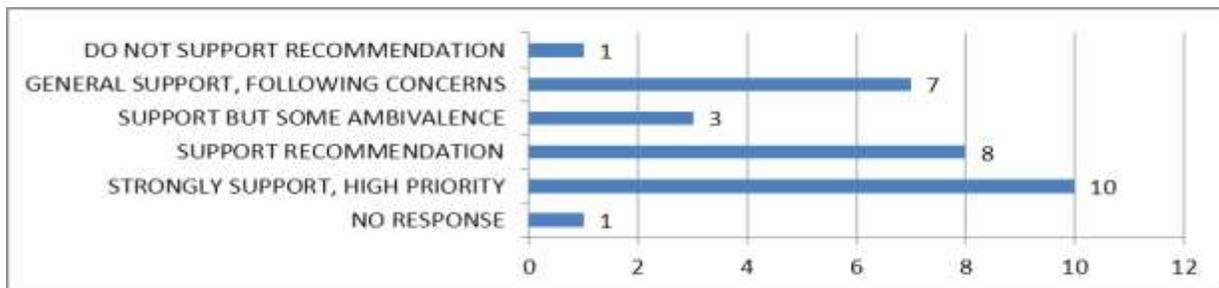
	Frequency	Percent
Advocacy organizations	1	20.0
Local government	1	20.0
Service providers and professional organizations	1	20.0
State government	1	20.0
Unions representing public employees	1	20.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- This seems too broad
- We do not support this recommendation as it currently reads. When you place an individual on a hold order, it must be understood that this is a deprivation of liberty and personal privacy. It is too easy now for a mentally ill person to have their constitutional rights abused. We cannot support any expansion of the definition that does not include a specification that anyone below the level of physician that does not have specific mental health certification such as an APN-trained in psychiatric practice, a psychiatric CNS or a LICSW.
- I am concerned about the MH practitioner signing as health officer. This is an unregulated, unlicensed individual who has authority for certain activities only while under direct supervision by a MH professional. The crisis team isn't really even an "entity"... I think this might be getting into an area where there will be liability concerns....the health officer authority has power to restrict individual rights. It is not out of the question; however, it would depend on the relationship with clinical supervisor and how crisis team is organized and managed.
- LOTS more discussion and research would need to be done before we would even know if this is realistic.
- Don't see the need for an expansion.

**RECOMMENDATION**

- Regarding the need to limit the amount of time law enforcement resources are tied up at emergency departments: There should be at least one hospital in each region with a sufficient amount of on-site security that would allow for law enforcement to disengage after transport. In addition, technical assistance should be sought by hospitals and emergency rooms to understand the parameters they must adhere to.



**Groups with concerns or who do not support recommendation:**

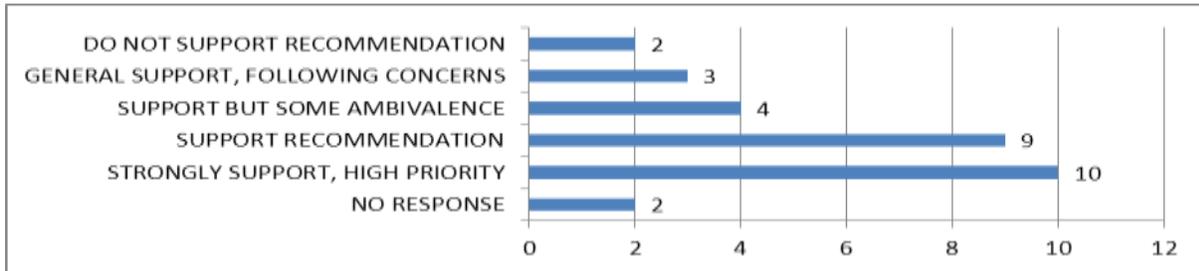
	Frequency	Percent
Local government	2	25.0
Other:	2	25.0
Service providers and professional organizations	1	12.5
State government	2	25.0
Unions representing public employees	1	12.5
Total	8	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Great idea, but deep rural hospitals probably cannot afford 24/7 security and hospital ER training should be funded by SOS.
- Some regions are very large. With just one hospital in a region with on-site security you may be transporting dangerous people a long way. It's also an additional cost to the hospitals to hire staff that they may be unable to afford.
- I am concerned that this could become an "unfunded mandate" on hospitals that are already under extreme financial pressures. I believe that identified "Level 1" psychiatric hospitals should be compensated adequately or to provide the full array of supports and services such as security.
- The way this is worded continues to perpetrate the dangerousness stereo-type. Law enforcement should leave once the person has filed the written request for admission. For purposes of CMS regulations, hospital security is defined as law enforcement so the hospital is under the same requirements as it relates to when a hospital can call in law enforcement as I understand the regulations. Any hospital with an emergency department has to be equipped to handle any person brought to the ED.
- This really gets into hospital administrative matters and EMTALA statute regarding anti-dumping. Still, it could be an idea worth looking at from various perspectives...regulatory, legal, clinical, financial, public safety, etc.
- For hospitals without adequate security would law enforcement be expected to stay or would they need to transport to another facility. If so, how does this best meet the patient's needs?
- Payment??? Regulation, oversight?
- This recommendation can only be operationalized if there are resources for security guards at these regional hospitals
- Every Hospital should have sufficient security to provide for safety of its patients, staff and the public. Sadly, this is the world we live in. Cameras are not a substitute for paid, professional security personnel.

**RECOMMENDATION**

- Regarding potential roles for Certified Peer Specialists in crisis intervention and transportation services: The statutory language relating to CPS services should be expanded to allow CPS staff to participate in mental health mobile crisis intervention services.
  - a. Subd. 3. Eligibility. Peer support services may be made available to consumers of (1) the intensive rehabilitative mental health services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) mental health mobile crisis intervention services and crisis stabilization services under section 256B.0624 (d) and (e).



**Groups with concerns or who do not support recommendation:**

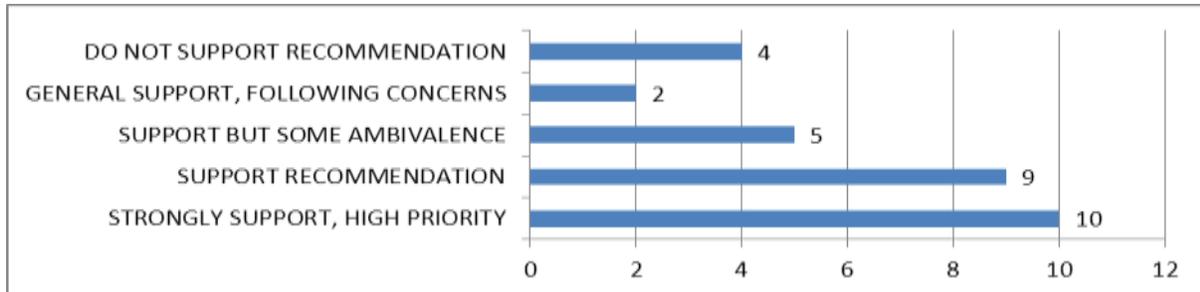
	Frequency	Percent
Local government	1	20.0
Other:	1	20.0
Service providers and professional organizations	1	20.0
Unions representing public employees	2	40.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- I think this is good idea only if CPS are highly trained in crisis management including personal safety and restraint.
- Crisis Assessment work is often carried out in venues involving parallel police interventions. It is often fast paced and high risk for all individuals involved. This should be a pilot first, fully funded by DHS.
- I would be concerned about a CPS alone on a mobile crisis intervention service...I can see it as part of a team...2 people together doing the direct service, but not alone with telephone consultation/supervision unless they qualified with the MH practitioner criteria.
- This would only be supported depending on the training provided. A CPS without adequate mental health training could be a detriment in a crisis situation.
- As stated before, what is the definition for a person providing peer support? If this is to be in statute, a definition should follow.
- Again, a regional discussion based on availability and need
- No expansion necessary.

**RECOMMENDATION**

- Regarding the complications and excessive travel related to court proceedings: The use of ITV to conduct commitment hearings should be better optimized but the decision to use ITV should be weighted by consumer preference.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	16.7
Local government	2	33.3
Other:	1	16.7
State government	1	16.7
Unions representing public employees	1	16.7
Total	6	100.0

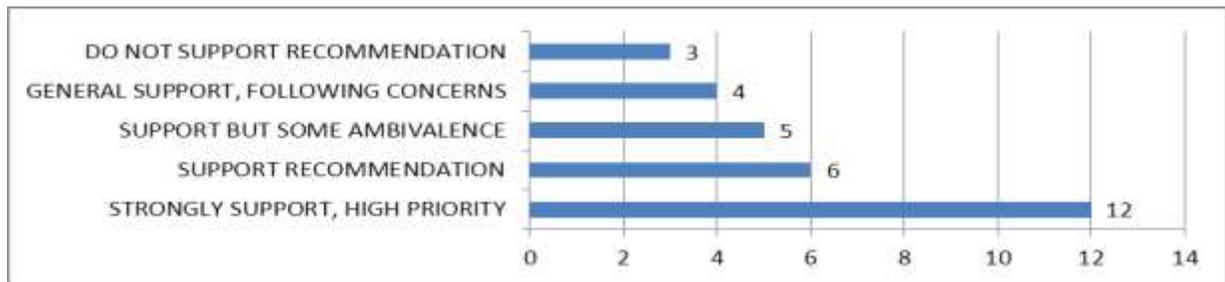
**Comments/Concerns/ Reasons for not supporting recommendation:**

- I don't think consumer preference needs to be a determining factor, unless they pay the transportation bill themselves.
- At that point I don't think that consumers may be acting in their own best interest. The decision needs to be based on practical realities.
- Sheriffs and attorneys have concerns with this recommendation. Many defense attorneys believe that they must be face to face with their clients in order to defend them according to statute.
- There is a need for the person to be able to meet FTF with the Court and others involved. So much happens in the 11th hour prior to court that may not occur due to lack of FTF time. However, the choice of the person is paramount.
- I think that the ITV should actually be a priority when available. Consumer preference may be against it solely based on not understanding its usefulness. I agree that ITV should be optimized but I don't agree that its use is limited by consumer preference as this recommendation may imply the way it is worded.
- Patients can request to be taken from a facility for reasons that do not relate to their need for justice. The decision should be the judge's.

**RECOMMENDATION**

- Regarding the need to further clarify counties’ obligation to provide transportation related to its role in ensuring access to mental health care: The workgroup recommends that the following language be added to the Mental Health Act. M.S. §245.473, Subd 5 should be added to read:

A) Subd. 5 Psychiatric Transportation Services. The county board shall ensure that persons having a psychiatric crisis are provided with psychiatric transportation services to and from emergency hospital services, acute care hospital treatment, crisis residential stabilization services, Community Behavioral Health Hospitals and mental health related court hearings. Access to these transportation services shall not be limited to persons who have been placed on a hold.

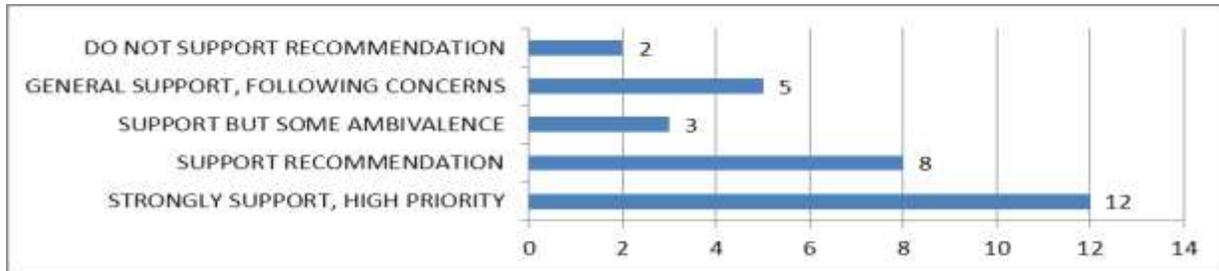


**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	14.3
Local government	3	42.9
Other:	1	14.3
Service providers and professional organizations	1	14.3
Unions representing public employees	1	14.3
Total	7	100.0

**RECOMMENDATION**

B) A definition of Psychiatric Transportation Services should be added to the Mental Health Act as well as basic standards: Psychiatric Transportation Services – Involves the transporting of persons who are experiencing a mental health crisis to an appropriate setting to have their condition assessed and to receive mental health treatment if needed. Those providing psychiatric transportation services should have received crisis intervention treatment training or seek the assistance of a mental health crisis intervention practitioner or professional.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	14.3
Local government	3	42.9
Other:	1	14.3
Service providers and professional organizations	1	14.3
Unions representing public employees	1	14.3
Total	7	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

**Part A**

- Cannot be mandated until SOS-provided and trained mental health transportation is actually in place. Also, need to designate the responsible county authority: social services, public safety or courts. They have different funding sources.
- \$\$\$
- This seems too broad to me; my question is: if we are treating under medical necessity for a medical condition, why is the transportation burden be placed on the county?
- This is a broad expansion of the counties role by making them responsible for Psychiatric Transportation. It would become an unfunded mandate. It impacts other legal entities; Ambulance coordinators, the county sheriffs, private hospitals, and private providers. This requires further study by DHS in conjunction with county human services and these other jurisdictions. How would such an expansion of required services be funded?
- Include neuro-cog deficits
- This is really about an unmet need and unfunded mandate. It makes sense to put this on counties...but there might need to be guidance and support in how to accomplish this or

how to minimize the need for emergency hospital services by improving crisis services and intensive community-based services that prevent the urgency.

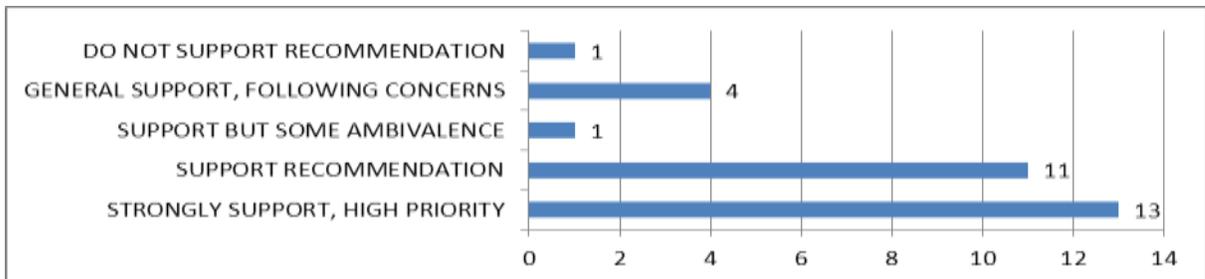
- There is not established alternative for psychiatric transportation. Health plans would support payment only for transportation to a medical service.
- Unfunded mandate
- Funding comes from where?

### **Part B**

- Cannot be mandated until SOS-provided and trained mental health transportation is actually in place. Also, need to designate the responsible county authority: social services, public safety or courts. They have different funding sources.
- What will be the infrastructure for this?
- It makes more sense to allow ARMHS workers and Crisis Mobile teams to be paid for transportation time and the need time for support while a person in crisis is being assessed or attending routine mental health services. Person served could have greater adherence to making appointments and following care, if ARMHS workers, for example, could assist in this way and get paid for time and travel...sharing the care objectives.
- It is too premature to add the definition of Psychiatric Transportation Services to the Mental Health Act without resolving jurisdictional issues and funding.
- Include neuro-cog deficits
- Pretty complicated... there are parts of each of these (Q96 and Q97) that together might work. (e.g. I like the no need for hold, but the flexibility of the Q97)
- Language is not specific enough as to who can provide transport; there are huge liability issues here.
- Unfunded mandate

### **RECOMMENDATION**

- The role of the mobile crisis intervention team should be clarified to include assessing the individual's need for emergency hospital services, acute care hospital treatment, crisis residential stabilization services, or Community Behavioral Health Hospital services and determine the most appropriate means of transportation to get the individual to the service.



**Groups with concerns or who do not support recommendation:**

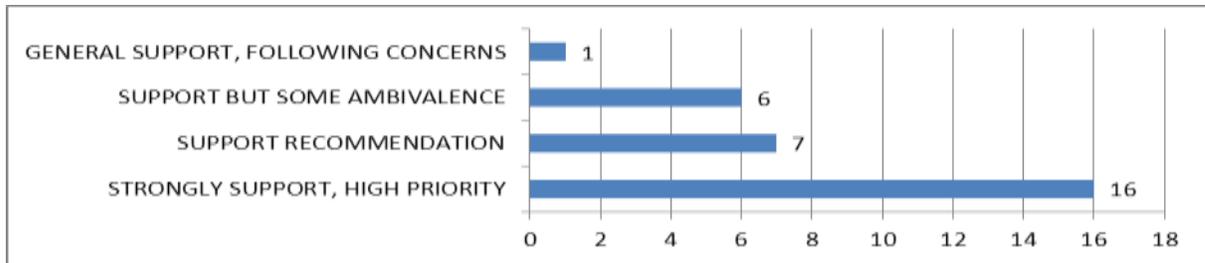
	Frequency	Percent
Advocacy organizations	1	20.0
Local government	1	20.0
Other:	1	20.0
State government	1	20.0
Unions representing public employees	1	20.0
Total	5	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- This recommendation is too premature without study and resolution of the jurisdictional and funding issues
- It should be made clear that law enforcement transportation is a last resort.
- Is assessing other medical conditions besides mental health beyond the scope of the mobile crisis team?
- I don't know why CBHHs are in there - no one can go there directly
- Unsure of what current parameters are and what is not working.

**RECOMMENDATION**

- All regions should establish a psychiatric responder round table which would promote collaboration between ambulance services, law enforcement, mental health mobile crisis intervention services and other transportation entities involved in the medical transportation of persons who need quick access to mental health treatment.



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Advocacy organizations	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Include neuro-cog deficits

## Dental Workgroup Recommendations

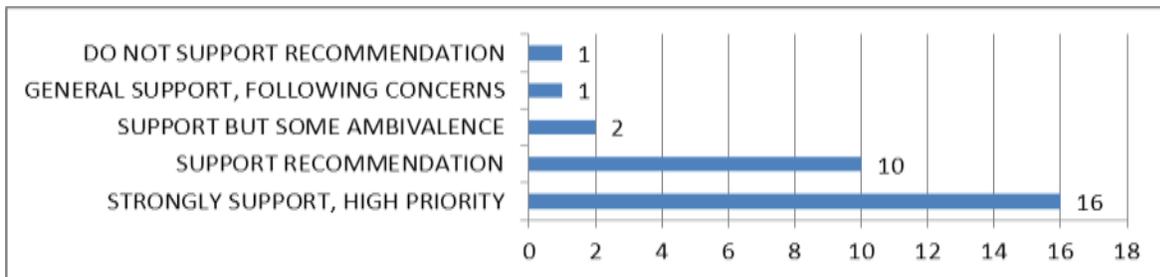
### RECOMMENDATION

1. Develop and implement a Comprehensive Assessment of Dental Needs in Minnesota utilizing a representative sample of the target populations, recognized oral health indicators and validated metrics.

The assessment should be done in coordination and partnership with MN Department of Health Oral Health Program, Office of Rural Health and Primary Care, MN Dental Association, MN Board of Dentistry, MN Dental Hygienists' Association, MN DD Nurses' Association, Safety Net Coalition, and other interested parties.

Assessment should include:

- a) Involvement of patients, families, guardians, social workers and care givers
- b) Assess necessary dental treatment needs: regular, episodic; primary, secondary, tertiary
- c) Analyze where services are needed and where services are currently provided (where is the target population density)
- d) Analysis of current system capacity and potential capacity
- e) Analyze existing data sets to develop a picture of the utilization patterns, needs and opportunities for enhanced access to services
- f) Current spending on dental and hospital care for target population (public and private)
- g) Develop a standard for what is meant by proper access
- h) The assessment should include a description of activity in other states
- i) Develop a MN standard for a minimum benefit set to meet the needs of the target populations
- j) Develop a MN standard for Best Dental Practices to meet the needs of the target populations



### Groups with concerns or who do not support recommendation:

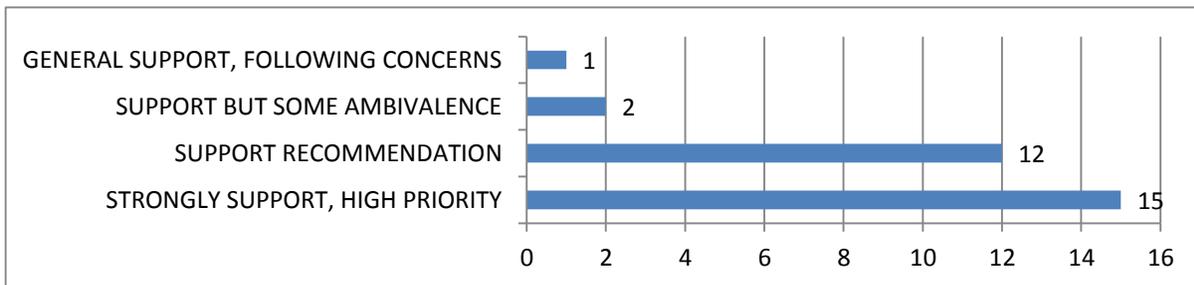
	Frequency	Percent
Service providers and professional organizations	1	50.0
Unions representing public employees	1	50.0
Total	2	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

- Who will this body report back to?
- Do we really need another study of a fairly clear cut problem?

**RECOMMENDATION**

- **Develop a comprehensive analysis of SOS clinics**
  - a) Analysis/Assessment of clinics, including
    - i) Billing and reimbursement practices
    - ii) Business management
      - (1) Staffing Ratios
      - (2) Chair turnover rate
  - b) Develop plan for enhanced utilization of clinics with clear roles and functions
  - c) Needs assessment
    - i) Necessary additional equipment/staffing
    - ii) Necessary equipment upgrades
    - iii) Potential for expansion



**Groups with concerns or who do not support recommendation:**

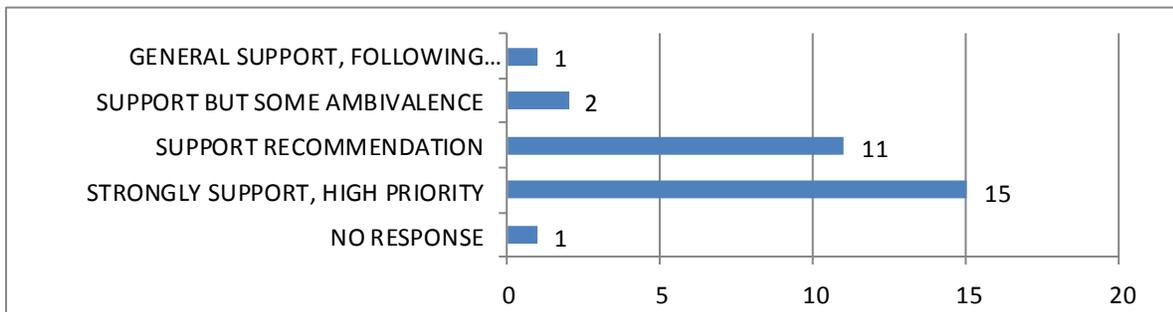
	Frequency	Percent
Other:	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- Who will this body report back to?

**RECOMMENDATION**

- **Development and recognition of a clear role for SOS Clinics in serving the target populations**
  - a) Marketing of Clinics to providers, care coordinators and client communities regarding appropriate care coordination and referrals
  - b) Development of partnership to serve as training sites and to recruit dental professionals
  - c) Develop partnership with educational institutions for rotation of students/residents



**Groups with concerns or who do not support recommendation:**

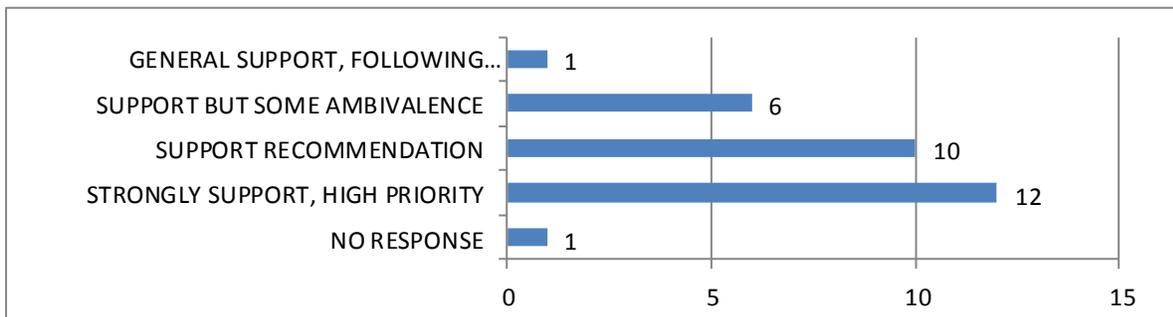
	Frequency	Percent
Other:	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

- This is specifying a clear role for SOS clinics before the assessment called for in the previous items has been completed.

**RECOMMENDATION**

- **Development and implementation of measures to gauge effectiveness**
  - Utilize claims data to measure services being rendered to target population vs. a baseline (2009 vs. 2010. vs. 2011)
  - Utilize claims data to measure impact of services under previous adult benefit set vs. 2010 adult benefit set
  - Consumer survey of perception of access to service (better or worse)
  - Provider survey of awareness of access to continuum of care (better or worse)\



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Other:	1	100.0

**Comments/Concerns/ Reasons for not supporting recommendation:**

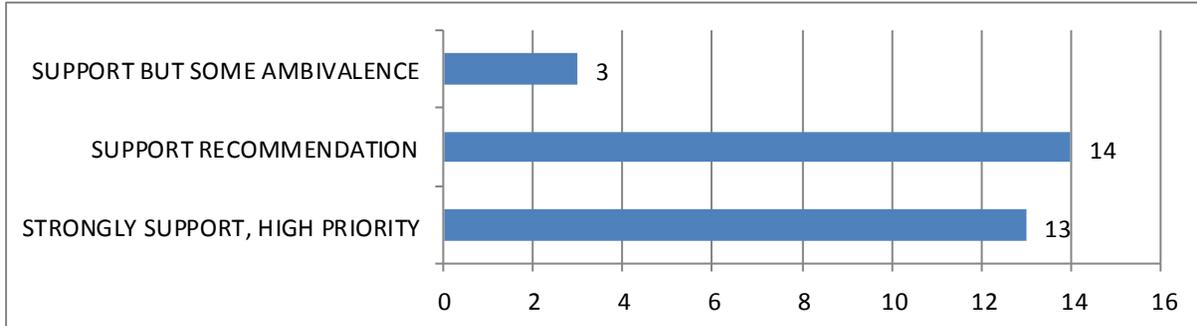
- Depending on who would be asked for claims data. This would be most appropriate to analyze DHS data since they receive all claims information from all the various health plans.

## RECOMMENDATION

- **Dental training possibilities**

*Identify potential project partners (i.e. Univ of MN, HCMC, Central Lakes Community College, Normandale Community College, Apple Tree Dental, etc)*

- i) Develop courses on special needs services
- ii) Additional training after dental school
- iii) Training on medical issues
- iv) Develop clinical competencies/standards around special needs services
- v) Develop rotations around special needs populations
- vi) Develop an assessment of General Practice Residency graduates and what they are doing now
- vii) Bring dental assistant students into SOS space for further educational experience around disabled populations
- viii) Develop model for loan forgiveness for dental providers serving special populations



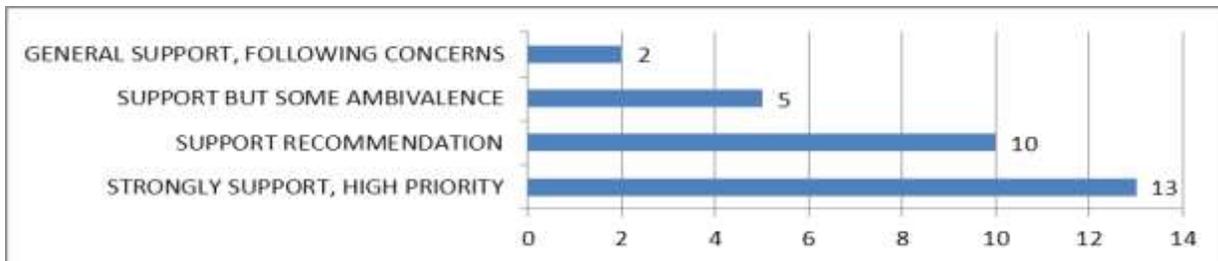
**Groups with concerns or who do not support recommendation:**

NONE

**RECOMMENDATION**

• **Potential Project Partners**

- a) *Minnesota Dental Association & All Dental Providers*
  - i) Educate members on SOS clinics
  - ii) Educate on how to partner with SOS to utilize services appropriately
  - iii) Educate members on potential utilization of mid-level practitioners (how to collaborate and how to utilize)
  - iv) Keep legislators informed
  - v) Develop grass roots supports to enhance ut members opportunity to shape the future of dentistry in MN
  - vi) Coordinate the development of a “continuum of care” model
  - vii) Seek enhanced participation by members
- b) *Minnesota Board of Dentistry*
  - i) General Consent needs to be broad and more streamlined to provide better service in single setting/visit
  - ii) Require serving disabled groups to gain CE
  - iii) Deeper links to Universities and educational opportunities
- c) *Minnesota Dental Hygienists’ Association*
  - i) Educate members on SOS clinics
  - ii) Educate on how to partner with SOS to utilize services appropriately
  - iii) Educate members on potential opportunities for hygienists practicing under limited authorization and Advanced Dental Therapists
  - iv) Keep legislators informed
  - v) Develop grass roots support to enhance members opportunity to shape the future of dentistry in Minnesota
  - vi) Assist in the development of a “continuum of care model”
  - vii) Seek enhanced participation by members



**Groups with concerns or who do not support recommendation:**

	Frequency	Percent
Local government	1	50.0
State government	1	50.0
Total	2	100.0

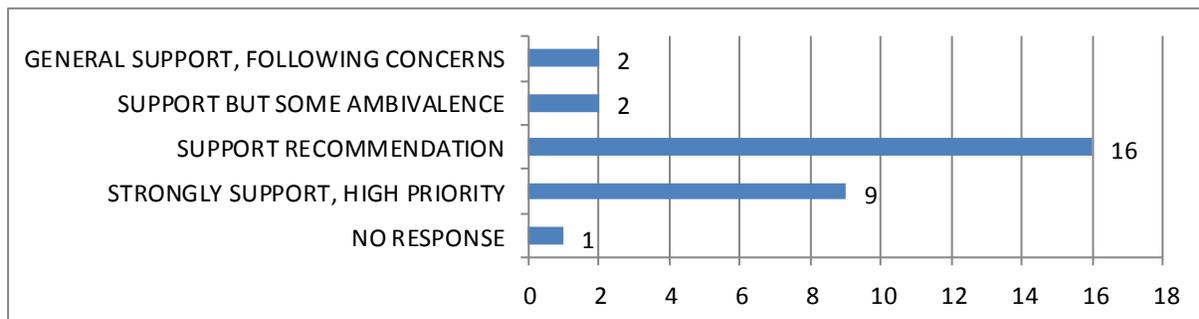
**Comments/Concerns/ Reasons for not supporting recommendation:**

- A few health plans have developed access networks which actually work. Bring them into the partnership.
- Consumers and Families must be equal partners

## RECOMMENDATION

### Dental Work Group Recommendations for 2011-2012

- 1) Model Development-what would a community wide “continuum-of-care look like”?
- 2) Potential for multi-service clinical sites (dental, physical, behavioral)
- 3) Model for dispersed training sites and clinical rotations serving disabled populations
- 4) Explore potential for revised/enhanced funding streams
- 5) Utilization of dental hygienists, dental therapists and advanced dental therapists
- 6) Partnering roles-develop a “linked” network of providers with clear understanding of who serves whom



### Groups with concerns or who do not support recommendation:

	Frequency	Percent
Consumers and family member	1	50.0
Local government	1	50.0
Total	2	100.0

### Comments/Concerns/ Reasons for not supporting recommendation:

- Serious and costly oral health issues exist due to current non-functioning access and inadequate numbers of dentists and mid-level practitioners. Dental schools and associations must actually allow mid-level providers to get trained and work with ALL Medical Assistance populations in non-traditional settings. Existing "dentist of record" guidelines of professional dental associations MUST allow dentists to drop proven "problem" clients, while still allowing the dentist to take on other public clients.
- Don't people who are poor and disabled deserve to get their dental care from a real dentist like everyone else?

## Children and Adolescents Intensive Services Workgroup

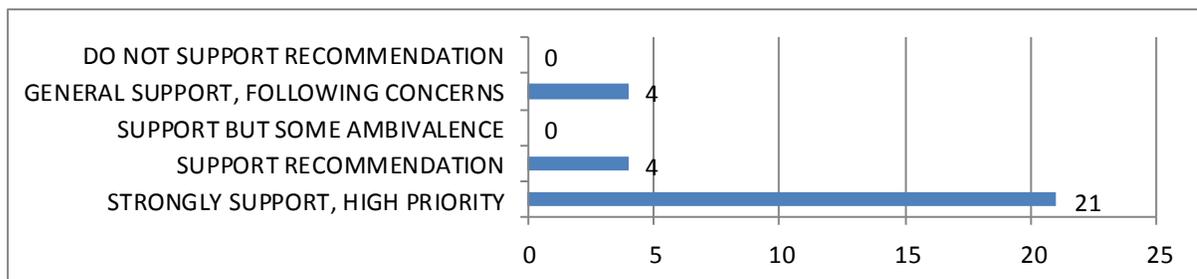
The recommendations from this workgroup resulted from a series of 23 listening sessions held throughout the State of Minnesota during October 2010. While the task force had a chance to review the initial draft recommendations presented below, this workgroup identified a need to continue its work into the next year in order to improve upon and provide greater analysis and detail to those recommendations. As a result of this decision, a supplemental report on Child and Adolescent Services will be published as an addendum to this report in 2011. The Task Force did vote and offer comment on the following:

### RECOMMENDATION

- **Public Safety Net**

Although not required to do so by statute, the State of Minnesota has traditionally served a “safety net” function for children and adolescents with severe mental health difficulties by providing psychiatric hospital care for those youth who require such intensive services and are unable to get their treatment needs met in other settings; such youth are currently served through the CABHS program at Willmar and the YAAP program at St. Peter. Child and Adolescent Intensive Services Workgroup believes the state has a responsibility to continue providing a “safety net” for this population and recommend that State Operated Services (SOS) continue to fulfill this obligation by maintaining its capacity to serve youth who require inpatient psychiatric care but whose treatment needs cannot be met in a community setting.

However, maintaining this capacity does not necessarily mean providing services to these youth in a state-operated facility. Alternative approaches to serving this population, such as contracting for psychiatric beds in community hospitals or supporting the development of psychiatric residential treatment facilities (PRTFs) should also be explored. Child and Adolescent Intensive Services Workgroup members noted, however, that alternatives developed within private facilities and/or through public-private partnerships must be designed to be able to meet the needs of all children and adolescents who present for the most intensive level of care.



### Comments/Concerns/ Reasons for not supporting recommendation:

- The State Operated Services Child and Adolescent Behavioral Health Services program should not take any decrease in funding as a means to fund contract beds or another level of care. The state has already lost program at the Brainerd campus.

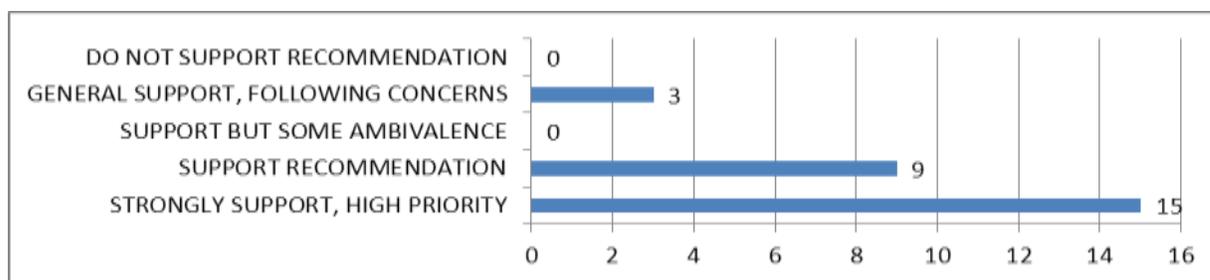
## RECOMMENDATION

- **Contract Beds**

Child and Adolescent Intensive Services Workgroup recommends that the Chemical and Mental Health Services Administration of DHS begin exploring the possibility of contracting with community hospitals in Minnesota and adjacent trade areas in neighboring states for extended-stay inpatient psychiatric beds for children and adolescents with intensive service needs.

This recommendation, in combination with 1. (above) leads to the following proposed action steps:

- a. Determine an appropriate portion of the state appropriation for the CABHS program which could be allocated to an RFP for contract beds in a metro-area community hospital(s) with current child and adolescent psychiatric inpatient programming. Contract(s) must specify core components of programming to fit the service to the population described earlier in this document as “difficult to treat.”
- b. Develop a second RFP for contract beds in a community-based hospital in northern Minnesota (or adjacent trade area), with the same requirements for core programming components fitted to the difficult to serve population.



### Comments/Concerns/ Reasons for not supporting recommendation:

- The State Operated Services Child and Adolescent Behavioral Health Services program should not take any decrease in funding as a means to fund contract beds or another level of care. The state has already lost program at the Brainerd campus.
- Contract beds are becoming the state’s safety net. Private hospitals are not comfortable with this role, especially if the state can’t/won’t cover the cost of care over the long term.

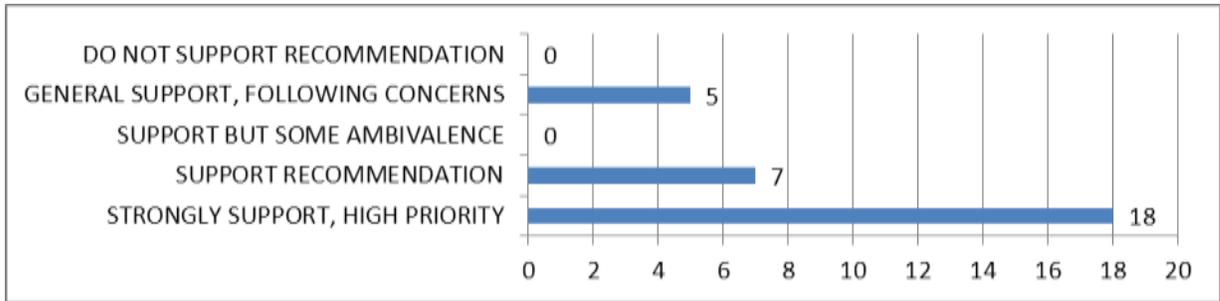
**RECOMMENDATION**

- **Intermediate levels of care**

Child and Adolescent Intensive Services Workgroup noted intense interest in some parts of the state in developing a level of care which could be considered more intense than most current children’s residential treatment, but less intensive than inpatient psychiatric hospitalization. Various perspectives on the nature of this type of facility-based care were expressed, including uses ranging from hospital diversion to transition from hospitalization back to community; public versus private capacity development; licensure type; and funding model. Specific discussion with a range of stakeholders, including hospitals and residential treatment providers, was recommended. Child and Adolescent Intensive Services Workgroup members also noted the need for clarification from CMS regarding specific requirements for PRTFs which could impede development of this model, viz., facility requirements and Medicaid coverage status for children served.

This recommendation leads to the following proposed action steps:

- Coincident with establishing contract psychiatric bed capacity in the metro region and northern Minnesota, conduct feasibility study of conversion of CABHS Willmar campus to PRTF level of care. The campus meets current CMS facility requirements, abbreviating the potential impediments to conversion.
- Assuming clarification of other CMS requirements, determine other current or projected facilities which might be candidates for conversion to PRTF, as well as the staffing, technical assistance or material support which would be needed to accomplish conversion.



**Comments/Concerns/ Reasons for not supporting recommendation:**

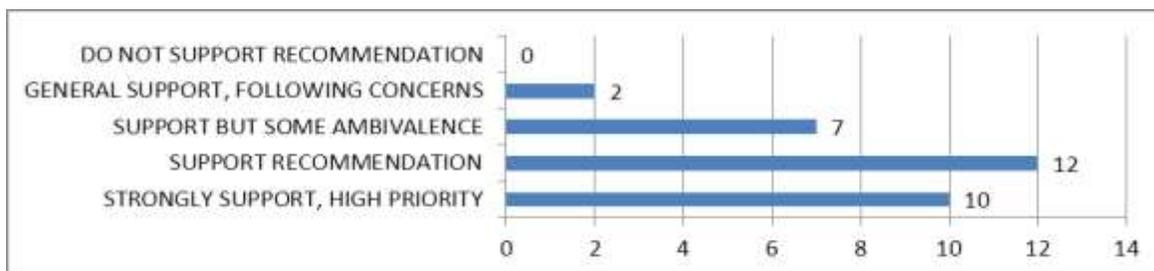
- The State Operated Services Child and Adolescent Behavioral Health Services program should not take any decrease in funding as a means to fund contract beds or another level of care. The state has already lost program at the Brainerd campus.

## RECOMMENDATION

- **Accountable Care Organization Development to meet Child and Adolescent Needs**  
In response to stakeholder feedback regarding the need for care coordination, continuity of services and improved access to the right level of care and intensity of intervention, Child and Adolescent Intensive Services Workgroup initiated a discussion of the merits of establishing a formal connection among providers of the inpatient, outpatient and rehabilitation service continuum. Child and Adolescent Intensive Services Workgroup recommends establishing of subgroup to explore the feasibility of a pilot(s) to develop this connection as an Accountable Care Organization.

This recommendation leads to the following proposed action steps:

- Establish a working group charged with creating a design for ACOs which would unite hospital, residential treatment and community service providers jointly responsible for the successful treatment of children and adolescents with intensive service needs in a specified geographic area. The group should report to Child and Adolescent Intensive Services Workgroup on specifications for one pilot in the metro area and one in a greater Minnesota location.



### Comments/Concerns/ Reasons for not supporting recommendation:

None.

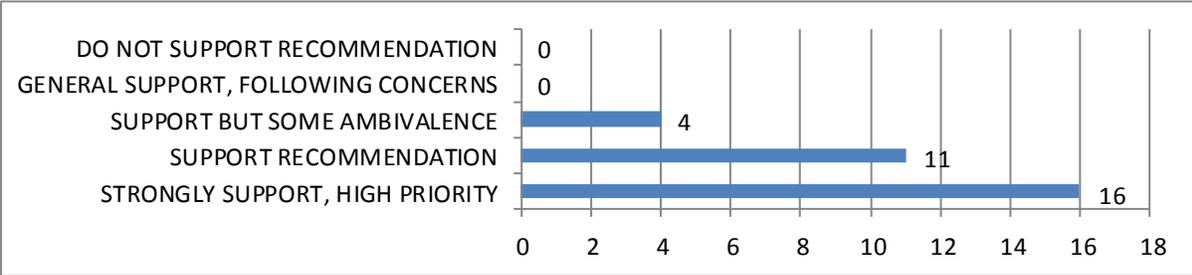
## RECOMMENDATION

- **Standards for Levels of Care and Transitions Among Levels of Care**  
Stakeholder feedback identified a number of ways in which the development of specific standards for levels of care would improve children's and families' experience of care. Of particular concern was the need for clear communication among providers, care/case managers, families and youth at points of transition between levels of care, e.g., within a care system, from hospital to community-based services, and between residential treatment and community service providers.

This recommendation leads to the following proposed action steps:

- Establish a subgroup within Child and Adolescent Intensive Services Workgroup to develop proposed level of care guidelines in order to differentiate and coordinate intensive services. This work can expand on current implementation of the Child and Adolescent Service Intensity Instrument (CASII), as well as coordinating with parallel work in the adult mental health system.
- The subgroup should also develop proposed communication guidelines for care transitions. Families and youth representatives should also be added to this group,

with their transition experiences helping to shape guidelines and proposed formats for planned transitions.

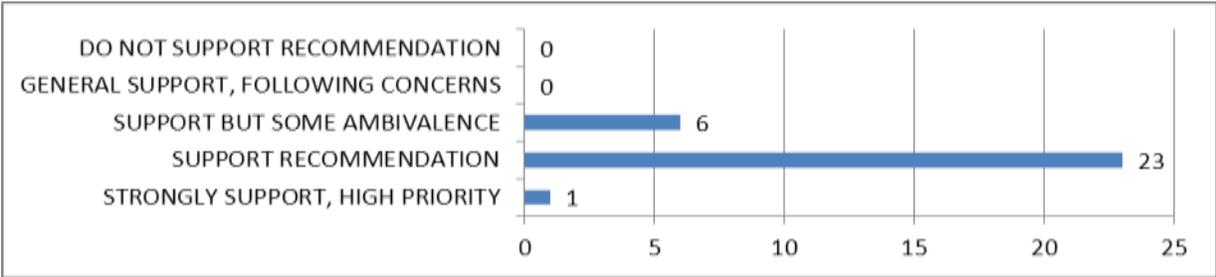


**Comments/Concerns/ Reasons for not supporting recommendation:**  
NONE

**RECOMMENDATION**

- Local “think tanks”**

Regional variation in responses to the Child and Adolescent Intensive Services Workgroup listening sessions was noted, leading to a suggestion that a small amount of funding, possibly developed from both public and private sources, be made available to local or regional groups ready to begin planning for the needs identified in their areas. Composition of local planning groups should focus on families and include at least all of the diversity currently represented in Child and Adolescent Intensive Services Workgroup; current local planning structures (LACs, LCCs, etc.) could be eligible, or new groupings could be created to respond to a request for interest. “Think tanks” should be ready to do much more than just thinking, but would be prepared to take the ideas and suggestions that have been gathered, particularly in their specific areas, and determine how to implement them locally. Through their understanding of local systems, they would be uniquely able to seek and find ways to overcome barriers and move more quickly to secure the services needed.



**Comments/Concerns/ Reasons for not supporting recommendation:**  
None

**RECOMMENDATION**

- Supporting Families**

Numerous listening session comments regarding family needs and the valuable role of families in children’s treatment were reinforced by data from more than 30 parents and

other caregivers who responded to an on-line survey sponsored by NAMI-MN and the Minnesota Association for Children’s Mental Health (MACMH) during the same time period. Parents and caregivers expressed considerable frustration with the difficulties they experienced finding out what resources might be available for their children, and how these could be accessed. While a number of actions can progressively be taken to assure better and easier participation for parents in system planning (cf. local “think tanks,” above) and family-centered interventions, one of the most basic needs is for statewide dissemination of information for families about how to access services as early as they may have a concern. These materials could be customized locally to facilitate access to appropriate services, and could be distributed by family, advocacy and provider groups to assure a common knowledge base of available services. Additional suggestions for supporting families included the development of parent-to-parent or other parent support groups in every county.

Family feedback and survey information also called for care coordination which crosses all systems touching the lives of children and families, perceived as broader in scope than current case management.

This recommendation leads to the following proposed action steps:

- In cooperation with family and advocacy organizations, DHS Children’s Mental Health should prepare information adaptable to a variety of formats regarding service access. The materials should be reviewed by Child and Adolescent Intensive Services Workgroup and other stakeholder groups and made available to families by spring, 2011.
- DHS should explore mechanisms for funding care coordination activities by providers which could ease access and transition issues for children, youth and families, and report on these to Child and Adolescent Intensive Services Workgroup.



**Comments/Concerns/ Reasons for not supporting recommendation:**

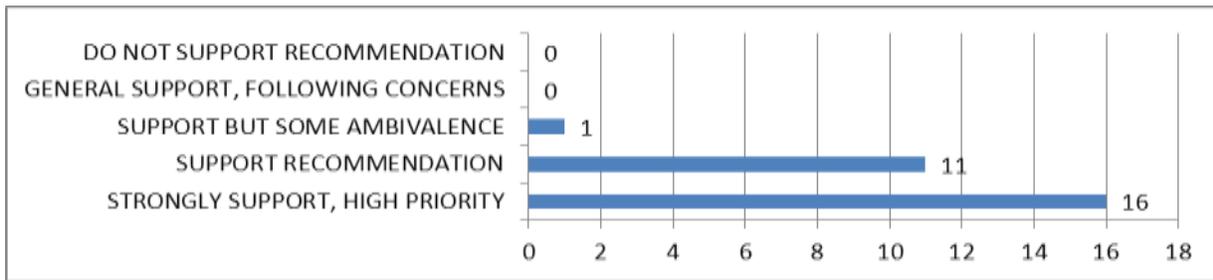
NONE

**RECOMMENDATION**

- **Integrated Systems and Services for Youth With Dual Mental Health and Chemical Dependency Needs**

Systemic structural barriers were identified through listening sessions and Child and Adolescent Intensive Services Workgroup member input, and these were described as

hampering access to integrated, concurrent services for youth with dual mental health and chemical dependency disorders. Separate funding and regulatory mechanisms act to prevent the development of services which would more effectively respond to the needs of the adolescent and most efficiently utilize scarce resources. Youth and families are subject to sequential sets of services, "bouncing" them between care teams based on either side of the mental health and chemical dependency divide or leading to the juvenile justice system. This fragmentation within the system is costly on every level, and can foster failure of service intervention, wasted time and resources, and missed or inadequate communication and undermining of important therapeutic relationships. Providers who attempt to provide dual interventions struggle with an endless debate about clinical documentation, adequacy of treatment plans, justifying of care often having reimbursement denied by one side of the system or the other. The State should provide leadership to determine how these structural barriers at both state and national level can be addressed to promote an integrated, single system of care for dually diagnosed mental health and chemically dependent youth.

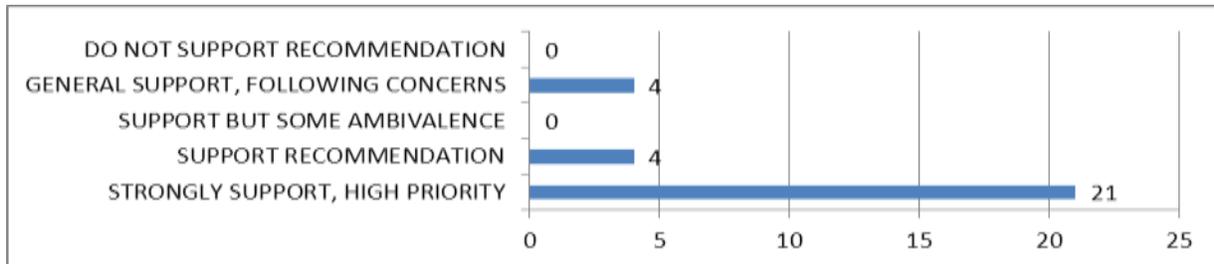


**Comments/Concerns/ Reasons for not supporting recommendation:**  
NONE

## RECOMMENDATION

- **Workforce Needs**

A theme in the feedback from stakeholders was the lack of consistent resources for youth with intensive service needs. Some providers noted that their inability to serve youth with violent behaviors was at least in part due to staffing levels in their programs, e.g., funding for residential treatment centers does not allow for the level of staffing needed when multiple residents require one-to-one staffing to remain safe. The well-known shortage of mental health professionals can affect this population in particular, especially in greater Minnesota, as families may not have ready access to psychiatry or a crisis response team with experience with children and adolescents. Training, particularly in trauma informed care, could be expanded to crisis teams, day treatment and respite providers. Broader use of telemedicine could improve access to mental health professionals. Feedback from families stressed the need for parent mentors who could help families navigate the complicated mental health system.



### Comments/Concerns/ Reasons for not supporting recommendation:

NONE

## RECOMMENDATION

- **Continuity of Planning**

Child and Adolescent Intensive Services Workgroup should be maintained as a planning and review group to assist DHS, provider organizations and family and advocacy organizations in improved service delivery for youth with intensive service needs and their families. Continued meetings through June, 2011 (or later) are recommended.



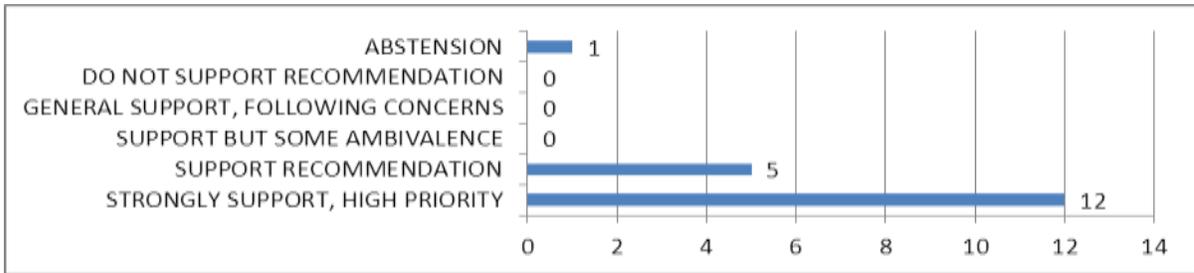
### Comments/Concerns/ Reasons for not supporting recommendation:

NONE

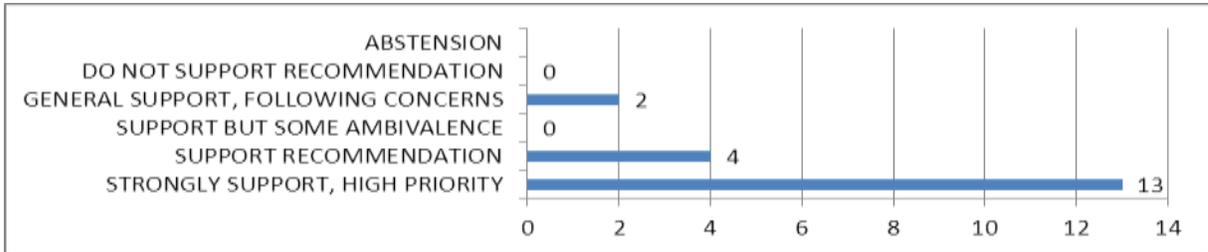
## Anoka Metro Regional Treatment Center Redesign Recommendations

The process used to determine recommendations for the resign of services provided at the Anoka Metro Regional Treatment Center was unlike the workgroup process used for the previous recommendations. As discussed earlier, the Department issued an RFI and due to the resulting response the department recommended the following the Task Force. The Task Force then proceeded to vote on those recommendations.

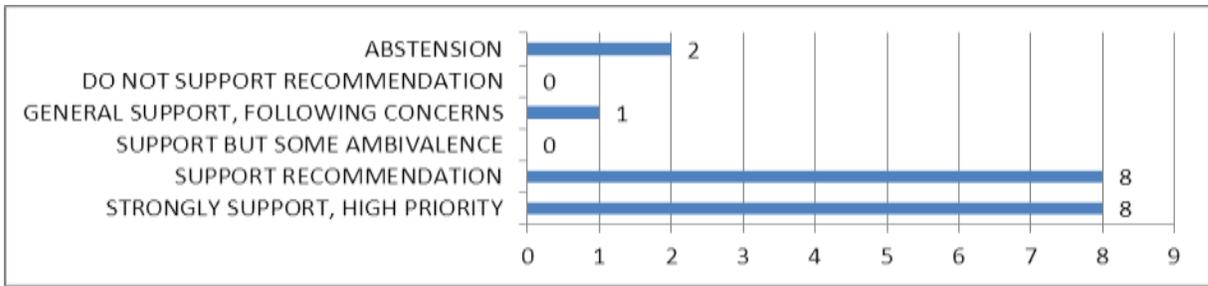
1. Staff of the Chemical and Mental Health Services Administration should meet with directors from the seven-county metropolitan area prior to January, 2011 to discuss an agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders.



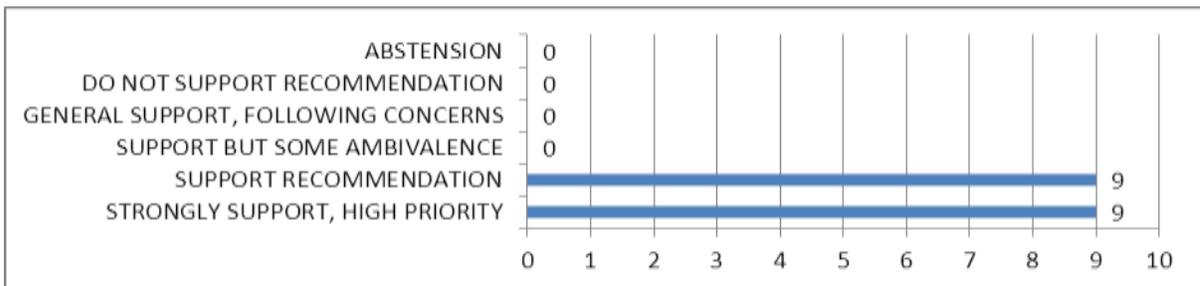
2. The process mutually agreed on above should be employed during January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members and advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a RFP to be developed by DHS. DHS will cover the cost of facilitator services to run and coordinate these meetings.



3. DHS should issue an RFP consistent with recommendations of the CMHS Transformation Advisory Task Force, input from the local process outlined above and the requirements in Laws of Minnesota 2010, First Special Session Chapter 1, Article 19 section 19 by March 1, 2011 with a projected due date of May 1, 2011 for local responses.



4. The Chemical and Mental Health Services Transformational Advisory Task Force should appoint a subcommittee to evaluate and advise the Department’s implementation of the recommendations above. Initially, and through the completion of the RFP process, the subcommittee will be composed of members who are representing advocacy organizations, consumers & family members, and the statutorily established advisory bodies for chemical and mental health services. The subcommittee will convene at least once to hear stakeholder presentations and advice on its task prior to the drafting of the RFP. In the event that the RFP process does not produce a plan for alternative services, the subcommittee will evaluate and advise any further action taken by DHS to plan and implement alternative services. The membership of the subcommittee overseeing the development and implementation of alternative services should expand once the RFP process is concluded to include key stakeholders initially excluded due to conflict of interest limitations.



## **V. APPENDICES**

- June 8, 2010 Memo on the Overview and Timeline for CMHS Redesign Process
- June 9, 2010 Invitation to CMHS Transformation Advisory Task Force
- Selected text from Minnesota Laws 2010, 1<sup>st</sup> Special Session, Chapter 1
- CMHS Transformation Advisory Task Force Member Director
- MHCP Enrollment of Clients Receiving Community Mental Health Services
- Background Materials Related to the Scope of the Population Served
- State Operated Services: Client/Patient Count by Care Center
- Scope of People Getting Public Mental Health Services in Minnesota
- Final Workgroup Report: Levels of Care
- Final Workgroup Report: Neurocognitive
- Final Workgroup Report: Access of Care
- Final Workgroup Report: Housing with Services
- Final Workgroup Report: Getting there with Dignity (Transportation)
- Final Workgroup Report: Dental
- Final Workgroup Report: Children's Mental Health
- Anoka Metro Regional Treatment Center Redesign Report

## APPENDIX I.



Minnesota Department of **Human Services**

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**DATE:** June 8, 2010

**TO:** All Workgroup Members

**FROM:** L. Read Sulik, MD, Assistant Commissioner  
Chemical and Mental Health Services Administration

**SUBJECT:** Overview and Timeline for the CMHS Redesign Process

I want to thank you for serving on one of the Chemical and Mental Health Services (CMHS) Transformation Workgroups. I appreciate your willingness to give us your time and share your expertise. I promise, your efforts will make a difference and benefit the citizens of Minnesota.

### CMHS Transformation Workgroups - Overview

- The workgroups must propose an overarching model and frame for what will, once implemented, constitute the network of services so that the needs of people around the state are uniformly fulfilled. The final work products are due September 1, 2010.
- The work products will be submitted to the CMHS Transformation Advisory Task Force for decision and recommendation. This will occur in monthly meetings during the summer.
- Recommendations from the CMHS Transformation Advisory Task Force will be submitted to the DHS Commissioner who will forward them to key legislators by December 15, 2010.
- The workgroups must operate under common principles and parameters:

### Principles

- The products of the workgroups need to be consistent with principles of Person-Centered Thinking, assuring attention to what is important to consumers.
- Recommendations should include evidence-based practices and best practices for adults (Trauma-Informed Care, Illness Management and Recovery, Assertive Community Treatment, Certified Peer Specialists, Integrated Dual Disorder Treatment, Supported Employment, Family Education and Support, Supported Housing, Supported Education, etc.) and Children and Adolescents (Cognitive Behavior Therapy, Positive Behavior Supports, Multi-Modal Approaches, Parent and Teacher PBS Training, Aggression Replacement Therapy, ABA, Trauma-focused CBT, etc.).
- Service design must be consistent with the expectation of recovery and resilience, and include family involvement when it works for the consumer.
- Recommendations should include the efficient and effective use of resources and sensitivity to local preferences.

#### Parameters

- Each workgroup must identify or develop metrics to evaluate effectiveness of the group's recommendations.
- Workgroups should begin with the SOS redesign stakeholder input information and proposals from that process.
- Each workgroup's deliberation process needs to account for people with multiple and complex needs, including any combination of mental illness, intellectual disability, chronic medical conditions.
- The deliberation process needs to include all the state's residents, regardless of age, culture, or background.

Utilizing the work products from the CMHS Transformation Work Groups, regional planning will begin initially in the metro area this summer. We anticipate additional regions will begin planning at this time as well. Regional plans will include changes in how service providers, including State Operated Services, will partner in each region.

Submitting each regional plan through the Advisory Task Force, the Commissioner, and ultimately key legislative committee chairs will ensure a broad knowledge and understanding of how CMHS transformation is occurring across the State.

I am very excited about the work you are doing and I am looking forward to your recommendations. The Child and Adolescent Intensive Services Workgroup will begin with the stakeholder input process that has already been completed for the adult mental health services; and therefore, will be meeting over a longer duration. All the other workgroups need to have preliminary proposals completed by July 30, 2010. Final proposals need to be submitted and ready to present to the Chemical and Mental Health Services Transformation Advisory Task Force by September 1.

Recommendations should be provided for the metro region separate from the greater Minnesota region due the requirement for the Task Force to have recommendations on the transformation of Anoka Metro Regional Treatment Center ready to submit to the Commissioner by October 1 and subsequently to the Legislature by October 15.

The Final Report of all recommendations from the workgroups is to be submitted by the Advisory Task Force to the Commissioner of DHS in time for the December 15, 2010 submission to the legislature.

## APPENDIX II.



Minnesota Department of **Human Services**

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June 9, 2010

RE: Chemical and Mental Health Services Transformation Advisory Task Force

The Department of Human Services is convening the Chemical and Mental Health Services Transformation Advisory Task Force in order to engage stakeholders and build consensus regarding the future role of state provided behavioral health services within the system of care and to comply with recent legislation. (Laws of Minnesota 2010, Chapter 1, Article 19, Section 4).

Your organization has been identified by the Department as a key stakeholder in the outcomes of this planning process and we would like to invite your respective representative to participate on the Advisory Task Force. Don Allen is coordinating the Advisory Task Force for the Department. Please reply to Don as soon as you are able with the name and contact information of your organization's chosen representative. Don's contact information is listed at the end of this letter.

We plan to model the operation of the Advisory Task Force on the successful Mental Health Action Group of a few years ago. The Advisory Task Force will meet monthly and function as a steering committee, reviewing and directing the work of several subgroups developed to work on specific aspects of our service delivery system. In the spirit of partnership, we hope to have stakeholder representatives nominate and elect two co-chairs at the first meeting to join me in leading the Advisory Task Force.

We have currently set the following dates and locations for the first three meetings of the Advisory Task Force in St. Paul:

- Tuesday, June 22, 2010, 8:30 am-12:30 pm at the Freeman Building (Department of Health), 625 Robert Street N, Room B-145.
- **Monday, July 12, 2010**, 1:00-4:00 pm at 444 Lafayette Road, Room 3148.
- Monday, August 9, 2010, 1:00-3:00 pm at the Elmer L. Andersen Building, Room 2380.

I hope that your organization will join us in this important work. I am confident we will all benefit from the experience and perspective your representative brings to the table. Again, please RSVP to Don Allen at 651-431-2325 or [don.allen@state.mn.us](mailto:don.allen@state.mn.us) with the name and contact information for your representative.

Sincerely,

L. Read Sulik, MD  
Assistant Commissioner  
Chemical and Mental Health Services Administration

### APPENDIX III.

Selected text from Minnesota Laws 2010, 1<sup>st</sup> Special Session, Chapter 1.

Sec. 4. **[246.125] CHEMICAL AND MENTAL HEALTH SERVICES TRANSFORMATION ADVISORY TASK FORCE.**

**Subdivision 1. Establishment.** The Chemical and Mental Health Services Transformation Advisory Task Force is established to make recommendations to the commissioner of human services and the legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, reduce cost, and improve efficiency.

**Subd. 2. Duties.** The Chemical and Mental Health Services Transformation Advisory Task Force shall make recommendations to the commissioner and the legislature no later than December 15, 2010, on the following:

- (1) transformation needed to improve service delivery and provide a continuum of care, such as transition of current facilities, closure of current facilities, or the development of new models of care, including the redesign of the Anoka-Metro Regional Treatment Center;
- (2) gaps and barriers to accessing quality care, system inefficiencies, and cost pressures;
- (3) services that are best provided by the state and those that are best provided in the community;
- (4) an implementation plan to achieve integrated service delivery across the public, private, and nonprofit sectors;
- (5) an implementation plan to ensure that individuals with complex chemical and mental health needs receive the appropriate level of care to achieve recovery and wellness; and
- (6) financing mechanisms that include all possible revenue sources to maximize federal funding and promote cost efficiencies and sustainability.

**Subd. 3. Membership.** The advisory task force shall be composed of the following, who will serve at the pleasure of their appointing authority:

- (1) the commissioner of human services or the commissioner's designee, and two additional representatives from the department;
- (2) two legislators appointed by the speaker of the house, one from the minority and one from the majority;
- (3) two legislators appointed by the senate rules committee, one from the minority and one from the majority;
- (4) one representative appointed by AFSCME Council 5;
- (5) one representative appointed by the ombudsman for mental health and developmental disabilities;
- (6) one representative appointed by the Minnesota Association of Professional Employees;
- (7) one representative appointed by the Minnesota Hospital Association;
- (8) one representative appointed by the Minnesota Nurses Association;
- (9) one representative appointed by NAMI-MN;
- (10) one representative appointed by the Mental Health Association of Minnesota;
- (11) one representative appointed by the Minnesota Association of Community Mental Health Programs;

(12) one representative appointed by the Minnesota Dental Association;  
(13) three clients or client family members representing different populations receiving services from state-operated services, who are appointed by the commissioner;  
(14) one representative appointed by the chair of the state-operated services governing board;  
(15) one representative appointed by the Minnesota Disability Law Center;  
(16) one representative appointed by the Consumer Survivor Network;  
(17) one representative appointed by the Association of Residential Resources in Minnesota;  
(18) one representative appointed by the Minnesota Council of Child Caring Agencies;  
(19) one representative appointed by the Association of Minnesota Counties; and  
(20) one representative appointed by the Minnesota Pharmacists Association.  
The commissioner may appoint additional members to reflect stakeholders who are not represented above.

Subd. 4. **Administration.** The commissioner shall convene the first meeting of the advisory task force and shall provide administrative support and staff.

Subd. 5. **Recommendations.** The advisory task force must report its recommendations to the commissioner and to the legislature no later than December 15, 2010.

Subd. 6. **Member requirement.** The commissioner shall provide per diem and travel expenses pursuant to section 256.01, subdivision 6, for task force members who are consumers or family members and whose participation on the task force is not as a paid representative of any agency, organization, or association. Notwithstanding section 15.059, other task force members are not eligible for per diem or travel reimbursement.

Sec. 5. **[246.128] NOTIFICATION TO LEGISLATURE REQUIRED.** The commissioner shall notify the chairs and ranking minority members of the relevant legislative committees regarding the redesign, closure, or relocation of state-operated services programs. The notification must include the advice of the Chemical and Mental Health Services Transformation Advisory Task Force under section 246.125.

Sec. 6. **[246.129] LEGISLATIVE APPROVAL REQUIRED.** If the closure of a state-operated facility is proposed, and the department and respective bargaining units fail to arrive at a mutually agreed upon solution to transfer affected state employees to other state jobs, the closure of the facility requires legislative approval. This does not apply to state-operated enterprise services.

Sec. 7. Minnesota Statutes 2008, section 246.18, is amended by adding a subdivision to read:

Subd. 8. **State-operated services account.** The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

- (1) intensive residential treatment services;
- (2) foster care services; and
- (3) psychiatric extensive recovery treatment services.

Sec. 19. Laws 2009, chapter 79, article 3, section 18, is amended to read:

**Sec. 18. REQUIRING THE DEVELOPMENT OF COMMUNITY-BASED MENTAL HEALTH SERVICES FOR PATIENTS COMMITTED TO THE ANOKA-METRO REGIONAL TREATMENT CENTER.**

~~In consultation with community partners, the commissioner of human services~~ The Chemical and Mental Health Services Transformation Advisory Task Force shall develop and recommend an array of community-based services in the metro area to transform the current services now provided to patients at the Anoka-Metro Regional Treatment Center. The community-based services may be ~~provided in facilities with 16 or fewer beds, and must provide the appropriate level of care for the patients being admitted to the facilities established in partnership with private and public hospital organizations, community mental health centers and other mental health community services providers, and community partnerships, and must be staffed by state employees.~~ The planning for this transition must be completed by October 1, 2009 2010, with an initial a report detailing the transition plan, services that will be provided, including incorporating peer specialists where appropriate, the location of the services, and the number of patients that will be served, to the committee chairs of health and human services by November 30, 2009, and a semiannual report on progress until the transition is completed. The commissioner of human services shall solicit interest from stakeholders and potential community partners 2010. The individuals working in employed by the community-based services facilities under this section are state employees supervised by the commissioner of human services. No layoffs shall occur as a result of restructuring under this section. Savings generated as a result of transitioning patients from the Anoka-Metro Regional Treatment Center to community-based services may be used to fund supportive housing staffed by state employees.

**Subd. 10.State-Operated Services**

**Obsolete Laundry Depreciation Account.**

\$669,000, or the balance, whichever is greater, must be transferred from the state-operated services laundry depreciation account in the special revenue fund and deposited into the general fund by June 30, 2010. This paragraph is effective the day following final enactment.

**Operating Budget Reductions.** No operating budget reductions enacted in Laws 2010, chapter 200, or in this act shall be allocated to state-operated services.

**Prohibition on Transferring Funds.** The commissioner shall not transfer mental health grants to state-operated services without specific legislative approval.

Notwithstanding any contrary provision in this article, this paragraph shall not expire.

<u>(a) Adult Mental Health Services</u>	<u>-0-</u>	<u>6,888,000</u>
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**Base Adjustment.** The general fund base is decreased by \$12,286,000 in fiscal year 2012 and \$12,394,000 in fiscal year 2013.

**Appropriation Requirements.** (a) The general fund appropriation to the commissioner includes funding for the following:

(1) to a community collaborative to begin providing crisis center services in the Mankato area that are comparable to the crisis services provided prior to the closure of the Mankato Crisis Center. The commissioner shall recruit former employees of the Mankato Crisis Center who were recently laid off to staff the new crisis services. The commissioner shall

obtain legislative approval prior to discontinuing this funding;

(2) to maintain the building in Eveleth that currently houses community transition services and to establish a psychiatric intensive therapeutic foster home as an enterprise activity. The commissioner shall request a waiver amendment to allow CADI funding for psychiatric intensive therapeutic foster care services provided in the same location and building as the community transition services. If the federal government does not approve the waiver amendment, the commissioner shall continue to pay the lease for the building out of the state-operated services budget until the commissioner of administration subleases the space or until the lease expires, and shall establish the psychiatric intensive therapeutic foster home at a different site. The commissioner shall make diligent efforts to sublease the space;

(3) to convert the community behavioral health hospitals in Wadena and Willmar to facilities that provide more suitable services based on the needs of the community, which may include, but are not limited to, psychiatric extensive recovery treatment services. The commissioner may also establish other community-based services in the Willmar and Wadena areas that deliver the appropriate level of care in response to the express needs of the communities. The services established under this provision must be staffed by state employees.

(4) to continue the operation of the dental clinics in Brainerd, Cambridge, Faribault, Fergus Falls, and Willmar at the same level of care and staffing that was in effect on March 1, 2010. The commissioner shall not proceed with the planned closure of the dental clinics, and shall not discontinue services or downsize any of the state-operated dental clinics without specific legislative approval. The commissioner shall continue to bill for services provided to obtain medical assistance critical access dental payments and cost-based payment rates as provided in Minnesota Statutes, section 256B.76, subdivision 2, and shall bill for services provided three months retroactively from the date of this act. This appropriation is onetime;

(5) to convert the Minnesota Neurorehabilitation Hospital in Brainerd to a neurocognitive psychiatric extensive recovery treatment service; and

(6) to convert the Minnesota extended treatment options (METO) program to the following community-based services provided by state employees: (i) psychiatric extensive recovery treatment services; (ii) intensive transitional foster homes as enterprise activities; and (iii) other community-based support services. The provisions under Minnesota Statutes, section 252.025, subdivision 7, are applicable to the METO services established under this clause. Notwithstanding Minnesota Statutes, section 246.18, subdivision 8, any revenue lost to the general fund by the conversion of METO to new services must be replaced by revenue from the new services to offset the lost revenue to the general fund until June 30, 2013. Any revenue generated in excess of this amount shall be deposited into the special revenue fund under Minnesota Statutes, section 246.18, subdivision 8.

(b) The commissioner shall not move beds from the Anoka-Metro Regional Treatment Center to the psychiatric nursing facility at St. Peter without specific legislative approval.

(c) The commissioner shall implement changes, including the following, to save a minimum of \$6,006,000 beginning in fiscal year 2011, and report to the legislature the specific initiatives implemented and the savings allocated to each one, including:

(1) maximizing budget savings through strategic employee staffing; and

(2) identifying and implementing cost reductions in cooperation with state-operated services employees. Base level funding is reduced by \$6,006,000 effective fiscal year 2011.

(d) The commissioner shall seek certification or approval from the federal government for the new services under paragraph (a) that are eligible for federal financial participation and deposit the revenue associated with these new services in the account established under Minnesota Statutes, section 246.18, subdivision 8, unless otherwise specified.

(e) Notwithstanding any contrary provision in this article, this rider shall not expire.

APPENDIX IV.

**Chemical & Mental Health Services Transformation Advisory Task Force  
Members Directory – 11/1/2010**

<b>Organization</b>	<b>Name / Address</b>	<b>e-Mail</b>
Association of Residential Resources in Minnesota	<b>Steve Anderson</b> Program Director Mount Olivet Rolling Acres 7200 Rolling Acres Road P.O. Box 220 Victoria, MN 55386-0220 952-401-4846	<a href="mailto:stevea@mountolivetrollingacres.org">stevea@mountolivetrollingacres.org</a>
American Federation of State, County & Municipal Employees Council 5	<b>Scott Grefe</b> 300 Hardman Ave S, South St. Paul, MN 55075 651-287-0506	<a href="mailto:scott.grefe@afscmemn.org">scott.grefe@afscmemn.org</a>
Association of Minnesota Counties	<b>Amy Wilde</b> , Meeker County Commissioner P.O. Box 384 Dassel, MN 55325-0384 320-275-3684	<a href="mailto:amy@wildestudios.com">amy@wildestudios.com</a> cc: <a href="mailto:pcoldwell@mncounties.org">pcoldwell@mncounties.org</a>
Brain Injury Association of Minnesota	<b>Pete Klinkhammer</b> , CBIS Associate Director 34 13th Avenue Northeast, Suite B001 Minneapolis, MN 55413 612-378-2742	<a href="mailto:petek@braininjurymn.org">petek@braininjurymn.org</a>
Children's Mental Health Subcommittee	<b>Linda Hansen</b> , Co-chair	<a href="mailto:linda.hansen@co.dakota.mn.us">linda.hansen@co.dakota.mn.us</a>
Client / Family Member	<b>Sue Hanson</b>	<a href="mailto:suedanshine@comcast.net">suedanshine@comcast.net</a>
Client / Family Member	<b>Kim Lutes</b> 2900 11 <sup>th</sup> Ave S, #310	<a href="mailto:kikrlu@aol.com">kikrlu@aol.com</a>

<b>Organization</b>	<b>Name / Address</b>	<b>e-Mail</b>
	Minneapolis, MN 55407 612-803-1369	
Client / Family Member	<b>Jode Freyholtz</b> 616 Fourth St. NE Suite 3, Staples, MN 56479 218-639-2010	<a href="mailto:jode.freyholtz@mhcsn.org">jode.freyholtz@mhcsn.org</a>
Client / Family Member	<b>Amaya Maura Deniz</b> Milestones Recovery Center Mental Health Consumer/ Survivor Network 1919 University Avenue Saint Paul, MN 55104 651-815-0717	<a href="mailto:fridakalo47@live.com">fridakalo47@live.com</a>
Consumer / Survivor Network of Minnesota	<b>Maureen Marrin</b> , Executive Director 1821 University Ave. W Suite # S-160 Saint Paul, MN 55104 651/236-8471	<a href="mailto:maureen.marrin@mhcsn.org">maureen.marrin@mhcsn.org</a>
County-Based Purchasing Agencies	<b>Ruth Boubin</b> , MA Restricted Recipient Case Manager South Country Health Alliance 110 W Fremont St Owatonna, MN 55060 507-431-6370	<a href="mailto:rboubin@mnscha.org">rboubin@mnscha.org</a> cc: <a href="mailto:jmonahan@mnscha.org">jmonahan@mnscha.org</a>
Culturally Specific Provider - African American	<b>Lissa Jones</b> African American Family Services 2616 Nicollet Avenue Minneapolis, MN 55408 612-238-2301	<a href="mailto:lissa@aafs.net">lissa@aafs.net</a>
DHS – Adult Mental Health	<b>Sharon Autio</b> , Director PO Box 64981 St. Paul, MN 55164-0981	<a href="mailto:sharon.autio@state.mn.us">sharon.autio@state.mn.us</a>

<b>Organization</b>	<b>Name / Address</b>	<b>e-Mail</b>
	651-431-2228	
DHS – Chemical and Mental Health Services	<b>Read Sulik</b> , Assistant Commissioner PO Box 64985 St. Paul, MN 55164-0985 651-431-2323	<a href="mailto:read.sulik@state.mn.us">read.sulik@state.mn.us</a>
DHS – Children’s Mental Health	<b>Glenace Edwall</b> , Director PO Box 64985 St. Paul, MN 55164-0985 651-431-2326	<a href="mailto:glenace.edwall@state.mn.us">glenace.edwall@state.mn.us</a>
DHS – Disability Services	<b>Alex Bartolic</b> , Director PO Box 651-431-2381	<a href="mailto:alex.e.bartolic@state.mn.us">alex.e.bartolic@state.mn.us</a>
DHS – Medical Director	<b>Alan Radke</b> , Medical Director PO Box 64985 St. Paul, MN 55164-0985 651-431-3684	<a href="mailto:alan.radke@state.mn.us">alan.radke@state.mn.us</a>
DHS – State Operated Services	<b>Mike Tessneer</b> , CEO PO Box 64985 St. Paul, MN 55164-0985 651-431-2369	<a href="mailto:mike.tessneer@state.mn.us">mike.tessneer@state.mn.us</a>
Mental Health Minnesota	<b>Ed Eide</b> , Executive Director 2021 E. Hennepin Avenue Suite 412 Minneapolis, MN 55413 612-331-6840	<a href="mailto:edeide@mentalhealthmn.org">edeide@mentalhealthmn.org</a>
Minnesota Association of Community Mental Health Programs	<b>Ron Brand</b> , Executive Director 1821 University Ave. Suite 307-South St. Paul, MN 55104 (651) 642-1903	<a href="mailto:ron.brand@macmhp.org">ron.brand@macmhp.org</a>
Minnesota Association of County Social Service Administrators - Rural	<b>Stacy Hennen</b> , Director, Grant County Human Services 218-685-4417	<a href="mailto:stacy.hennen@co.grant.mn.us">stacy.hennen@co.grant.mn.us</a> cc: <a href="mailto:lerner@mncounties.org">lerner@mncounties.org</a>
Minnesota Association of	<b>Gwen Carlson</b> ,	<a href="mailto:gwen.carlson@co.hennepin.mn.us">gwen.carlson@co.hennepin.mn.us</a>

<b>Organization</b>	<b>Name / Address</b>	<b>e-Mail</b>
County Social Service Administrators - Urban	Area Manager Adult Behavioral Health Hennepin County Human Services and Public Health Dept. 300 So 6th St. Mpls., Mn. 55487-0160 612-348-8400	cc: <a href="mailto:lerner@mncounties.org">lerner@mncounties.org</a>
Minnesota Association of Mental Health Residential Facilities	<b>Diane Ollendick-Wright</b> Community Options / Northwest Residence 5615 Brooklyn Blvd, #200 Brooklyn Center, MN 55429 763-537-6612	<a href="mailto:dowright@supportivelivingservices.com">dowright@supportivelivingservices.com</a> cc: <a href="mailto:lauriep@ewald.com">lauriep@ewald.com</a>
Minnesota Association of Professional Employees	<b>Marge Ramsey</b> DHS/METO 1425 East Rum River Dr S Cambridge, MN 55008 763-689-7359	<a href="mailto:marjorie.ramsey@state.mn.us">marjorie.ramsey@state.mn.us</a> cc: <a href="mailto:kfodness@mape.org">kfodness@mape.org</a> cc: <a href="mailto:spokorny@mape.org">spokorny@mape.org</a>
Minnesota Association of Resources for Recovery and Chemical Health	<b>Jonathan Lofgren</b> African American Family Services 2616 Nicollet Avenue Minneapolis, MN 55408 612-871-7878	<a href="mailto:jonathan@aafs.net">jonathan@aafs.net</a>
Minnesota Council of Child Caring Agencies	<b>Mary Regan</b> , Executive Director 1000 Westgate Drive, Suite 252 Saint Paul, MN 55114 651-290-6272	<a href="mailto:mregan6264@aol.com">mregan6264@aol.com</a>
Minnesota Council of Health Plans	<b>John Kowalczyk</b> UCare PO Box 52 Minneapolis, MN 55440 612-676-3287	<a href="mailto:jkowalczyk@ucare.org">jkowalczyk@ucare.org</a> cc: <a href="mailto:brust@mnhealthplans.org">brust@mnhealthplans.org</a>
Minnesota Dental Association	<b>Dan Rose</b> 727 Buckskin Avenue West	<a href="mailto:danrose@rosehillranch.org">danrose@rosehillranch.org</a>

<b>Organization</b>	<b>Name / Address</b>	<b>e-Mail</b>
	Pillager, MN 56473-2509 218-296-0489	
Minnesota Detox Association	<b>Alan Hoskins</b>	<a href="mailto:alan.hoskins@embarqmail.com">alan.hoskins@embarqmail.com</a>
Minnesota Disability Law Center	<b>Patricia M. Siebert</b> 430 1st Ave North #300 Minneapolis MN 55401-1780 612-746-3734	<a href="mailto:psiebert@midmnlegal.org">psiebert@midmnlegal.org</a>
Minnesota Hospital Association	<b>Susan Stout</b> Director, State Government Relations 2550 University Avenue W., Suite 350-S St. Paul, MN 55114-1900 651-603-3526	<a href="mailto:sstout@mnhospitals.org">sstout@mnhospitals.org</a> cc: <a href="mailto:mkrinkie@mnhospitals.org">mkrinkie@mnhospitals.org</a>
Minnesota House of Representatives	<b>Rep. Bud Nornes</b> 22195 River Oaks Drive Fergus Falls, MN 56537 218-736-7777	<a href="mailto:rep.bud.nornes@house.mn.us">rep.bud.nornes@house.mn.us</a>
Minnesota House of Representatives	<b>Rep. John Ward</b> 1602 - 13th St. SE Brainerd, MN 56401 218-828-3626	<a href="mailto:rep.john.ward@house.mn">rep.john.ward@house.mn</a>
Minnesota Middle Management Association	<b>Tony Brown</b> Business Representative Middle Management Association 525 Park Street, Suite 333 St. Paul, MN 55103-2106 (651) 288-6392	<a href="mailto:tbrown@middlemanagementassn.org">tbrown@middlemanagementassn.org</a> cc: <a href="mailto:cmcclellan@middlemanagementassn.org">cmcclellan@middlemanagementassn.org</a>
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APPENDIX V.

**MHCP Enrollment of Clients Receiving Community  
Mental Health Services**  
Fiscal Year 2009

Statewide	All Ages		Adults		Children	
	Unduplicated total clients receiving community MH services	Percent of all county and state clients receiving community MH services	Unduplicated total adults receiving community MH services	Percent of all county and state adults receiving community MH services	Unduplicated total children receiving community MH services	Percent of all county and state children receiving community MH services
Total County Clients from CMHRS	102,932	55.1%	79,693	57.6%	23,239	48.0%
County Clients Only (not enrolled in MHCP)	25,511	13.6%	20,624	14.9%	4,887	10.1%
County Clients Enrolled in MHCP						
MA	63,522	34.0%	46,118	33.3%	17,404	35.9%
GAMC	10,723	5.7%	10,723	7.7%	0	0.0%
MinnesotaCare	5,967	3.2%	4,880	3.5%	1,087	2.2%
Other State Funded	7,052	3.8%	6,528	4.7%	524	1.1%
Unduplicated Count of MHCP Clients	76,051	40.7%	57,789	41.7%	18,262	37.7%
State Clients in MHCP Only						
MA	66,464	35.6%	43,367	31.3%	23,097	47.7%
GAMC	10,875	5.8%	10,875	7.9%	0	0.0%
MinnesotaCare	12,965	6.9%	10,326	7.5%	2,639	5.4%
Other State Funded	4,912	2.6%	4,622	3.3%	290	0.6%
Unduplicated Count of MHCP Clients	85,327	45.7%	60,023	43.4%	25,304	52.2%
All County and State Clients Enrolled in MHCP						
MA	129,986	69.5%	89,485	64.6%	40,501	83.6%
GAMC	21,598	11.6%	21,598	15.6%	0	0.0%
MinnesotaCare	18,932	10.1%	15,206	11.0%	3,726	7.7%
Other State Funded	11,964	6.4%	11,150	8.1%	814	1.7%
Unduplicated Count of MHCP Clients	161,308	86.3%	117,806	85.1%	43,502	89.8%
Grand Total of All County and State Clients	186,903		138,441		48,462	

## APPENDIX VI.

### CMHS Advisory Task Force

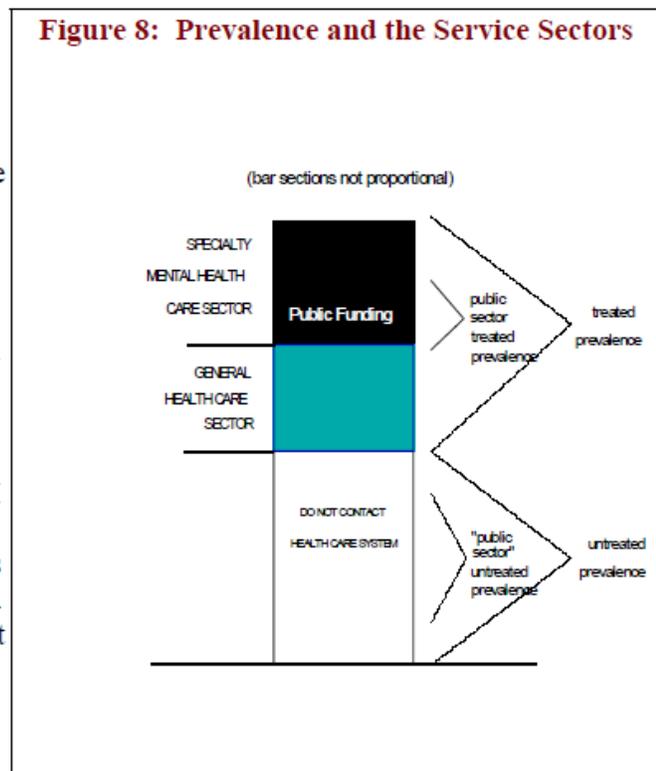
#### Background Materials Related to the Scope of Population Served

*(The following material is excerpted from Minnesota's annual application for the federal Community Mental Health Services Block Grant)*

##### Estimate of Prevalence - Adults

The state mental health acts define two primary target populations, one for adults and one for children. The primary target population for the adult system is termed "adults with serious and persistent mental illness," or SPMI. The definition for severe mental illness (also referenced as SPMI, as defined by the National Advisory Mental Health Council of the National Institute of Mental Health (National Advisory Mental Council, 1993). The new federal definition of serious mental illness (SMI) is considerably broader than the primary target group in Minnesota, and in the remainder of this document, the term SPMI will be used to denote the Minnesota target population. SPMI does not include persons with developmental disabilities or chemical dependency, unless these conditions coexist with mental illness. The term SMI will be used to denote Minnesota's approximation from data sources of the federal definition of the SMI.

**Figure 8: Prevalence and the Service Sectors**



The SMHA will use the federal definitions and prevalence estimates of SMI and SED, and the 2004 estimated population. Using this method, the rate of SMI in the adult population of Minnesota is estimated at 5.4% or 208,367 adults. The prevalence of SPMI, the target population, is estimated at 2.6% or 100,325 adults.

Not all of the 100,325 adults with SPMI are in need of services from the public sector. The graph in figure 8 illustrates that some persons in the target population who seek services, as many as 50% by some estimates, receive these services from the general health care sector, while some of those seeking services in the specialty mental health care sector are able to pay for these services from private sources. The precise percentage of the SPMI prevalence populations that need services from the public sector is not known; although data from the National Comorbidity Survey suggest that 64% of

persons with “severe mental disorders” have private insurance coverage. The SMHA is continuing to estimate that 75% (or 75,244) of the target population are the responsibility of the “public sector,” although the very large increase in numbers resulting from new federal estimates will cause us to reevaluate this strategy.

### **Estimate of Prevalence – Child**

The primary target population for the children’s system is children with serious emotional disturbance (SED). The state’s definition of SED is narrower than the federal definition. This is because the state’s definition of SED contains specific criteria which determine what children qualify for mandated services under the Children’s Mental Health Act. The state’s definition for “emotional disturbance” corresponds with the federal definition of SED. For the purposes of prevalence estimates, the state will use the federal definition of SED. The SMHA will use the federal definitions and prevalence estimates of SED, and the 2004 estimated population. The prevalence of SED is estimated at 5% for 5 to 8 year olds (12,996 children), and 9% for 9 to 17 year olds (58,351 children) for a total of 71,347. This prevalence is based upon assuming the low end of the range for children with a level of functioning rating of 60 produced by federal methodology for 9 to 17 year olds or 9%. The low end was chosen because of the state’s high economic ranking. A prevalence rate of 5% was assumed for 5 to 8 year olds.

For children, we are estimating that 45%, or 32,106, of these 71,347 children are the responsibility of the public sector. The public responsibility percent is based on a Duke University study of health insurance in North Carolina which estimated the percentages of children on Medicaid and those without insurance who have a SED. For the purposes of our performance indicators for this grant, we will only be addressing children ages 9 to 17 for which there is federal guidance regarding prevalence. The SMHA estimates there are 26,257 children ages 9 to 17 who are the public responsibility.

**APPENDIX VII.**

**Minnesota State Operated Services: Client/ Patient Count by Care Center**

<b>CARE CENTER</b>	<b># OF SITES (as of 12/31/09)</b>	<b># OF CLIENTS<sup>1</sup> (FY 2009)</b>
<b>Adult Mental Health (AMH)</b>		
Anoka Metro Regional Treatment Center	1	560
Community Behavioral Health Hospitals	9	1,356
Crisis & Other (Community Programs)	5	609
<b>AMH TOTAL</b>	<b>16</b>	<b>2,393</b>
<b>Child Adolescent Behavioral Health Services (CABHS)</b>		
Inpatient	1	140
Community Services	30	39
<b>CABHS TOTAL</b>	<b>31</b>	<b>174</b>
<b>Community Addiction Recovery Enterprise (C.A.R.E.)</b>	<b>6</b>	<b>2,291</b>
<b>Community Support Services (CSS)<sup>2</sup></b>	<b>9</b>	<b>182</b>
<b>Dental Clinic Services<sup>3</sup></b>	<b>5</b>	<b>5,620</b>
<b>Forensics</b>		
MN Security Hospital	1	218
Transition Services (St. Peter)	1	155
Forensic Nursing Facility	1	22
Adolescent YAAP	1	28
Other (Community Res & Treat to Comp)	2	171
<b>FORENSICS TOTAL</b>	<b>6</b>	<b>552</b>
<b>MN Extended Treatment Options (METO)</b>	<b>1</b>	<b>59</b>
<b>MN Neurohabilitation Services (MNS)</b>	<b>1</b>	<b>171</b>
<b>MN State-Operated Community Services (MSOCS)</b>		
Residential	135	850
Day Training & Habilitation	19	863
<b>MSOCS TOTAL</b>	<b>154</b>	<b>1,534</b>

<sup>1</sup> Represents total unduplicated count of clients served in a care center and may not be representative of actual patient count. The counts do not include patients in the Minnesota Sex Offender Program. Statewide unduplicated count was 12,172 in SFY09.

<sup>2</sup> CSS has 9 teams providing technical assistance and direct services to all 87 counties in Minnesota.

<sup>3</sup> Includes outpatient psychiatric services provided at Southern Cities Community Clinic (Faribault).

**APPENDIX VIII.**

**Scope of People Getting Public Mental Health Services in Minnesota**

Chemical & Mental Health Services Advisory Task Force - July 12, 2010		
<b>Adults - Prevalence Estimates</b>		
Estimated number of Minnesota Adults with SMI		208,367
Estimated number of Minnesota Adults with SPMI		100,325
<b>Adults - Number in Public MH System - FY2009</b>		
Number of Minnesota adults receiving publicly funded mental health services		186,903
Number of these adults getting services solely through MHCP		85,327
Number of these adults getting services through both MHCP and county system		76,051
Number of these adults getting services solely through the county system		25,511
<b>Adults - Number in SOS MH Programs - FY2009</b>		
Number of adults served at AMRTC		560
Number of adults served in one of the CBHs		1,356
Number served through SOS crisis services or other community programs		609
<b>Children - Prevalence Estimates</b>		
Estimated number of Minnesota children (age 5-17) with ED		71,347
<b>Children - Number in Public MH System - FY2009</b>		
Number of Minnesota children receiving publicly funded mental health services		48,462
Number of these children getting services solely through MHCP		25,304
Number of these children getting services through both MHCP and county system		18,262
Number of these children getting services solely through the county system		4,887

## APPENDIX IX.

### LEVELS OF CARE WORKGROUP- DRAFT FINAL REPORT

#### WORKGROUP CHARGE:

The level of care workgroup was directed to address two inter-related components of the mental health system, namely: acute psychiatric inpatient treatment and medically monitored transitional and long term community based treatment services/supports. The specific charge of the group was:

- To design a multi-level, state/private partnered acute care mental health system for persons traditionally served by State Operated Services. The system should improve the processes by which individuals move from acute care settings to less restrictive alternatives as soon as clinically indicated so that individuals receive the right services at the right time in the right place. The workgroup products should include a rational way to optimally use psychiatric acute care inpatient settings and medically monitored transitional and long term community based treatment services/supports by creating a framework that includes a) levels of acute psychiatric inpatient settings and b) transitional and long term community-based mental health treatment services and supports.

#### DESCRIPTION OF THE PROBLEM

The work group charge addresses gaps in the mental health delivery system that were also identified in the March 2009 and March 2010 legislative reports titled, *Mental Health Acute Care Needs* and *State Operated Services Redesign in Support of the Resilience and Recovery of the People We Serve*. Statewide stakeholder meetings, the State Operated Services utilization management system and an earlier examination of barriers to the timely discharge of psychiatric patients in the Twin Cities metropolitan community hospitals also identified similar service gaps.

The 2006 Twin Cities Patient Flow Study found that **45,000 inpatient bed days ( 25 percent of acute care bed days) were occupied by individuals who no longer needed acute care services** and were waiting for intermediate level of care resources to become available. Anoka Metro Regional Treatment Center (AMRTC) data found that **an average of 30 individuals per month were determined to not be in need of acute psychiatric inpatient treatment**. Information from several metropolitan hospitals indicates that unnecessary bed days continue to be problematic. **Current wait time for transfers of individuals from community hospital inpatient units to AMRTC averages about three weeks but can be as long as six weeks.** Both the *Mental Health Acute Care Needs* and the *State Operated Services Redesign* reports identified the following major service gaps –lack of a range of housing options; inadequate or absent community based services to serve individuals with complex behavioral and/or co-occurring medical conditions and the inherent liability risks and inadequate resource capacity of community-based providers to serve a high acuity, complex client population in the community. The *Mental Health Acute Care Needs* report also found, based on an analysis of available data, an adequate supply of adult acute inpatient psychiatric beds.

Many of the individuals identified as creating the greatest concerns were those with multiple and challenging diagnoses and behaviors including aggressiveness/violent actions and/or complex

co-morbidities including medical conditions, cognitive deficits and substance use disorders. These individuals tended to be frequent visitors to emergency departments and often remain on hospital inpatient units well beyond the acute care treatment phase because of minimal or nonexistent options in the community to meet their individual treatment needs. Many had long and repeated failures with community living arrangements due to the lack of adequate services. It was recommended that this population would benefit from a chronic care model of treatment/services with sound clinical practice approaches while also addressing fiscal and regulatory barriers that historically are challenges to implementing this model.

### **WORKGROUP COMPOSITION/PROCESS:**

A workgroup of twenty nine members with statewide representation and composed of consumers, family members, advocates, hospital and community mental health providers, counties, and third party payers was formed (See Attachment A for a listing of members). The group was chaired jointly by two DHS behavioral health directors and a non-DHS medical director with knowledge of the current delivery system. A total of six bi-monthly workgroup meetings were held. Several smaller group discussions between meetings resulted in work products for discussion and input from the entire workgroup.

At the first meeting, each member introduced themselves and identified an outcome that they would like the group to achieve. Common themes that emerged include:

- Creating a seamless system with clearly articulated interconnections among the various levels of care;
- Driving the system with recovery- based principles and practices – not by funding streams;
- Recognizing the opportunities/challenges in the “real world” to collaboration and coordination between DHS State Operated Services and community-based providers as equal partners;
- Redesigning/transforming the system **not** just reassigning responsibility and cost without realigning resources;
- Improving the quality of handoffs between levels of care and providers such as a shared recovery plan; and
- Redesigning those services and processes that will “unstick” the system to encourage flow through and community tenure of the people served.

In reviewing the charge, workgroup members offered the following comments/suggestions that the group needed to acknowledge as the work evolved:

- Recognize the critical impact that both transportation and housing play in “flow”; and the need **to jointly plan and resource** these components to meet the physical and mental health needs of the people served;
- Acknowledge the need to be careful, especially with limited resources and cuts to community-based mental health services and changes to GAMC, that acute care settings are not overly resourced at the expense of the community-based system;
- Recognize the need to critically examine whether there is/could be an adequate distribution of hospital inpatient psychiatric beds across the state that could meet Level I requirements in order to assure that individuals and their families are not forced to drive long distances to access this service;

- Support desired clinical outcomes that should a) improve access; b) intervene early; c) prevent relapse; d) respond rapidly, if a relapse occurs; e) increase independent living in the community and f) reduce unnecessary and more costly services; and
- Assure that all new or enhanced services are supported by evidence-based or research informed practices.

The work group felt it was important to clearly define the target population recognizing that this is a small subset of the larger population with serious mental illness who are being served with improved outcomes in both acute care and community-based mental health settings. For the purposes of this report, **the target population is defined as: “a heterogeneous population of ‘cohorts of one’ who may have multiple disabilities and multiple diagnoses with poorly managed chronic medical conditions, behavioral dysfunction, low stress tolerance and chronic functional deficits”**. The needs and preferences of the individuals in this group are diverse. The lack of a full range of adequate community resources to serve this population results in multiple hospitalizations and institutional dependency.

Given the findings from earlier reports, feedback from a broad range of stakeholders, future health care reform and the expertise of the workgroup members, there was consensus that much of **the focus needed to be spent addressing the array of needed medically monitored transitional and long term community-based treatment services and supports**. The desired outcome would reduce current unnecessary hospital admissions to and extended stays in acute care inpatient psychiatric settings and assure more timely transitions across services. There was general agreement that, in a very practical manner, if we want to transform the system to optimize efficiency and effectiveness (both benefit clients and save money), this is the area which will give us the best results.

To that end, the workgroup divided itself into two groups. The following describes the work of the transitional and long term services and supports subgroups. **It is important to note that although the report separates these services and supports into two distinct sections, the intent of the work group was not to recommend that a rigid step wise and lock step model be adopted. Rather, many of the settings/services listed under the transitional category may also be considered for long term services/supports.**

### **Medically Monitored Transitional Services/Supports**

The group recommended that the state be divided into appropriate regions which would be based upon resources available, clinical needs and geography. There would be identical expectations of services, quality, benefits, payment, access standards, measurements, and consumer choice. Furthermore, there would be shared responsibility and accountability and fluid movement of persons experiencing a mental illness within the designated region to meet individual client needs. Traditional boundaries of county lines and host county concurrence rules would not drive access to care or care itself. DHS would need to work with existing clinicians, clinics, hospitals and agencies and other authorities to ensure that the state is adequately resourced.

The components to be assembled to create a region could include:

**Structures/Facilities ( Consistent with Evidence-based best practices, these settings should be competent in addressing integrated dual disorder treatment- given that over**

**80 percent of the target population have dual diagnoses of mental illness and substance use disorder).**

- Psychiatric hospitals (including access to a Level I hospital which is defined later)
- Partial hospital programs
- Intensive Residential Treatment settings ( IRTs) that are certified to provide additional services such as medical monitoring by a psychiatrist, physical health care services and/or higher staff to client ratios. These settings would serve individuals who are marginally stable and need significant structure, intensity and flexibility of services. Treatment would be designed to maintain independence and functionality with the goal of moving toward more independent living in the community. Admissions would occur seven days a week
- A range of housing options with varied and flexible services and structures.

**Services: These are a range of services – the actual mix needs to be individualized to address the clinical needs of the individual. These settings should also be competent in providing integrated dual disorder treatment.**

- ACT Teams or Intensive Community Rehabilitation teams
- Psychiatrist appointments with medical care backup
- Supported Employment
- Case Coordination rather than the current targeted case management model of brokering services
- Medication monitoring
- Prescribers of psychiatric medications
- Primary care medical services
- Day treatment
- Psycho-social rehabilitation services such as Adult Rehab Mental Health Services that are geared to restore functioning
- Crisis response services
- Availability of detox settings that can serve persons who present in need of detoxification from substances other than alcohol and/or who have suicidal ideation that is related to the abuse of substances.

The involved facilities/structures/services would all agree to share responsibility and accountability for clients. An example of this would be an individual who is being discharged from a hospital and who might be offered services from the following menu:

- Detailed behavioral management plan
- Relapse prevention plan
- Wellness Recovery Action Plan (WRAP)
- Site visits by behavioral clinicians as needed
- Transitional medication appointments by the psychiatrist at the hospital until the person can see their community psychiatrist
- Behavioral management plan that is jointly developed by the hospital and community-based treatment providers and the client
- Outreach by the hospital psychiatrist who knows the patient
- Timely readmissions based on the clinical judgment of the community provider

For those individuals who are the most fragile and have complex behaviors, are multiply diagnosed and have a history of major challenges living in the community, the work group recommends a more intense case coordination service to ensure that the mental health, substance abuse, medical needs and other co-occurring conditions are met. Brokering this through a third party is not recommended. Any case coordination that needs to be done should be structured so the case coordinators are part of the treatment team and not merely brokers.

To the extent that there is an urgent need to combine behavioral health and medical needs, it is important that attention be paid to creating a health care home for these individuals. As an interim step, a registry for individuals who have aggressive behaviors and/or are medically complex could be created that would identify the case coordinator and other key providers.

It is recommended that DHS partner with counties, community mental health providers, private entities and psychiatrists to create these systems. A necessary component will be to help lessen liability (both legal and financial) so more community based mental health providers will be willing to partner with each other and DHS. If this is not feasible in a given region or because of a clinical need, DHS may need to become the provider of service and use State Operated Services resources to create these services.

To the extent that hospitals, community mental health providers and housing with supports settings would be asked to either treat more complex patients and/or provide services not previously offered, these services need to be adequately resourced and funded. The current fee for service payment system will not cover everyone and will not be capable of adequately resourcing the above entities and their staff. Block grants or other types of flexible funding will need to initially be used for this transformation. Group Residential Housing (GRH) funding will also need to be used in a much more flexible way to meet client needs. A utilization review system should be developed to eliminate ineffective services and right size under-utilized services to assure return on investments as services are expanded/created for a new model. The above system will also require trained, competent staff to do reliable initial assessments and periodic re-assessments and updates regarding the individual's functionality in order to continually match the person's clinical needs with their functional status longitudinally over time.

The workgroup recommends that DHS pilot the above system in two regions- one in the seven county metropolitan area and the other in Greater Minnesota within the next year. A component of the pilots would include service level agreements between acute care and community based providers with protocols to monitor and evaluate these agreements.

### **Long Term Supports and Services**

The subgroup chose to approach this set of services and supports by first agreeing on the target population, acknowledging that we were not focusing on all adults with a serious mental illnesses but rather on the smaller subset of individuals with complex behaviors and/or medical conditions as well as multiple co-occurring disorders. This is a population as noted earlier that have not done well transitioning to and remaining in the community because of a lack of community programs, services and housing options to support and treat each person's unique set of needs.

The group also felt it was important to establish a vision and a set of critical service components to address the clinical needs of this population. Rather than prescribing a specific set of services, the group felt those decisions could best be made at the regional/local level based on the actual numbers of individuals who met the target group criteria, the current service mix and availability/capacity of human and fiscal resources. The vision and service components would serve as a framework for regional planners.

The group envisioned a delivery system that is: an integrated (seamless), continuous, comprehensive service system that can address individual needs and provide the person with choices for successful and sustainable community tenure. There was agreement that “one size” did not fit all and that each person, despite major challenges, had strengths and capabilities to build upon.

The goal is independent living in the natural community to the fullest capability of the individual. All providers are expected to embrace that goal in their work with clients.

To accomplish this vision, the following are critical components:

1. A stable, structured, adequately supervised living arrangement that is individualized and allows for choice- this could include “front desk” support, security measures to protect vulnerable clients from potentially dangerous external situations; ‘housing first” models
2. Flexible community-based supports and services – including funding and policies that can address the nuances of individualized services;
3. An active psychosocial rehabilitation program;
4. Care coordination efforts focused on transition between levels of care to assure and support continuity of care and continuity of relationships;
5. A skilled and competent team who are well trained in long term supports and services with a dynamic team leader who provides ongoing mentoring/supervision consistent with recovery principles and evidence based or research informed practices. Certified peer specialists are integral members of these teams;
6. Shared treatment plans that are dynamically managed to assure continuity of care;
7. “Warm” handoffs during the discharge process with inpatient psychiatric providers and community mental health providers verbally communicating with each other, not just sending written reports. As examples, the inpatient psychiatrist should verbally communicate to the community-based treating prescriber about the current medication regime; Assertive Community Treatment (ACT) teams should be involved from the time of admission and be actively engaged at the time of discharge;
8. Planning for transition to the community should occur at the time of admission to an acute care setting or shortly thereafter. This should include involvement of community providers with the client during acute care hospitalizations; and
9. Decision trees should be in place to keep all involved actively engaged in the transition decision process.

### **Possible Strategies**

One option would be to develop multiple levels of care in one setting that can accommodate individual apartments, communal living and the availability of psycho-social rehabilitation programming open to those living in other community arrangements.

## **HOSPITAL LEVELS OF CARE**

At the suggestion of the workgroup, the hospital representatives met between meetings and presented a draft product describing the key requirements for various levels of hospital based psychiatric acute care settings. The following represents the final product of this effort.

**Premise:** Minnesota will have an accessible network of high quality psychiatric inpatient services that provides appropriate care for all patients with mental illnesses and any co-occurring disorders. Such facilities will be recovery oriented and utilize best practices.

**Medical Necessity is defined as:** Serious and imminent risk of harm to self or others due to a psychiatric condition; OR Serious and acute deterioration in functioning from a psychiatric condition that significantly interferes with the person's ability to safely and adequately care for themselves in the community; OR Severe disturbance in affect, behavior, thought process, or judgment that cannot be safely managed in a less restrictive environment.

**The following levels of acute care inpatient psychiatric services are only meant to describe the requirements of the setting.**

### **Level I Hospitals**

#### **Facility Requirements:**

Has an emergency department with at least master level crisis workers and psychiatric providers available 24/7, preferably a separate area dedicated to psychiatric emergencies;

Able to **safely** care for the entire spectrum of patients' clinical presentations up to and including those who have combative/violent behavioral dysregulation, and/or complex multi-system medical problems, and /or psychiatric co-morbidities (such as Developmental Disabilities, Substance Use Disorder, Traumatic Brain Injuries, Severe Personality Disorders);

Able to assure safety of patients and staff in admitting individuals with a violent presentation and those who have significant medical problems in addition to their mental illness;

Has a secure component able to manage admission from jails or prisons of patients who require legal custody and who meet medical necessity criteria;

Able to reliably admit, evaluate and treat complex/high acuity patients 24 hours/day 7 days/week;

Is part of a comprehensive medical/surgical center with immediate access to medical/surgical consultations and transfers to said services within the same hospital if deemed necessary;

Able to provide continuity of care as patients progress through different levels of medical and psychiatric care ranging from intensive care units to partial hospitalization programs (directly or in partnership with other hospitals);

Has a nursing staff available 24/7/365 with skills and expertise to provide comprehensive services to patients with complex needs; and

Engages other services/programs in their respective regions to improve communication, coordination of care and collaboration.

**Eventually will be able to:**

- Provide leadership in education, training, research, prevention, and system planning in collaboration with DHS and leaders of community-based systems
- Standardize best practices in a continuous learning environment where patient satisfaction, key safety/process measures, and patient outcomes are broadly shared and improved.

**Level II Hospitals**

**Facility Requirements:**

Has an emergency room with a mental health professional providing consultation 24/7;

Provides a daily psychiatric provider presence and ability to admit psychiatric patients 7 days/week and 24 hours/day (a psychiatric provider is defined as either a psychiatrist, physician assistant and/or an advanced practice registered nurse under the supervision of a psychiatrist);

Able to care for patients on 72 hour holds and those going through the commitment process;

Able to care for patients with moderate medical and psychiatric co-morbidities; and

Able to access medical and surgical consultations seven days/week.

**Level III Hospitals**

**Facility Requirements:**

Not necessarily connected to an Emergency Department;

Able to admit psychiatric patients 7 days/week (but not necessarily 24 hours/day);

Able to admit and care for patients who are not overly aggressive and who do not have active medical co-morbidities requiring ongoing medical consultation or care; and

May **not** be structured in a way to care for patients on 72 hour holds and those going through the commitment process.

**Level IV Hospitals**

**Facility Requirements:**

Has an emergency department (ED) and can assure a reasonable psychiatric and substance use disorder triage function in the ED setting; and does not have a psychiatric unit.

Given the multi-factorial nature of where the population lives, where psychiatric resources exist, and future medically monitored transitional and long term community based resource expansion; we are currently **not** making a recommendation on regional distribution of level 1 and level 2 hospitals. Specific recommendations are included in the Recommendations Section below.

## RECOMMENDATIONS

The Levels of Care workgroup recognizes that there exist critical service gaps in the comprehensive system that affect the continuity of care and patient flow. Addressing acute psychiatric inpatient treatment and medically monitored transitional and long term services and supports will only impact the more intense levels of care.

**As the target population for these services is the most complex individuals who can exhibit the highest acuity treatment needs, these recommendations are focused on increasing community tenure by reducing often unnecessary emergency department visits and inpatient psychiatric admissions and the delays with timely discharges of individuals who no longer need acute inpatient psychiatric services.**

People in the target population do at times require 24-hour structure and supervision with active treatment. Two caveats must be recognized: 1) moving from one level of care to another is not a lock-step process; it is based on the person's strengths and needs and 2) community based transitional services and supports may not be permanent; they could be replaced by community housing and an array of treatment and supports that, at this time, are either undeveloped or unfunded.

### **Medically Monitored Transitional and Long Term Services/Supports**

1. The transformation is based upon defining practical regions and empowering the relevant agencies, facilities and providers to perform and be responsible for necessary tasks to meet the needs of clients in that region. Identical expectations and standards need to be upheld regarding consumer choice, access, quality and consumer satisfaction, flow and cost metrics. The Adult Mental Health Initiative regions are a reasonable starting point for these discussions.
2. It is recommended that traditional boundaries of county lines and host county concurrence rules not drive or be a barrier to access.
3. Shared decision making responsibility, accountability and risk across the acute care and community based mental health system must be an expectation. DHS, in partnership with other key decision makers, need to address the barriers that current tort laws create in this area and work with others on tort reform.
4. Flexibility of funding to address the range of client needs has been proven to be highly effective as a tool to assure community tenure; it should be a key component of services to the target group.
5. Two pilots, as described under transitional services, using the current service capacity, should be created this year to test the model. Additions to or changes in pre-existing services that are reimbursable under the Minnesota Health Care Programs will require state plan changes and federal Center for Medicare and Medicaid Services (CMS) approval as well as funds for additional state match. DHS Health Care Administration will need to be involved in these discussions.
6. Community capacity, both acute care and community-based services, must be developed and implemented before reducing capacity within the State Operated Services system.
7. Given that the target population are the most clinically complex group of individuals who can exhibit the highest acuity treatment needs, services must be designed to address each individual's clinical picture- one size does not fit all.

8. Staff must be skilled and clinically competent to provide transitional and long term supports and services and must be cognizant of the role of natural supports. Services in both acute care and community-based settings must be either dual disorder competent or dual disorder enhanced, given the high percentage of individuals who have both a mental illness and substance use disorder. In addition, there is an important role for the use of Certified Peer Specialists in providing on-going supports and services. Adequate resources (both human and fiscal) are needed to develop and implement a set of standards and to train and provide consultation to settings as they use these standards. Training alone does not effect change.
9. Intermediate services may be necessary but there should be a specified sunset date to assure that a rigid lock step model of service delivery is not created. Continuous reassessments of client needs and desires should drive their next level of care, structure and services. The capacity of each resource should be adjusted to meet the demand.
10. Service level agreements need to be developed between acute care and community based providers and protocols established to monitor and evaluate said agreements.
11. For the target population, a model of intensive case coordination should be developed and funded. This model has case coordinators as active members of the treatment team and not merely brokering services.
12. A Utilization Review system should be developed to eliminate ineffective services and to right size under-utilized services with the goal of assuring return on investments as we expand/create services for a new model.
13. Given that our approach is to be client centered and recovery oriented, the transformed system needs to meet the consumer where he or she is (readiness to change); and when appropriate, consider a harm reduction approach and focus on increasing community tenure as a goal instead of decreased re-admissions.

### **Hospital Levels of Care**

1. Level 1 hospitals need to be reimbursed at a rate higher than the other levels acknowledging the additional services and staffing requirements needed to provide more intensive services in secure units for patients with higher acuity and more complex care needs. This could be done through state grants/subsidy dollars commensurate with the increased expense/resources needed to provide such services. Addressing these funding mechanisms will require negotiations with CMS, DHS Health Care Administration, and the hospitals themselves.
2. Determination of how and in what manner the levels of hospital care resourcing should be examined at a regional level based on the region's current service array and in collaboration with local entities.
3. The triage process is a key asset to utilizing this proposed network of psychiatric inpatient services. We recommend that the ACCESS work group address the need for highly trained and experienced psychiatric providers to be responsible for the triage process.
4. A methodology needs to be developed that allows for the movement of patients from one setting to another based on the clinical complexity of the individual and an agreed upon mechanism for timely transfers. This could be accomplished through the use of service agreements or formalized partnerships.

### **MEASUREMENT**

As the system is redesigned, the work group believes it is crucial to be able to know whether the redesign is improving conditions. In order to do this, the work group recommends obtaining

baseline measures of how well the system is functioning now and to repeat these measures to monitor for improvement.

Given the inadequacy of current data systems, it will not be easy to obtain baseline measures. Therefore, what the work group is proposing is significantly limited by current data sources. A pilot study may be needed to obtain initial baseline data on a more limited basis, and then expand the measurement capacity and resources more broadly so that the system can continually improve. DHS, in partnership with the private sector, should initially obtain data only on adults who have mental illnesses and chemical dependency diagnoses, who are tracked in the Minnesota Health Care Program data bases and who have been hospitalized equal to or greater than 3 times per year. This cohort will serve as the foundation for the following metrics:

- The percentage of the year and number of days present in the community per client per year (i.e. not hospitalized). It is hoped in the future that data can be obtained from the criminal justice system (jails, prisons, and workhouses) and detox centers to get a better idea of tenure in the community.
- Direct social service, mental health and physical health care costs per client per year. Once again, it is hoped that DHS will partner with the private sector and the community based system to eventually include costs from the criminal justice system and detox centers. This may require legislative attention to address limitations in the state data practices statutes.
- The number of Potentially Avoidable Days( PAD) in the hospital per client per year, This metric will be categorized by the intermediate or outpatient resource that they are unable to get into. For example, client X might have spent 35 days in the hospital waiting to get into a facility that can handle significant medical problems and mental health problems simultaneously.
- The number of civil commitments or stays of commitment per client per year.
- Client satisfaction.
- Client quality of life and functionality.
- The number of emergency room visits per client per year, and, if possible, average time spent in the emergency room per client per year.
- The number and length of stay for inpatient psychiatric and medical admissions;
- Percentage of persons who are screened and appropriately treated for substance use disorders.

## **ATTACHMENT A**

### **LEVELS OF CARE WORKGROUP MEMBERS**

- Ron Brand, Executive Director; Minnesota Association of Community Mental Health Programs
- Gwen Carlson, Behavioral Health Director, Hennepin County Human Services
- Louise Clyde, Director of Behavioral Health, Blue Cross Blue Shield/Blue Plus- representing MN Joint Council of Health Plans, Behavioral Health
- Bill Conley, Minnesota Consumer/Survivor Network
- Ed Eide, Executive Director, Mental Health Association of Minnesota

- Gary Green, Treatment Director, Woodlands Intensive Residential Treatment, Atwater; representing Minnesota Association of Mental Health Residential Facilities
- Joanne Hall, Director, Behavioral Health and Rehabilitation, Hennepin County Medical Center
- Dave Hartford, Hospital Administrator, Anoka Metro RTC
- Paula Halverson, Manager, State Operated Services, Anoka Metro RTC
- Sue Hanson, representing NAMI-Minnesota
- Tracy Hinz, Team Leader, Great River Assertive Community Treatment/ Central MN Mental Health Center, representing ACT providers
- Gordy Hoelscher, CEO, Range Mental Health Center- representing MN Association of Community Mental Health Programs
- Kathy Knight, Behavioral Health – Fairview Riverside Hospital ; representing MN Hospital Association
- Michael Landgren , Mental Health Program Consultant , DHS, Adult Mental Health
- Ruth Moser, Mental Health Program Consultant, DHS, Adult Mental Health
- Mary O’Neil, Olmsted County, Representing MN Association of County Social Service Administrators
- Annie Pierre, Le Sueur, MN ; representing the State Advisory Council on Mental Health
- Michael Popkin, M.D.; Hennepin Faculty Associates
- Steven Pratt, M.D., Southern Network Medical Director, Anoka Metro RTC
- Patricia Siebert, JD, representing Minnesota Disability Law Center
- Grace Tangjerd-Schmitt, President, Guild Incorporated
- Steven Vincent, PhD.,LP; Care Center Director, Behavioral Health Services, St. Cloud

#### **Ad Hoc Members**

- Don Allen, Behavioral Health Care Manager, Chemical and Mental Health Services Administration, DHS
- Richard S. Amado, PhD,LP; Director, Office for Innovations in Clinical & Person Centered Excellence, Chemical and Mental Health Services Administration, DHS
- Ann Berg, Deputy Medicaid Director, DHS
- Cynthia Godin, Mental Health Administrative Supervisor/ Evidence-Based Practices Lead, Adult Mental Health Division, DHS

#### **Co-Chairs**

- Sharon Autio, Director, Adult Mental Health Division, DHS
- Alan Radke, M.D., State Operated Services Medical Director, DHS
- Michael Trangle, M.D. Associate Medical Director, Health Partners/Regions Hospital

## APPENDIX X.

# NEUROCOGNITIVE WORK GROUP REPORT

## Executive Summary

Programs serving individuals with neurocognitive disabilities were identified early on as an essential component of State Operated Services (SOS) transformational planning. In an effort to plan for changes in these services, representatives from a wide range of backgrounds representing neurocognitive services (including brain injury and intellectual and developmental disabilities) were identified to participate on a work group to create a vision of neurocognitive services that would be available in Minnesota by the year 2015. Rapid agreement emerged on an overarching vision: *“people with neurocognitive disabilities have a meaningful life in their community”*. Using a structured facilitation technique designed to focus group members on the future (vs. dismantling current services) the group envisioned services that would be available in 2015 and described how they looked. Through this process, members identified 12 critical elements that comprise a conceptual model essential to bring transformational change for people with neurocognitive disabilities in Minnesota focusing on the overwhelming majority of clients who can be served safely in the community. This report contains 1) a description of each of these twelve elements, 2) related objectives, 3) action steps necessary for the realization of each element, and 4) potential outcome measures. A brief conclusion is also provided.

## Introduction

While neurocognitive disability may be the primary focus of treatment and support it can also be a co-occurring condition in conjunction with mental illness and/or substance use disorders. Nonetheless, the goal of integrated services and supports for people with neurocognitive disabilities is similar to those with mental health and substance use issues. Services and support for people with neurocognitive disabilities are intended to assist them in living the most independent lives they can lead which in turn decreases homelessness, increases stability, and improves individual and personal outcomes. Their common challenges with mental processing and problem solving, while important, is just one consideration along with their personal recovery goals, supports needed to achieve their goals, and continuous efforts to tailor supports and offer choices that support self-efficacy.

The service system currently supports individuals with these disabilities across a wide variety of services including Personal Care Assistance, Home and Community Based Waiver Services, mental health services, neuropsychological evaluation and behavioral plans, cognitive rehabilitation, and through State Operated Services. Our service system must be prepared to meet the complex needs with which our consumers present with a rigorous and responsive system of support and services for this population. Serving this group of individuals can only be addressed in an effective and efficient manner by an infrastructure that is capable and equipped to screen, assess, and develop person focused plans incorporating the individual’s unique needs, goals, priorities, and preferences. In addition to partnerships among health care and human services, collaboration must also involve other access points for these individuals such as education, county social services, criminal justice, transportation and housing. This preliminary work among a group of passionate stakeholders represents an initial step in beginning the

collaborative work necessary for planning a new system of effectively integrating services and supports for people with neurocognitive disabilities in Minnesota.

Services and support to people with neurocognitive disabilities are provided by professionals and paraprofessionals in specialized fields such as intellectual and developmental disabilities, brain injury, and other related fields. These fields and the services within them have operated in silos within their special population, specific funding, training, policies, and even history. State Operated Services, like other programs, has done the same with the end result being the provision of disconnected services in parallel or sequential manner in which people are moved from one program to another in efforts to address a “primary” disorder. For people with neurocognitive disabilities this is often costly, confusing, inefficient, and ineffective because they have dual disorders and may meet eligibility criteria in more than one system. The emergence of neurocognitive disability as an area of focus in the CMHS transformation provides a positive opportunity to build a vision that drives change in behavioral health care by drawing ideas and experiences from many fields. This report was developed by a group of expert stakeholders who have years of experience in working with, supporting or advocating for people with neurocognitive disabilities.

The report focuses on the overwhelming majority of clients who can be served safely in the community and whose legal status does not prohibit or hinder integration into the community. Acknowledgement must be made, however, that a large proportion of individuals served within the criminal justice system have undetected neurocognitive conditions which hinder their success and release planning. Because of their criminal histories they are likely to be served in prison or similar facilities. It is critical that the specialized needs of this group be addressed as soon as possible through collaborative efforts among forensic services, Department of Corrections (DOC), community corrections, Minnesota Sex Offender Program, county attorneys, and other stakeholders.

The report and its proposed recommendations do not stand alone and should be considered in conjunction with the other complimentary work group efforts that are occurring as a part of the SOS transformational effort. Unlike other transformation work group initiative such as access, levels of care, housing and transportation, neurocognitive services are not a service per se but rather an all too common condition that adds another layer of complexity which threatens many consumers’ very recovery. Informed and person centered approaches become even more important for this group of consumers who face the greatest challenges in navigating the disjointed network of services established and funded for diagnostic categories and people with circumscribed problems. The establishment of a full range of levels of care, true access to the right services at the right time and place, and the mobility to take advantage of those services near home while supporting the unique neurocognitive needs will be important if we are to break the cycle of creating treatment failures for people with the greatest vulnerabilities. The development of a range of resources in the community is a prerequisite to people with neurocognitive disabilities having a meaningful life in their communities. The current work group report paints a picture of the destination its members would like to see services arrive at by 2015. The picture is of a world where personal and public services work together for people instead of the other way around. It is a place where safety is important and is balanced against calculated risks to optimize choice, recovery, and wellness for the people we serve. It is a place

where people have valued roles and in which supports and services are designed to assist people in becoming community members, neighbors, advocates, family members and friends.

## Work Group Process

**Neurocognitive Work Group Charge:** Create a conceptual model of services that will best meet the needs of individuals with neurocognitive disabilities by 2015 in concert with other transformation initiatives initially within State Operates Services and eventually the broader system of services and supports to people with disabilities.

## Principles of CMHS Neurocognitive Transformation Workgroup

- Services are comprehensive, integrated, and flexible, All services, including crisis services, are available in the community and accessible within the communities in which people with needs are living,
- The proposed products are consistent with principles of person-centered practice, assuring attention to what is important to people who receive supports,
- Service design proposals are consistent with the expectation of recovery and include family involvement when it works for the person receiving services and supports,
- Recommendations are consistent with evolving best practices and can easily incorporate evidence-based practices in the next operational planning stages.

**Members:** A stakeholder workgroup was convened representing individuals involved with service and support to individuals with neurocognitive disability. The workgroup represented adult and child interests within both the developmental disability and brain injury sectors. Stakeholders included professionals, family members, advocates, providers and county/state governmental agencies.

Member and Affiliation		Member and Affiliation	
Steve Allen	Department of Corrections	Elana Gravitz	MACSSA/Hennepin County
Rick Amado	Chemical and Mental Health Services Administration	Jodi Greenstein	TBI Advisory/Courage Center
Maria Anderson	Adult Mental Health Division	Sharyl Helgeson	Adult Mental Health Division
Beth Bohnsack	Bethesda Neurorehab Hospital	*Amy Hewitt	University of Minnesota
Coleen Brady	Hennepin County Attorney's Office	David King	MN Brain Injury Association
David Campbell		Steve Larson	Arc of Minnesota
*Erwin Concepcion	State Operated Services Forensics State Operated Services	Sue McGuigan	TBI Advisory/Family support of person with brain injury
Steve Dahl	SOS Synergy/CSS	Dianne Naus	MN Disability Law Center in Duluth
Ruthie Dallas	Alcohol and Drug Abuse Division	Kathy Nesheim-Larson	TBI Advisory/REM
Glenace Edwall	Children's Mental Health Division	Gerry Nord	Disability Services Division
Mary Enge	Disability Services Division	Doug Seiler	State Operated Services Special Populations
Linda Esjornson		Dawn Smith	TBI Advisory/Dungarvin
Paula Halverson	Metro Crisis Coordination Program SOS Transition Services		

**Methods:** The group met three times and developed 3 subgroups to focus on specific elements during the times between the second and third meetings. The focus of meetings was to create a vision for what services and supports would look like in 2015 and to then describe those services. Members were specifically asked not to become side tracked with how they would be developed and not to be constrained by relying on constraints imposed by or improvements needed in the existing system. In order to accomplish this a structured exercise was conducted similar to guided imagery in which participants reveal what they “saw” in 2015 when they looked at a system that met the needs of people with neurocognitive disability. A chronology of work group activities is listed next.

**Step 1** - Implemented a structured activity to describe services and supports in 2015 that met the needs of people with neurocognitive disabilities and their families. From this exercise identified key elements necessary to help people with neurocognitive disability succeed in having a life in the community by 2015. Recorded findings and shared with group.

**Step 2** – Formalized the list of elements through consensus building. Divided work group into three smaller groups with assignment to generate detailed description of elements through the use of mind mapping and other tools.

**Step 3** - Three subgroups met independently outside full group to develop assigned elements and prepare for presentation at third meeting session.

**Step 4** – Subgroup presentations to full work group for feedback, adherence to principles, and consensus.

## **Results**

Most remarkable in conducting an exercise to establish the vision for 2015 was what participants saw and the similarity in needs for programs, services, and resources despite their varied background. Despite the diversity of backgrounds, which included developmental disability and acquired brain injury, children and adult interests, and a range of settings from criminal justice to community supports, there was agreement that the first core element was that *people with neurocognitive disability have a meaningful life in the community*. With this as a foundation the group proceeded to identify that services must be comprehensive, informed, and responsive. This overarching principle became the foundation around which other elements were developed and which are, in turn, necessary to achieve the overall vision. These other elements are discussed in subsequent sections. The broad objective of having a meaningful life in the community will become the standard by which success is measured and also provides guidance to system transformation by impacting policy, program and workforce development as well as funding priorities and methods.

## **Keys to Successful Life in the Community**

1. People have to have safe and affordable places to live in communities of their choice;
2. People have their choice of people to provide paid and unpaid direct support who understand them and their hopes and wishes;
3. People who receive supports and services are empowered to advocate for these services and supports for themselves and encouraged to take calculated risks

4. The communities in which people live are educated about and have awareness and understanding of neurocognitive disabilities; and
5. The community accepts individuals with neurocognitive disability as valued members of the community

### **Essential Elements of the Vision**

Elements that emerged from the visioning process are interdependent and can be seen as two sides of the same coin. They are the required building blocks to enable people to have a meaningful life in the community but at the same time also the outcome results of individuals who have meaningful lives in the community. These elements and outcomes which form the outline of the work group's conceptual model are:

1. People are empowered to direct their lives and the services they need to live where and how they want to live
2. People have their choice of living arrangement in the community with neighbors and roommates (if they want them) of their choice
3. People have relationships and connections to people they like and with whom they want to be connected
4. Families feel supported both as individual family members and as a family unit
5. People have support coordinators who know and understand them and their unique situation and advocate effectively for them based on taking the necessary time to learn their personal story
6. People have highly trained staff who they choose to provide their support that are energetic, positive, motivated and who communicate hope;
7. There are processes in place to identify persons with neurocognitive disability who need this service
8. There is a prompt response to identifying and supporting individuals with neurocognitive disability who represent emerging populations
9. People are encouraged to consider employment and have meaningful jobs with support available as needed
10. There is a high level of public education and awareness about the identification and prevention of neurocognitive disabilities and how to support individuals with those disabilities
11. There is technology that works for people
12. The needs for safety for the individual, supports, staff, and for public safety are addressed everywhere

## **Elements of Living a Meaningful Life in the Community**

### ***1. People are empowered to direct their lives and the services they need to live where and how they want to live***

#### **Objectives**

This element is a key factor in people having hope and a life in the community and cuts across disability groups. People must be empowered to direct their lives and the services they need to live where and how they want to live. Since this theme is extremely broad, it encompasses virtually all of the services and resources available for individuals with neurocognitive disabilities. This area has the potential to help, support and strengthen all areas of the lives of these individuals but its success is also dependent on a culture and society in which empowerment is understood, fostered, and respected, hence a large dependence on education and awareness. Empowerment includes self-direction which provides not only the opportunity to choose services and supports but to control the resources that pay for services and supports.

#### **Steps to Success**

1. Services are not tied to funding or disability group
2. People have the opportunity to be educated about services that are possible (not just those that currently exist or are readily available)
3. People have the choice of who provides the services they receive
4. People are allowed the dignity of risk and the right to fail
5. Services such as personal care attendant (PCA) or independent living skills (ILS) are not tied to housing so that consumers do not have to find a new housing provider if they no longer need or want those services
6. People have the opportunity to control the resources allocated to them for services and supports

### ***2. People have their choice of living arrangement in the community with neighbors and roommates (if they want them) of their choice***

#### **Objectives**

Housing is a right of the person and is a relationship they develop with their landlord/banker. The basic assumption should be that people live in their own home with exceptions to this instead of the other way around. People need to have choices in determining where they live geographically and in what type of housing but choices need to be available before they can be offered. People should be able to choose to live alone or with others and have support to either rent or own and have available reasonable access to “back-up” on any rent or housing cost requirements should inpatient treatment be necessary in order to avoid losing their housing. A high priority for successful transformation is a system that is able to preserve housing for individuals that access treatment services.

The current availability of options is insufficient to meet individual needs with many people settling for “placement” in “openings” instead of the ability to develop a living situation that best meets their needs. The need is for a funded range of options in the community instead of funded openings we “force” people into. Even the way existing options are communicated requires improvement to optimize what is currently available. Success in this area also depends on access

to care, service options, and having a support coordinator to help advocate and navigate within the system. A system that provides this assures:

1. People understand the potential options for housing and living arrangements (in contrast to only knowing what is currently available)
2. People have stable and secure housing such that they are able to return to previous settings and rejoin support and social networks if treatment outside their home becomes necessary;
3. People are able to choose where they live and are not limited by “openings”
4. People are able to choose who they live with regardless of disability including choice of intimate partners and/or supports
5. People’s needs are re-evaluated on a regular basis to ensure that their needs continue to be met
6. Housing funds are invested long term into the housing needs of the person vs. a provider or landlord
7. If people choose to live at home with their family members those family members have options for respite and family support as needed in order to make the living arrangements in the family home successful and sustainable

### **Steps to Success**

1. Supportive services are available within the community including respite for the family and competent direct support workers
2. State, county and city policies support development of appropriate services and housing options
3. Caregivers and service coordinators are trained in supporting individuals in selecting appropriate housing, appropriate housing services, and developing housing situations that meet their needs and desires
4. Policy revisions support funding such as GRH and other Housing Grant funds to be funneled to benefit individuals rather than providers. Funding supports individuals to live independently in non-group situations
5. Guarantors are available to co-sign rental agreements
6. Financial Institutions are available to provide lending services
7. Somebody is identified as responsible for developing the necessary options
8. There is funding and appropriate options to meet individual needs

### ***3. People have relationships and connections to people they like and with whom they want to be connected***

It is recognized that all people have relationships with other people in various capacities. Relationships include both paid and unpaid individuals with the understanding that both the former and latter have personal value. These relationships take on various forms, such as being a friend, partner, parent, family member, casual acquaintance, co-worker, community member, employee, or as a person receiving a service from a paid caregiver. Relationships take place in a variety of settings, such as neighborhoods, families, homes, schools/universities/colleges, places of employment, places of worship, and recreation/leisure settings. People are free to choose to what extent they desire involvement in the relationships in their lives as guided by mutuality and appropriate boundaries. Relationships are determined by a variety of factors, such as shared interests, common values, proximity, or service need. In being person centered and recovery

focused a key philosophy is supporting wellness in the individual's relationships. This requires a balance between their vulnerabilities and wishes, with the awareness of the boundary and health of the relationship. In order for relationships to work well, it is understood that certain interpersonal skills are required by both parties. For some people, these skills are already in place and come easily. Other people require training, practice, opportunity for feedback and access to flexible support services as needed in order to be successful.

### **Objectives:**

1. People with neurocognitive needs have training and support to build relationships with others
2. People in relationships with a person with neurocognitive needs have opportunities for training and support in order to have successful relationships
3. Families and caregivers will understand how to support the person's needs

### **Steps to Success:**

1. Relationships skills are a required component of professional care giving roles;
2. Training opportunities are made available for all interested persons;
3. Specific training is made available regarding the particular needs of the person with neurocognitive needs, e.g. Individual Treatment Plan; and
4. Funding streams are flexible and cover access to relationship skill building training in creative ways across a variety of venues (link to education, training, stigma & awareness)
  - a. Online training
  - b. Support group
  - c. Continuing education/adult education
  - d. Art and literature
  - e. Movies and television.

#### ***4. Families feel supported both as individual family members and as a family unit***

As in other dimensions of the person's life, the role of family is their choice with the belief that family members have the best intentions and wellness of the person in mind. The family relationship is a balance between the level and type of involvement negotiated through mutual agreement between the family and the person. Once the negotiation is complete and the family's role is established, the role of others is to provide the level of support needed to fulfill that role. Family does not automatically consist of blood relatives but anyone identified by the person as family.

#### **Support Services for Families Include:**

- Education, including evidence based instruction about the individual's disability, and associated functional and behavioral issues, and parenting
- Respite, including both periodic and crisis based which is structured, reliable, and available as needed
- Counseling for the person's identified individual family member or family unit as needed or desired
- Transportation not only for the individual but also for identified family and other supports to be able to accompany the individual with flexibility to meet their needs and those of the family supporting them

- Housing arrangements that accommodate the entire family's needs
- Formal and informal support networks, including one support coordinator

### **Objective**

The impact of providing supports for families of individuals with neurocognitive disabilities would, in turn, support the individual and likely result in the family being better able to provide natural supports in the family home at substantially less cost as compared to other settings.

### **Steps to Success**

1. Family members are able to balance support and caregiving of individuals with neurocognitive disorders while living their own meaningful lives, including holding jobs, maintaining relationships, attending school, etc.
2. Families have freedom of movement with access to services without geographic limitations
3. Families are involved when and to the extent that works for the person
4. Many families play a vital role in helping to identify the individual's past goals and preferences and are advocates in de-stigmatizing their disability. Families are recognized and supported by the service system for their own needs, choices, and wishes
5. Families have access to the same opportunities in the community as families without special needs family members
6. Families feel supported both as individual family members and as a family unit
7. People with neurocognitive disabilities lead meaningful lives in the community when families feel supported both as individual family members and as a family unit

***5. People have support coordinators who know and understand them and their unique situation and advocate effectively for them based on taking the necessary time to learn their personal story***

Support coordination works integrally with consumer directed services and is flexible based on the needs of the person, not based on inflexible program requirements. Case loads should be reflective of the frequency and intensity of interactions. Persons who serve as support coordinators are:

- Knowledgeable about both the specific disabilities (and abilities) of the individuals they serve and about appropriate services
- Proactive and focused on prevention of crisis and enhancement of wellness and recovery
- An advocate first and highly focused on the needs of the person served and only secondarily to the system
- Able to creatively problem solve
- Relentless in their use and promotion of positive, person-centered practices
- Qualified/certified in their ability to meet the needs of the specific populations they are supporting
- Empowered to create options for people in conjunction with having a role in consumer directed services

## **Objectives**

Support coordination serves an extremely important function of supporting people with disabilities by serving in a proactive manner to prevent problems and to solve problems and advocate for the person experiencing the challenges when they arise. By having the ability to proactively address problems there can be a reduction in those issues evolving into emergencies and crisis. Strong support and services in this area can serve a secondary prevention function of helping to avoid further complicating problems for the individual, their supports, their providers and the community/public. Support coordination must focus on key issues to quality lives such as assisting people to have homes, transportation, relationships and jobs first.

## **Steps to Success**

1. Flexible service with caseloads that allow intensive work and assures that support coordinators know and understand the people they are assigned to support
2. Support coordination is available to all populations so persons who are older or have disabilities can obtain assistance via one-stop-shopping versus having to navigate/negotiate on their own various complex program service models
3. Support coordinators are certified by demonstrating competency before being enrolled as a provider
4. People have the choice of support coordinators
5. Support coordination includes a range of services and intensity based on the individual needs of the person, from very frequent visits/interactions to less frequent visits
6. Support coordinator caseloads are flexible and not tied to a program but designed to meet the needs of individuals they serve

## ***6. People have highly trained staff who they choose to provide their support that are energetic, positive, and motivated***

Persons with neurocognitive disabilities deserve high quality, effective and appropriate support and services delivered by people who are trained and competent. Because of the subtleties and complexities of neurocognitive disabilities and often co-occurring conditions, staff training is essential to meet this goal. Staff working with people with neurocognitive issues must be trained to understand the needs and disabilities of the people they support so that they can be the most effective. Staff should either be credentialed or have immediate access to one for problem solving and consultation. Staff view their work as a sought-after career path. Compensation across all levels of providers of care and services for persons with neurocognitive impairments should be reviewed for adequacy. Compensation should be commensurate with pay to providers with similar responsibilities elsewhere in society and sufficient to support staff throughout the system of care with a passion for working with people and who are motivated to make work in this field their career choice.

Effective services depend upon highly trained, creative, flexible, and motivated staff. Unless services are effective, they can result in waste of scarce resources, disappointed and demoralized clients and families, and loss of public confidence that services can be effective and should be supported. These failures can also create a downward spiral in which staff also become demoralized, further affecting the quality of service provision.

## **Objectives**

1. Having effective services in which people are not experiencing crises and are able to remain out of hospitals and the criminal justice system. Support staff are able to intervene proactively, reducing behavioral problems and preserving a positive relationship
2. Hope and quality of life for persons receiving services and their loved ones is improved
3. Staff retention and job satisfaction are improved

## **Steps to Success**

1. Professional-level training of staff is readily available and supported
2. Direct support staff are trained, competent and certified
3. People who conduct assessments also provide training and technical assistance to customers of their evaluations
4. Specialty services by neuropsychologists are accessible by programs and clinics that see large volumes of individuals with neurocognitive disability to appropriately inform and guide services and supports

### ***7. There are processes in place to identify persons with neurocognitive disability who need this service***

Two fundamental problems in the provision of appropriate treatment and other supportive services for persons with neurocognitive impairments are the under-identification of this group and the late identification which often occurs only after the devastating effects of these complex conditions have started to take their toll. People who present to treatment providers or law enforcement are easily misidentified or not identified as having brain injury, fetal alcohol syndrome (FAS), developmental delay, intellectual disability, autism or related neurocognitive condition. The failure to identify these disorders can and often does result in the person failing to obtain necessary medical and other services needed to appropriately address these conditions and to properly support them. Further, when these conditions are not properly diagnosed and supported, there is significant risk for behavioral problems to emerge which can lead to loss of housing, legal problems, or the development of maladaptive behaviors stemming from inappropriate placements including mental health placements or correctional settings. The problems of individuals with neurocognitive disorders being served in the right place at the right time applies as much to corrections as it does for other service areas.

Appropriate and effective treatment and support services begin with good assessment and services planning. People with neurocognitive disabilities need to first be identified. Proper identification with this population, however, is challenging requiring specialized training as these conditions are often masked or confused with other, and sometimes co-occurring, conditions. Failure to properly diagnose leads to the poor use of scarce resources, both in the failure to provide the right resources to those needing them as well as sometimes providing the wrong interventions and supports. This element requires a large net of people from across a wide range of backgrounds and potential service entry points to be able to identify and understand the challenges and needs of individuals with neurocognitive disabilities. Additional specialized assessment such as neuropsychological evaluation and consultation is helpful with individuals who have more complex neurobehavioral conditions.

## **Objectives**

Competent assessments completed by competent staff lead to greater efficiency and effectiveness of services. Services can be most successful when they proactively address the person's needs and strengths and the person and their family are educated about how to be most successful living with the disorder. When you have great identification and awareness it becomes a secondary prevention function in which you prevent many other problems and costs for the individual and to “the system”.

The field of intellectual and developmental disabilities is ahead in some ways of the brain injury field in this area with their identification of individuals and focus on developmental care and planning model(s). Brain injury is often missed and subsequent problems and cost to the individual are quite high. Therefore, it is critical to have a process that identifies individuals with neurocognitive disabilities early and to do this training of the current workforce is absolutely necessary. The expectation should be that individuals in known high risk subpopulations have higher rates of neurocognitive disability rather than the exception (e.g. assessment to rule-out brain injury in persons who are homeless, returning service members/veterans, persons with criminal history/offenders, those in mental health and/or substance use disorder treatment, Native American, Native Alaskan, victims of domestic violence, etc.) Success in this area depends partly on staff being highly trained as well as providing resource for early detection such as funding for screening.

## **Steps to Success**

1. Annual training requirements for psychologists or other qualified individuals to assess for neurocognitive impairments and resulting functional impairment
2. Universities are required to include coursework and professional training for all students going into health care fields in order to broaden the network of professionals qualified to assist in the identification process
3. Standardized screening for brain injury is universal and funded
4. Mandatory education and training of a wide range of health and human service, criminal justice, and education professionals to assist with early identification. Persons with undiagnosed neurocognitive impairments are likely to be seen in health care and other settings where professionals are in a position to assist with identification and make referrals for further assessment.

## ***8. There is a prompt response to identifying and supporting individuals with neurocognitive disability who represent new populations***

Populations new in our area, such as new immigrants, returning veterans and other groups who share common characteristics are proactively identified by the service system. Partnerships are developed with these groups and their friends and allies to foster effective work with them in identifying and effectively supporting people within these groups who have neurocognitive issues. Developing these processes also includes ways for supports and providers to identify options and services that fit with the culture, including military culture, while respecting where individuals are in addressing these needs. This approach to identifying new communities likely involves working with communities who may not be familiar with services being provided, the need for the services, and the fact that most services can be provided in the community. Identifying new populations early and reaching out to them in an effective way is critical

because the group may have reasons to avoid traditional medical care or to refrain from reporting problems, and thus slip through the cracks in assessments.

### **Objective**

New populations will receive needed services at least at the same level or quality and availability as the existing population.

### **Steps to Success**

1. Partnerships created between DHS, refugee resettlement organizations, county planners, state demographer, and both traditional and nontraditional community providers to report on new populations either anticipated or emerging
2. Development of a process by which to engage new populations in identifying their experience with and perspective on individuals with neurocognitive disorders
3. There are strategies for learning about cultural perspectives on disability while also informing new populations about support and services for those individuals and their families in a culturally sensitive manner and understanding potential services that could be developed

### ***9. People are encouraged to consider employment and have meaningful jobs with support available as needed***

Based on their interests, needs, and abilities, people have hope and the option to choose to work, to not work, or to retire. While meaningful activity is of benefit to everyone, this element is limited in scope to those individuals who would like to be employed. Services and resources proposed to meet this goal for individuals with neurocognitive disabilities include:

- Support coordinators and range of positive messages about work and providing access to financial benefits analysis and counseling
- Supports to help people find jobs from an array of options, keeping in mind their individual needs and work histories as well as interests and goals
- Timely availability of services to help people maintain jobs and change to support continuity in employment
- Services to help develop and maintain technical, job seeking, interpersonal and navigational skills in employment
- Services that are financially feasible
- Services that include options for entrepreneurial endeavors, including small business grants
- Supports to employers to provide education and opportunities to get to know people receiving neurocognitive services
- Employment that offers flexible schedules with support from employers, transportation providers and support teams to maximize the person's abilities, preferences, and goals.

### **Objectives**

The impact would include securing and maintaining meaningful employment for individuals receiving neurocognitive services, with supports provided when needed in a manner that provides coaching and support and is based on the needs of the person.

### **Steps to Success**

1. Employment services are provided to all individuals interested in employment, regardless of their identified potential for work by professionals.
2. Employers consider creative options for employees, including telecommuting, flexible schedules, an array of employment options and focus on getting to know the person and their needs as an employee.
3. Benefits analysis and counseling result in no financial disincentives related to working for individuals receiving neurocognitive services.
4. Retirement or not being employed should be an option for individuals if they choose.
5. Working is an option for all individuals if they have an interest. Both paid supports and related family communicate hope and positive impact related to work and availability or benefits analysis to guide informed choice.

### ***10. There is a high level of public education and awareness about the identification and prevention of neurocognitive disabilities and how to support individuals with those disabilities***

Public awareness is critical to the success of the general effort. However, there must be careful planning as well as resources for people to readily access. Partners must include Department of Education and the Department of Health with their key roles in this area and others such as ARC, Brain Injury Association of Minnesota. This education is also important in conjunction with training, building relationships, and empowerment. It is important to educate members of the community in faith organizations, neighborhood associations, schools, recreation centers, clubs, service organizations and work places that people with neurocognitive disabilities are valued and contributing citizens. Their needs are similar to those of all people in society and they want to be included and involved citizens. Stereotypes exist about people with neurocognitive disabilities that need to be dispelled. While we have come a long way in building bridges to the community there is still much work to do in including people with neurocognitive disabilities in our communities as co-workers, neighbors, friends and allies. A carefully thought out marketing and public awareness strategy that is coordinated with the efforts and resources of others is essential.

### **Objective**

The number of individuals affected by neurocognitive disability is underestimated and an effort at public education would not only help reduce stigma but identify individuals who could be helped.

### **Steps to Success**

1. A website with information about neurocognitive issues and services is created which is user-friendly. It appeals to many different age groups and is in multiple languages
2. Public service announcements appear on television and on the internet
3. Department of Education creates mandatory curriculum on neurocognitive issues benefiting from partnership with MN Department of Health who have already developed a brain injury educator's manual and teacher competencies
4. Stigma is eradicated.

## ***11. There is technology that works for people***

Technology includes a vast array of objects, items, systems and arena. While it is difficult to keep up with the advances in technology, these advances and innovations will continue at an ever increasing pace even after 2015 and require a way of tracking and tailoring to the unique needs of individuals with neurocognitive disability. Technology is currently available which has the potential to increase people's independence, safety, continuity of care, choices, and connection with the community. It is essential that as a service system we keep up with and use technological advances to maximize available resources and create efficiencies and greater independence for people with neurocognitive disabilities. Specific benefits include:

1. Assistive technology will increase efficiencies and decrease frustration for people as they become increasingly active in their lives
2. Continuity of care such as "telemedicine" will allow for access to services and supports when a person needs them and the ability to increase integrated services
3. Monitoring technology will allow for better care, and increased privacy, service options, housing options, and resource efficiencies
4. Individuals will be educated on possible technology options, skills necessary to use the technology, resources to pay for the equipment, their rights, and the appeal process

### **Objectives**

People and financial resources will be used more efficiently to the satisfaction of individuals across disability groups who experience increased independence, safety, continuity of care, and choice because of the technology.

### **Steps to Success**

1. Procedures for funding and policy are able to keep up with new technology
2. Individual services are not tied to any funding or disability group
3. Individuals have opportunities to be educated about possible options for the use of technology (not just those currently available or used)
4. People have resources available to assure their needs are met
5. Technology is a tool to help create and support flexible, comprehensive, etc. services for those we serve
6. People identify technology that enables them to live independently longer

## ***12. The needs for safety for the individual, support, staff, and public safety are addressed everywhere***

As noted in the Introduction to this report, there are a percentage of persons with a neurocognitive condition who cannot be served in the community in a manner consistent with public safety. Many of the persons within this subgroup have criminal histories, and they may be subject to correctional or commitment supervision or institutionalization. However, community inclusion presents many beneficial opportunities for the majority of people with neurocognitive challenges... Community inclusion presents many beneficial opportunities for people with neurocognitive challenges and beneficial opportunities for the community. At the same time these opportunities can at times present concern for personal and public safety. Thoughtful planning and intervention to address these safety concerns include safe environments for the

person, safe and accessible communities for the person to live in, training for public safety workers to help with understanding needs and interventions, and access to flexible support services and appropriate levels of care when and as they need them. Addressing this special need requires concerted efforts toward appropriate placement, skilled services, and safety measures for staff and supports. A service that would work to support this would be a nimble crisis team to help provide services in the community and prevent re-hospitalization or return to a correctional setting.

### **Objectives**

1. Public safety workers such as law enforcement, criminal justice personnel and crisis workers will understand the needs of the person and be able to better assist during times of crisis
2. Families and caregivers will understand how to support and respond to the person's needs and feel safe around the person
3. Resources are provided to the person proactively to prevent crisis
4. In situations where the individual's needs are temporarily being met in a forensic or correctional setting for safety reasons, there are highly trained professionals with knowledge of neurocognitive disabilities who assist in understanding the needs and determining the provision of services
5. Communities are safe and accessible to the person

### **Steps to Success**

1. A plan is developed to educate communities on people with neurocognitive needs and the benefits of community integration for these individuals and the community
2. Individuals are provided access to proactive resources to assist in identifying and addressing neurocognitive needs and community integration
3. Communities develop plans to address safe and accessible living communities for individuals with neurocognitive challenges.
4. Families and caregivers are provided support and education in understanding and responding to persons' needs
5. Trauma debriefing services are available for persons served and their supports
6. Training such as Crisis Intervention Training (CIT) is provided to all Public Safety Officers, ambulance response agencies, and hospital first line providers
7. For services that already include CIT, services are enhanced with more intensive training in understanding behavior common to persons with neurocognitive needs and how to work effectively with people through more nimble crisis response teams

## Potential Outcome Measures

The following outcome measures, while appropriate for some general services provided across our system of care, are specifically identified for individuals with neurocognitive disabilities because of their strong relationship to the impact and success that is expected when effective supports are provided to this group of consumers. Outcome measures also address the needs, access to resources, and satisfaction of family and significant people in the consumer's life.

### Empowerment

- People receiving the services are asked if they are satisfied and how to improve their services and supports. Improvements are implemented in response to issues identified. This process is actively repeated on an ongoing basis and is the core mechanism for ensuring both individuals' satisfaction as well as appropriate and effective use of services.
- Individuals with neurocognitive disabilities residing in the community report high levels of choice, control, and satisfaction over those things that are most important in their life.

### Housing

- The percentage of people that report living in their preferred housing option.
- The level of stability and satisfaction with their housing situation.
- People return to their housing after hospitalization or change in funding mechanisms.
- Caregivers and other support staff view assisting a person in finding, securing and maintaining housing and or work as keys to successful treatment.

### Relationships

- Measure community's perceptions of support and interactions in the community
- Families and caregivers report understanding needs of the individual to support community integration and safety
- Measure person's satisfaction with interactions in the community
- Individuals report satisfaction with their relationships with friends and family, inversely, friends and families report satisfaction in their relationship with the person
- The number of participants trained on developing and maintaining appropriate relationships including a topic area such as conflict resolution

### **Employment**

- Employment statistics within the state of Minnesota demonstrate an increase in the sector of individuals with neurocognitive disabilities

### **Detection**

- The number of persons screened with the best available tools
- The number of referrals for neurocognitive services for individuals screened positive
- Screening is routinely conducted in a wide range of service areas in which neurocognitive disability is expected such as corrections, shelters, tribes, and people at higher risk for concussion like athletes, people in substance use disorders treatment, history of suicide attempt, etc.

### **Emerging Populations**

- The percentage of persons in the emerging population group who seek assessment versus the general population is roughly proportional with state demographics and in line with the unique needs of each population.
- The percentage of persons in the emerging populations who seek treatment or services after being assessed versus the general population.
- Members of emerging populations arriving to Minnesota are offered help and support in identifying individuals with neurocognitive disability in a manner that fits with their cultural expectations
- Individuals with neurocognitive disability and their family/supports arriving in Minnesota as part of an emerging population report feeling welcomed, understood, and respected.

### **Level of Care**

- There is a decrease in emergency room visits, number of psychiatric hospitalizations and the length of hospital stays, without associated increase in other institutional or transient care such as corrections facilities, nursing homes, and homeless shelters. This decrease will be associated with an increase in the number of people who receive services or crisis support in the community.
- Trend analysis on service utilization and expenditure data are conducted annually and reported to all stakeholders. Ideally, there would be measurable movement/progress on those relevant issues identified within the Statewide Needs and Resource Assessment and other reports
- Providers, support staff and family view assisting a person in finding, securing and maintaining employment to be a key to successful treatment and support.
- Even the most specialized, intensive services are readily available in Minnesota for persons of all ages

### **Public Awareness**

- Students have basic knowledge about neurocognitive disabilities
- Community providers report that individuals they serve readily answer questions about neurocognitive issues

### **Safety**

- Staff, clients, and community are safe as noted by facility, program, home, and community measures
- Public Safety officers are evaluated on knowledge of increased risk populations, identifying and understanding the needs of the individuals with neurocognitive needs
- Training such as Crisis Intervention Training (CIT) is provided to all Public Safety Officers, ambulance response agencies, and hospital first line providers
- The impact of CIT training is measured
- Communities have plans to address safe and accessible living for individuals with neurocognitive challenges.
- Supports have access to proactive resources to assist in identifying and addressing neurocognitive needs and community integration issues before they become a crisis

### **Workforce Development**

- Staff receive regular training and clinical supervision that supports their growth and development in working with individuals with neurocognitive disorders
- Consumers rate provider performance at or above expectation on performance reviews
- Work with persons with neurocognitive impairments is seen as desirable and a sought-after career path
- There are policies in place which require annual training for all who have a role in the support of this population (MD's, clinical social workers, educators, vocational counselors, public health, mental health, chemical dependency counselors, law enforcement, courts, and corrections)
- Numbers of credentialed staff to skillfully support individuals with neurocognitive disabilities and their complex needs
- Community providers conduct or refer individuals they serve to readily accessible trained assessors to help identify strengths and needed services in the context of the individuals' preferences, priorities, and readiness for change

### **Technology**

- People use technology to their level of desire and satisfaction

## **Conclusion**

Neurocognitive disabilities are everyone's concern as a result of the high frequency with which individuals with mental illness, developmental disability, substance use disorders and high risk populations demonstrate challenges in this area. The 12 elements recommended as a conceptual service model share some core features that highlight the need to not only take note of the overlap between elements but with other initiative work group proposals as well. These core features begin to establish new expectations for who the people we serve are and the best ways to address their needs such as:

- Co-occurring disorders should be an expectation not an exception for many of the people that we serve and
- Neurocognitive limitations or disabilities are also an expectation, not the exception, for a large number of those people with co-occurring disorders.
- Prevention can be thought of as primary or secondary depending on when and how we identify neurocognitive issues and support those individuals
- In order to support individuals it is important to understand their developmental and recovery trajectory through ongoing evaluation of individual needs and preferences with their direct input; and
- Many of the most significant challenges people with neurocognitive disabilities face have more to do with basic fundamental needs of them as human beings. They need stable housing, jobs, people in their lives that love and care about them and they need to be listened to and empowered to make decisions about their own lives. Services and supports fundamentally must focus on things other than interventions and treatments and in proactive and on-going ways ensure housing, employment, relationships and meaningful lives for people with neurocognitive disabilities.

## **Follow-Up Cambridge Neurocognitive Redesign - Program Review**

### **PROBLEM AND BACKGROUND**

On August 23, 2010 the DHS CMHS Neurocognitive Redesign Work Group presented its recommendations to the Legislative Transformation Advisory Committee resulting in a follow-up request made by the advisory committee membership. The current summary report is submitted on behalf of the Neurocognitive Redesign Work Group in fulfillment of the request to review the proposed METO program conversion to a specialized subacute intensive residential treatment program against the 12 essential elements comprising the work group's conceptual model recommendations. Caution must be used in use of this report as the materials reviewed were originally generated for purposes of establishing a mental health Intensive Residential Treatment Services (IRTS) program and are limited in depth and scope of the program description. Further, it is apparent that reliance on IRTS licensure application material does not promote focused attention to the complexity and co-occurring nature of the conditions presented by those being served by the program nor the innovation and richness of the person centered approaches that could be used to address those needs. Discussion in the work group regarding the Brainerd program resulted in the same concerns and considerations.

## **EXECUTIVE SUMMARY**

The proposed program reveals both strengths and challenges in its demonstration of various elements proposed by the Neurocognitive Work Group. Strengths include a person centered and recovery perspective while challenges are noted in a striking lack of focus on the two co-occurring specialties beyond mental health, people with substance use disorders and neurocognitive disability. In the end, the program does not reach its full potential in the current licensing application proposal as it is meant to meet the system where it is today, as a way to move forward in helping individuals who have become stuck in that facility, rather than being able to proactively meet people where they are. Themes that emerged from critical review of the 16-bed program licensing application were:

- The application refers to the use of integrated dual disorders treatment as an evidence based practice within the program service but is generally silent about more specific strategies to address these issues within various clinical process phases such as screening, assessment, treatment planning, and aftercare. The proportion of individuals admitted with co-occurring substance use disorder is estimated to be approximately 10%.
- The application appears tied to a funding stream dependent on IRTS waived service being a mental health service and seems to short sell the cognitive disorders which will be a significant disability in conjunction with co-occurring mental illness. However, discussion by the group also acknowledged that Cambridge has been a specialty developmental disability site whose staff is now in a position of needing to address mental health in a more direct and thoughtful way.
- Staff training and expertise seems focused on mental health issues. There is little acknowledgement of the neurocognitive expertise that staff must have to help the people they serve succeed in the program and after they leave regardless of the level of cognitive functioning or complexity of their condition. This challenge seems to be a secondary effect of needing to generate an application for mental health problems rather than being able to address the real issues of multiple co-occurring conditions.
- In the section of the application where program content is described there is not a connection made between this and the evaluation outcomes which are mentioned later in the documents.
- The section that outlines staffing levels does not talk about how staffing levels match up to need. Staffing levels also did not seem to talk of transitional staffing pattern to ensure success. A provider in the room indicated that this is often true of non-community based treatment programs. A consumer may do well in a structured program setting but may only maintain that level through continued high service and support in another setting.
- More than any other group, there is a need to minimize the number of transitions this group of people serve must make to find their way into a home. Transitions are particularly disruptive and decrease the chances of success.
- The role of family relationships is addressed through family psychoeducation but proposal description is minimal

Significant discussion was held regarding this proposal serving as preliminary guidance and structure with three additional services available to address higher and lower acuity needs as well as transitioning of the individual across different levels of care. These ancillary services include:

1. Enhancement of acute psychiatric services to meet the specialized needs of the most acute individuals with neurocognitive disability should intense assessment and stabilization be needed
2. Two 4-bed transitional adult foster homes for individuals whose past histories include behavioral challenges which jeopardize placement and that would benefit from the opportunity to demonstrate successful community integration with the supports they need. This is an initial step in creating homes with appropriate levels of support for individuals.
3. Enhanced support coordination and augmented community service array options provided by a designated Community Support Services team

### **PROCESS/METHOD**

Two sources of information were used in conducting the current review. First, group members received a draft version of the application for licensing of the facility as an Intensive Residential Treatment program. Members were reminded to use caution in over-interpreting the material provided as its purpose was to qualify the program as a mental health rehabilitation and as such spoke primarily to operational features of the program more than principles, program implementation, or role of the service within a broader continuum of network services. In order to introduce planning of broader continuum of care services the group received a 20 minute presentation by Mike Tessneer, State Operated Services CEO, specifically regarding ancillary support services proposed to assist in supporting transition of individuals no longer needing hospital level care provided by the former METO to more independent community supported living options.

Factors that impacted the review were: 1.) Participation and presentation by the program developers was not possible and not conducted, 2.) other materials such as the procedure manual were not available for review, and 3.) the design of the program continues as of this writing and will benefit from feedback provided by the group.

### **OVERARCHING ELEMENT – People with neurocognitive disability lead meaning lives in the community**

The program design and methodology section of the proposal clearly states, “The goal is to provide clients what they need, when they need it, and where they need it so they can live in the community.” This embodies a person centered philosophy and reflects the large overarching core value of the NC group of individuals leading meaningful lives in the community. However, additional detail and description as recommended would greatly add to readers’ ability to see how that is operationalized in concrete and creative ways.

The scope of service indicates that the program will offer an array of treatment services that includes evidenced-based practices, and community engagement model to increase client stability and recovery, leading to increased community tenure with a goal of successfully integrating clients into the community and transitioning them into permanent housing.

### **DESCRIPTION OF FINDINGS LISTED BY CONCEPTUAL MODEL ESSENTIAL ELEMENTS**

Results of the review are presented by essential element. The majority of information connecting back to the essential elements is found in the first paragraph of the proposal (i.e. Philosophy/Mission Statement of Purpose)

<b>Essential Element</b>	<b>Feedback</b>	<b>Recommendation</b>
<p><b>1. People are empowered to direct their lives and the services they need to live where and how they want to live</b></p>	<p>The tone of the proposal is positive and in keeping with the type of licensing avoids a patriarchal model in which treatment is done to patients and their disorders and focuses instead on a more holistic approach to the whole person in which “the client has the central role in defining their treatment and goals.” The program is described further as “an alternative to an institutional placement or unnecessary inpatient hospitalization.</p> <p>One key goal of the program is, “To promote rehabilitation and recovery for clients with developmental disabilities or neurological impairment and co-morbid serious mental illness, and to encourage the highest possible level of independence and self-determination for each person we serve by emphasizing individual and group responsibility and decision making.”</p> <p>The assessment described is a traditional assessment which could be enhanced for the consumer’s benefit.</p> <p>Individuals are described as having “an individualized treatment plan that is person-centered, strength based and that promotes recovery and rehabilitation if appropriate.”</p>	<p>It was acknowledged that the treatment program will at some level be, for most people, not what they choose but rather what is chosen for them during times of psychiatric decompensation or behavioral instability. A recommendation is to ensure recovery goals, individual options, and choice within the program framework is supported as much as possible and more fully described.</p> <p>This could be enhanced by adoption of a formal shared decision process supported by policy and including development and dissemination of decision aids for consumers.</p> <p>The area of strengths could be augmented by inclusion of areas critical to empowering people like their personal preferences, priorities, and recovery goals.</p> <p>It could be made more directly clear that part of the purpose of this is to empower individuals in their own treatment.</p>

	<p>Discharge criteria can empower people when indicating that one of the criteria is “Successfully completed program...with mutual agreement between client, his or her legal representative, and program staff to terminate services.”</p> <p>Peer led self-help and support groups are included as part of the program services which are person centered and recovery based depending on the consumer’s readiness and preferences</p>	<p>This could be enhanced by introducing a share decision aid as a tool communicate choice and empower individuals</p> <p>Should ensure that choice remains in place even with these services.</p>
<p><b>2. People have their choice of living arrangement in the community with neighbors and roommates (if they want them) of their choice</b></p>	<p>Limitations in an area like living arrangement is one of 4 areas considered in DSM criteria for mental illness.</p> <p>While availability and offering of “transitional housing alternatives” as part of the Cambridge plan begins to address this essential element, the consensus is that transitions for these individuals is a barrier to success and disruptive. An enhanced support coordinator out of Community Support Services (CSS) is also part of the plan with a key role in helping people make transitions, being consistent advocates no matter</p>	<p>While acknowledging that in order for 15 individuals served at Cambridge to move to more independent living the immediate plan requires transitional housing with supports, the NC group strongly recommends that the challenges and issues relating to this condition be actively pursued with stakeholders, including counties, and addressed through a systematic process proactively in order to move the program into a place where permanent living arrangements are developed for individuals to enter following treatment.</p> <p>Related to this is the group’s recommendation that all efforts be made to ensure services, including crisis, are provided at or near the home with preservation of the individual’s home should treatment at a facility be required. This would require review and revision of policy and funding.</p>

	<p>where the person receives services from or by whom, and ensuring all supports and providers are aware of the individual’s goals, strengths, values and wishes.</p> <p>A goal of the program is, “To develop a model of Person-centered treatment, intervention and support, which helps clients to become integrated and functioning members of their community leading to a transition to permanent housing.”</p>	<p>This is good to see because it alludes to the very highest core element of the group for individuals to lead meaningful lives in the community. Describing this in more detail is going to be important to ensure that the program is as actively focused on how it delivers care in a way that meets the 12 essential elements.</p>
<p><b>3. People have relationships and connections to people they like and with whom they want to be connected</b></p>	<p>Part of the referral/intake process includes obtaining a “list of community resources that client was previously accessing and currently has been referred to for aftercare plans.” This is a positive continuity piece that could be enhanced further.</p> <p>The program’s independent living skills development includes social and interpersonal skills development</p> <p>Program services include socialization services through community programs, outings to the local Community Support Program but does not include use of established relationships in the community also as an avenue to do this. The area of recreation and leisure also focuses on offering the opportunity to provide socialization through community programs with an absence in the use of family or supports for this role.</p> <p>Motivation and re-motivation services are included in program</p>	<p>Working with identified family and supports can enhance this greatly. Community resources could be broadened to include relationships that are supportive and important to the individual.</p> <p>Incorporate relationships and family as part of socialization services. Don’t forget to include those individuals who are anticipated to provide support in the community and involve them early in the process when possible.</p> <p>Motivational interviewing by staff is entirely appropriate but also</p>

	services but limited to using motivational interviewing technique	consider adding natural and peer supports to engagement strategies where appropriate
<b>4. Families feel supported both as individual family members and as a family unit</b>	Family is only described in the context of people staff will collaborate with but not in what way or in a broader context of how they themselves will be served or involved.	Look for more opportunities to include identified family in important clinical processes that can generalize back to the community and support recovery of the consumer as well as family what the family needs to fulfill this role on a long-term basis
<b>5. People have support coordinators who know and understand them and their unique situation and advocate effectively for them based on taking the necessary time to learn their personal story</b>	<p>One of the program services offered is crisis services which does not appear to have the support coordinator role formally integrated</p> <p>The social services role for the program seems comprehensive but does not incorporate that service's role or interface with a support coordinator or indication if that is the support coordinator.</p>	<p>Include support coordinator in crisis services</p> <p>Include the program social services, county case management, and support coordinator roles in this program</p>
<b>6. People have highly trained staff who they choose to provide their support that are energetic, positive, motivated and who communicate hope</b>	<p>The program proposal includes a description of staff as developing "skills in critical thinking to respond to ambiguous situations with creative solutions that balance risk, recovery, and safety.</p> <p>There is a section, "Client is actively involved in treatment or if not actively involved, staff document the stage of change and their attempts to engage and persuade active participation." This area is one in which having</p>	<p>An opportunity is not available or is missed to ensure that staff performance includes a positive attitude and desire for working with and supporting individuals with these complex conditions and behavioral challenges.</p> <p>Staff training description could be more specific toward content areas linked to competencies necessary to serve these individuals in person centered and effective ways.</p> <p>This is again a place where staff will want to work with the support coordinator to help identify those goals and activities toward which the consumer has preference and gravitates in engaging people who get "stuck."</p>

	<p>highly trained staff will make the difference between program failure and consumer success.</p> <p>The proposed plan includes a list of core competencies to be held by staff in motivational interviewing, Integrated Dual Diagnosis Treatment, Harm Reduction, Person-Centered Planning, Behavioral assessment and treatment modalities, and Illness Management and Recovery but no mention of attitude and values</p> <p>Training is described in generic terms only and a full training plan was not available at the time.</p>	<p>Recommend that the desired beliefs, attitudes, and values which help staff be successful with this group of individuals be incorporated.</p> <p>Should be made clear that curriculum and training are selected and provided with a goal of training staff to high levels of competency and quality necessary to help people with neurocognitive disabilities meet their goals and successfully move toward meaningful lives in the community.</p>
<p><b>7. There are processes in place to identify persons with neurocognitive disability who need their service</b></p>	<p>Criteria for admission are provided as standard requirement for licensing but there is not a broader discussion of how individuals needing the service might be ensured of access as appropriate</p> <p>The description of the program’s pre-admission process suggests an opportunity to address capacity to identify persons with neurocognitive disability who need this service.</p>	<p>Similar to other areas, this simply requires a broader description of the core program and its ancillary services as part of a larger care model to support these individuals where they are. How could marketing be done in a way that increases awareness and understanding of problems these consumers have and the services available to help them?</p> <p>Develop a training program for pre-admission staff to communicate details of the program and criteria to facilitate their ability to help serve the function of this essential element</p>
<p><b>8. There is a prompt response to identifying and supporting</b></p>	<p>Not addressed</p>	<p>This would more likely be a system role for Centralized Pre-Admission of or Community Support Service</p>

<p><b>individuals with neurocognitive disability who represent emerging populations</b></p>		
<p><b>9. People are encouraged to consider employment and have meaningful jobs with support available as needed</b></p>	<p>Limitations in an area like work is one of 4 areas considered in DSM criteria for mental illness.</p> <p>Program services include independent living skills development which address employment related skills but do not address how or at what level</p> <p>Work is addressed through vocational services section of the plan.</p>	<p>This area could site strategies similar to the evidence based practice of supported employment which relies on matching the person’s interests, readiness, and abilities with employment or pre-employment activities that meet them where they are in this important area of their life.</p> <p>The recommendation is the same as above regarding reliance on a staging approach based on the person’s interests, readiness, and abilities.</p>
<p><b>10. There is a high level of public education and awareness about the identification and prevention of neurocognitive disabilities and how to support individuals with those disabilities</b></p>	<p>The proposed program includes an advisory committee called the Community Liaison Committee which has been established and meets quarterly. Program consumers, community human services providers, law enforcement, and business leaders from the Cambridge community are represented at each meeting. The meeting is open to anyone interested which facilitates public education and awareness.</p>	<p>While the Neurocognitive Work Group made recommendation at the time of the meeting for the addition of regional county representatives, discussion with Paula Halverson at a later date indicated that regional counties are anticipated to attend.</p>
<p><b>11. There is technology that works for people</b></p>	<p>Not addressed</p>	<p>Examples of technology to help balance privacy and safety cold be addressed</p>
<p><b>12. The needs for safety for the individual, supports, staff,</b></p>	<p>There are several places which describe goals of the program as including the ability to provide support for the individual in an</p>	<p>This is in line with the safety element as discussed by the NC work group.</p>

<p><b>and public safety are addressed everywhere</b></p>	<p>environment that helps them balance risk, recovery, and safety</p> <p>The Community Liaison Committee includes law enforcement and provides an opportunity for raising awareness of the needs of these individuals, eliminating stigma where it exists, and collaborating in managing safety in the best interest of individual's served.</p>	
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**CONCLUSIONS**

It is the work group's opinion that in pursuing an application for an intensive residential treatment (IRT) program, licensing has driven the program which has dictated treatment service, which has established staff training and competencies resulting in a mental health program providing evidence based practices rather than a specialized integrated treatment program for individuals with complex co-occurring conditions.

While a rapid change in licensing and funding are unlikely, it is anticipated that these will be top priorities to truly move the system of care from meeting people where it is today to meeting people where they are by 2015.

**OPPORTUNITIES FOR UNIQUE CONCEPTS & INNOVATION IN PROGRAM DESIGN**

- Enhancement of the capacity and role of Community Support Services to fulfill the role of support coordinator as described in the neurocognitive report for those requiring this intensive community transition service to succeed. Services could be provided in a consultative team model through an array of neurocognitive experts providing a matrix of services such as wrap-around in the community, care coordination, and education/ training for the individual's constellation of personal and professional supports.
- Consider developing a waiver that gets away from identifying and serving one problem by having a "Waiver of One" in which a person's multiple co-occurring problems can be addressed in a person centered and holistic way. The work group believes that the population of individuals served in neurocognitive programs is ideal for looking at how a personal individualized waiver can help bridge the systems of care to meet the unique and complex needs of people with neurocognitive disability.
- Establishing minimum neurobehavioral capacity in future Level I Psychiatric Centers to provide an alternative strategy for qualifying individuals for the neurobehavioral level of waiver
- Creation of a new license for programs providing integrated services for co-occurring and complex conditions.

## **RECOMMENDATIONS**

Despite efforts at incorporating best practices for individuals with neurocognitive disabilities who experience co-occurring problems, the resulting licensing application and program foundation is hindered by the narrow scope of problems for which current licensing is designed to help address. Establishing a program under a mental health license detracts from the focus on neurocognitive problems and fails to take into account the integral nature of co-occurring disorders. Likewise, it can be anticipated that seeking licensing that addresses neurocognitive disabilities will minimize the focus on mental health problems and again leave the interactive effects of these conditions unaddressed. Planners and stakeholders are urged to develop a more creative way of licensing programs that provide them the freedom and financial support to tend to peoples' needs in this most challenging area of community reintegration.

# Access of Care Work Group

September 13, 2010



**Minnesota Department of Human Services**

**State Operated Services**

## Table of Contents

Executive Summary.....	3
Access Service Work Group Charter .....	4
Legislation.....	7
Work Group Membership .....	9
Sub-committee Reports	
• <b>Rapid Access</b> .....	11
Chair, Doug Seiler, Administrator – State Operated Services	
• <b>Psychiatric Collaboration</b> .....	14
Chair, Becky Secore, Children’s Mental Health Coordinator – Beltrami	
Area Service Collaborative	
• <b>Mental Health Urgent Care</b> .....	19
Chair Sue Abderholden, Executive Director - NAMI	
Recommendations.....	23

# **Executive Summary**

## **Background**

The 2010 legislation that changed the General Assistance Medical Care program included language regarding mental health urgent care and psychiatric care as a way to save \$32,000 in this biennium and \$477,000 in the next biennium.

The Access of Care Workgroup broke into three sub-committees: Rapid Access, Psychiatric Collaboration and Mental Health Urgent Care.

## **Charge**

The Chemical and Mental Health Services of the Department of Human Services charged this workgroup to create (provide or contract for) a statewide access function so that every person with an emergent or urgent mental and/or chemical health situation, who seeks a chemical health, mental health, or specialty health care service receives a resolution appropriate to the person's needs at the time. Specifically, the access function should:

- Complement, augment, and provide leadership for existing public resources for mental and chemical health screening, triage, assessment, consultation and referral services within Minnesota's mental chemical system;
- Develop a system that provides an appropriate resolution for every person referred to it and is based in relationships and collaborations with local community providers;
- Ensures that persons committed to the care of the Commissioner of Human Services for treatment have timely access to service options appropriate to their needs and the interests of the court that access to state operated services is contingent to being committed.

The first priority was to address the 2010 legislation.

## **Process**

- Review and clarification of Charge
- Presentations by:
  - Adult Mental Health Division
  - Children's Mental Health Division
  - SOS Centralized Pre-admissions
  - ITV and phone interviews with assorted providers
  - Questionnaire
  - Individual sub-committee meetings
- Wrap-up presentation for feedback of draft sub-committee reports

# ACCESS SERVICE WORK GROUP CHARTER

**CHARGE** – Create (provide or contract for) a statewide access function so that every person who seeks a chemical health, mental health or specialty health service receives a disposition appropriate to the person’s needs at the time. Specifically, the access functions should:

- Complement, augment and provide leadership for existing public resources for mental and chemical health screening, triage, assessment, consultation and referral services within Minnesota’s mental and chemical health system;
- Develop a system that provides an appropriate disposition for every person referred to it and is based in relationships and collaborations with local community providers
- Ensures that persons committed to the care of the Commissioner of Human Services for treatment have timely access to service options appropriate to their needs and the interests of the court and that access to state operated services is not contingent on being committed.
- The first priority is to address the 2010 legislation (see attached).

**RATIONALE** *Why does the project need to happen and how critical is this work? What issues or problems does it address? What improvements does it intend to make?*

- To streamline decisions regarding eligibility and level of care
- To develop a system of access that assists mental health providers and other first point of contact such as emergency rooms, primary care, and jails a simple consistent service entry
- Streamline triage and consultation in order to assist providers in making appropriate referrals
- Provide a simple process for getting the patient to the right level of service
- Provide integration and connection between primary care providers and mental health providers
- Provide psychiatric consultation at the first point of contact, particularly at emergency rooms and primary care facilities (often first point of contact). Note this might even reduce the need for higher level service if triage and assessment can happen between the two systems (primary care and mental health).
- Comply with 2010 legislation (see attached outtake).

Overall rationale “the right service at the right time for the right need”

**AUTHORITY AND BOUNDARIES** *What authority does the team have to directly implement change, to approve actions recommended by others, to recommend change in an advisory capacity, to pose options for discussion? Over what areas of the agency does it have those authorities?*

The Access Service Work Group is advisory to the Assistant Commissioner of the Chemical and Mental Health Services Administration. The work group is to recommend implementation

strategies, policy changes, and legislation necessary to achieve the charge of the group. This advice will be employed as the AC sees appropriate in the SOS Redesign and future policy and direct service initiatives of the Department of Human Services. The workgroup will not address transportation or access to chemical abuse treatment, both are addressed by other groups. It will address chemical health treatment providers as an access point to mental health services.

Proposals from the workgroup must be:

- 1 Efficient – proposals should produce the most value from existing resources;
- 2 Realistic – proposals should use available resources and technology;
- 3 Effective – proposals should be based in what works, relying on evidence-based practices, best practices, and data-based evaluation of proposed systems, activities, and procedures.

**METHODS** *Mention any expectations you have about how to go about the project, understanding that you do not need to identify all steps and tasks. Indicate the level of complexity and risks that will need to be addressed.*

Convene a stakeholder workgroup representing those involved with access, referral, intake, and discharge. The workgroup should geographically represent all of Minnesota. Use whatever group processes are appropriate to design a system and establish stakeholder consensus on the viability of the system.

**DELIVERABLES** *What are the clearly defined results, goods or services produced during the project or at its outcome?*

- A recommended plan for implementing mental health and urgent care services as required in Laws of Minnesota Chapter 200, Article 1, Section 1. (See Attached)
- A recommended plan for integrating the mental health and urgent care services with the intake process for state administered direct services and coordination with local community mental health and health care services.
- Data-based evaluations of all proposed elements.

Other policy, legislation, and budget recommendations which are needed to support the Access Function Plan.

**TIMELINE** *Mention any expectations you have about when the project will start and end; and any requirements for frequency of meetings. Indicate the level of effort and anticipated resource constraints.*

The target date within the workgroup for the first proposals is May 11, 2010. The final design of the Access Function must be completed by July 1, 2010; the supporting policy, budget, and legislation recommendations can be completed by August 1, 2010.

**TEAM MEMBERS** *Who should be involved in the project and in what roles? Include a project manager and project staff.*

## Access of Care Work Group Membership

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**Attachment: Out Take of MN Legislation**

**Laws of Minnesota 2010, Chapter 200, Article 1, Section 1**

**Section 1. [245.4862] MENTAL HEALTH URGENT CARE AND PSYCHIATRIC CONSULTATION.**

**Subdivision 1. Mental health urgent care and psychiatric consultation.** The commissioner shall include mental health urgent care and psychiatric consultation services as part of, but not limited to, the redesign of six community-based behavioral health hospitals and the Anoka-Metro Regional Treatment Center. These services must not duplicate existing services in the region, and must be implemented as specified in subdivisions 3 to 7.

**Subd. 2. Definitions.** For purposes of this section:

(a) Mental health urgent care includes:

- (1) initial mental health screening;
- (2) mobile crisis assessment and intervention;
- (3) rapid access to psychiatry, including psychiatric evaluation, initial treatment, and short-term psychiatry;
- (4) nonhospital crisis stabilization residential beds; and
- (5) health care navigator services that include, but are not limited to, assisting uninsured individuals in obtaining health care coverage.

(b) Psychiatric consultation services includes psychiatric consultation to primary care practitioners.

**Subd. 3. Rapid access to psychiatry.** The commissioner shall develop rapid access to psychiatric services based on the following criteria:

- (1) the individuals who receive the psychiatric services must be at risk of hospitalization and otherwise unable to receive timely services;
- (2) where clinically appropriate, the service may be provided via interactive video where the service is provided in conjunction with an emergency room, a local crisis

service, or a primary care or behavioral care practitioner; and  
(3) the commissioner may integrate rapid access to psychiatry with the psychiatric consultation services in subdivision 4.

**Subd. 4. Collaborative psychiatric consultation.** (a) The commissioner shall establish a collaborative psychiatric consultation service based on the following criteria:

(1) the service may be available via telephone, interactive video, e-mail, or other means of communication to emergency rooms, local crisis services, mental health professionals, and primary care practitioners, including pediatricians;

(2) the service shall be provided by a multidisciplinary team including, at a minimum, a child and adolescent psychiatrist, an adult psychiatrist, and a licensed clinical social worker;

(3) the service shall include a triage-level assessment to determine the most appropriate response to each request, including appropriate referrals to other mental health professionals, as well as provision of rapid psychiatric access when other appropriate services are not available;

(4) the first priority for this service is to provide the consultations required under section 256B.0625, subdivision 13j; and

(5) the service must encourage use of cognitive and behavioral therapies and other evidence-based treatments in addition to or in place of medication, where appropriate.

(b) The commissioner shall appoint an interdisciplinary work group to establish appropriate medication and psychotherapy protocols to guide the consultative process, including consultation with the Drug Utilization Review Board, as provided in section 256B.0625, subdivision 13j.

**Subd. 5. Phased availability.** (a) The commissioner may phase in the availability of mental health urgent care services based on the limits of appropriations and the commissioner's determination of level of need and cost-effectiveness.

(b) For subdivisions 3 and 4, the first phase must focus on adults in Hennepin and Ramsey Counties and children statewide who are affected by section 256B.0625, subdivision 13j, and must include tracking of costs for the services provided and associated impacts on utilization of inpatient, emergency room, and other services.

**Subd. 6. Limited appropriations.** The commissioner shall maximize use of available health care coverage for the services provided under this section. The commissioner's responsibility to provide these services for individuals without health care coverage must not exceed the appropriations for this section.

**Subd. 7. Flexible implementation.** To implement this section, the commissioner shall select the structure and funding method that is the most cost-effective for each county or group of counties. This may include grants, contracts, direct provision by state-operated services, and public-private partnerships. Where feasible, the commissioner shall make any grants under this section a part of the integrated adult mental health initiative grants under section 245.4661.

## **Rapid Access to Psychiatry Sub-committee Summary**

**Out take of MN Legislation: Laws of Minnesota 2010, Chapter 200, Article 1, Section 1.....**

**Subd. 3, Rapid Access to Psychiatry, The commissioner shall develop rapid access to psychiatric services based on the following criteria:**

- (1) the individuals who receive the psychiatric services must be at risk of hospitalization or otherwise unable to receive timely services:**
- (2) where clinically appropriate, the service may be provided via interactive video where the service is provided in conjunction with an emergency room, a local crisis service or a primary care or behavioral care practitioner and**
- (3) the commissioner may integrate rapid access to psychiatry with the psychiatric consultation service in subdivision 4.**

**Charge:** Create (provide or contract for) a statewide access function so that every person with an emergent or urgent mental and/or chemical health situation, who seeks a chemical health, mental health, or specialty health care services receives a resolution appropriate to the person's needs at the time. Specifically, the access function should:

- Complement, augment, and provide leadership for existing public resources for mental and chemical health screening, triage, assessment, consultation and referral services within Minnesota's mental chemical system;
- Develop a system that provides an appropriate resolution for every person referred to it and is based in relationships and collaborative with local community providers;
- Ensures that persons committed to the care of the Commissioners of Human Services for treatment have timely access to service options appropriate to their needs and the interests of the court that access to state operated services is contingent to being committed.
- The first priority is to address the 2010 legislation.

Other directives for the group: address specifically Hennepin and Ramsey County, children on a statewide basis and role of state operated services in these recommendations.

Subcommittee members were: Kelly Ashley, Mary Amundson, Gene Anderson, Brian Theine, Carlos Morales, Cathy Shea, Robert Jones, Lenore Barsness, Patricia Coldwell, Michael Peterson, Ron Brand, Mary Jo Verschay, and Doug Seiler.

What do we, as a sub committee, see in 2015 as it relates to **Rapid Access to Psychiatry?**

- ✓ **A credentialed psychiatric LIP can be reached in 60-120 minutes.**

**Measure:** There is a web based system in place to record system utilization that allows us to measure use of service and response time to each call. As part of this web based system there is also a location for providers of the service to provide feedback on

utilization of the system. Data is initially analyzed daily, weekly and monthly. Reports and analysis are on the Web Based system for users to evaluate.

- ✓ **In each jail and detention center there is a phone # that when dialed provides them access to live or tele-presence psychiatric services.**

**Measure:** A registry has been established that denotes what services each jail or detention center have. A Regional System is in place to fill in the gaps. The registry questionnaire has been of assistance in organizing the registry process.

- ✓ **Robust mobile adult and children's crisis teams are accessible across the state.**

**Measure:** There is a mobile crisis center in every region which is available/accessible to work with adults and children and provides, and upon request, collaborates with Emergency Departments, Jails and Detention in the provision of crisis services. Data Source: CMHSA Divisions

- ✓ **Mobil Crisis Team Services are reimbursable when provided in ER's , Jails and Detention Centers.**

**Measure:** A periodic assessment with Mobil Crisis Team Service Providers indicates that this group of service providers are being paid for there services in ER's, Jails and Detention Centers.

- ✓ **Shared care models exist across the state have psychiatric collaboration.**

**Measure:** shared care is defined, definition written, and consultation services are available upon request. Using Web Based system defined earlier.

- ✓ **People have confidence with the rapid access response process and it is tried and true.**

**Measure:** Web based feedback has been shared, self correcting module has addressed issues, feedback substantiates it is used and provider and user satisfaction with the system evident.

- ✓ **Rapid access model is regionalized, with written regional plans that demonstrate regional linkages etc in the event of significant crisis or disasters. Plans incorporate collaboration with other regional health care partners. (Plan has mutual aide tied into the plan and is linked with county emergency disaster response team.)**

**Measure:** Plan is written and functional model exists within each region of the state.

- ✓ **There are formal and ceremonial relationships between tribal independent nations and tribal independent nations and the state around rapid access to psychiatry.**

**Measure:** Regional plans demonstrative tribal involvement in their development. Agreements between independent nations and between independent nations and the state have been formally and ceremonially executed and are in action.

- ✓ **Rapid Access Service is global. (Meaning across the state of Minnesota with equal access to this service regardless of where the person lives, Metro or Greater Minnesota.)**

**Measure:** Web based data hits demonstrates access is equal and available.

- ✓ **Common language and assessment tool exists to access the need for urgent or emergent behavioral health care.**

**Measure:** Emergency departments, hospitals, clinics and their practitioners working in behavioral health have a common assessment which is used.

- ✓ **There are ongoing communication, education and evaluation plans in place which have been implemented around the Rapid Access Service.**

**Measure:** Web Based data evaluated, web page kept current, annual survey of users and providers is done, education plan is present and multi-media communication strategy implements with measures quarterly.

The subcommittee made no specific recommendations around Hennepin and Ramsey counties feeling this particular service **needed to be statewide**.

The subcommittee made no specific recommendations around children either feeling this service needed to address the needs of individuals of **all** ages.

The recommendation around SOS was that they would be **a platform for the regional planning for this service**. Their participation in the service may vary region to region from no involvement to significant involvement. This would be determined in the regional planning process.

## **Psychiatric Collaboration Sub-committee Summary**

The point of recognition and initial intervention for the overwhelming majority of mental health problems is not in mental health settings, but in the community. The Collaborative Psychiatric Work Group recommends that psychiatric consultation and collaboration be available for children and adults throughout a continuum of service needs in numerous community settings.

### **Introduction:**

The purpose of this document is to create a vision for our state that incorporates the capacity to promote health and wellness through rapid access to services that encompass a collaborative approach to physical and mental health. The Mental Health Access Work Group was convened specifically to address the need for mental health urgent care, and psychiatric consultation/collaboration.

The primary mission of the group is to create a flexible service delivery model that takes into account local service gaps and local resources. The model's primary focus is developing a system of care that utilizes psychiatric consultation and collaboration at all level's of care, with particular focus on urgent care.

### **1. What:**

- a. Psychiatric consultation
- b. Collaborative care planning to include mental health provider, case manager, physician, psychiatry (local and acute), mobile crisis, other as needed on a client basis
- c. Available on a full continuum of care to include psychiatric collaboration for screening, triage, acute, and chronic care
- d. To include care planning from screening to discharge planning
- e. The model should be flexible and allow for local input in regards to needs and resources

In summary we recommend a coordination of care model that takes into account individual/patient needs, and local resources.

### **2. Who:**

- a. Mobile Crisis Teams
- b. Emergency Rooms
- c. Jails and detention centers
- d. Primary Care
- e. Mental Health Clinics
- f. Psychiatrist to psychiatrist bridge (primarily discharge planning from acute care)
- g. Law Enforcement
- h. Public Health

### i. Tribal Indian Health

Psychiatric consultation and collaboration will be available for children and adults throughout a continuum of service needs in numerous community settings.

### 3. Where:

Available in local community settings that tend to be a first point of entry for people who are experiencing either acute mental health needs. The structured service coordination model will include global screening, triage, and psychiatric consultation in a primary care setting or other common settings such as emergency rooms, jails, schools, and mental health clinics, etc.

#### **Work Group Discussion:**

- Screening and triage are an important component in regards to preventative services and could play an important role in collaboration regarding services.
- Local resources and needs should be a primary consideration in developing the model
- Some regions have an excess of psychiatry and other resources – how do we share the wealth?
- Since psychiatrists and pediatricians are the only resource for third party billing in a collaborative model how do we sustain this model?
- There is an assumption that some of the consultation/collaboration will be provided by State Operated Services
- Consultation between acute care and local services should be a priority in on-going discharge planning.
- Consultation is not a billable service in many insurance company models
- Video technology is a very important component of any model that is developed
- Training will need to be provided to all partners
- The psychiatrist could be employed by an emergency center or contracted by the state.
- The model should not be focused only on acute/chronic needs, but should be a part of a broader comprehensive screening/triage/care coordination model.
- Community psychiatrists and community hospitals should have the privilege to admit to CBHH and be a part of a continuum of care plan.
- SOS psychiatry should provide follow up care.

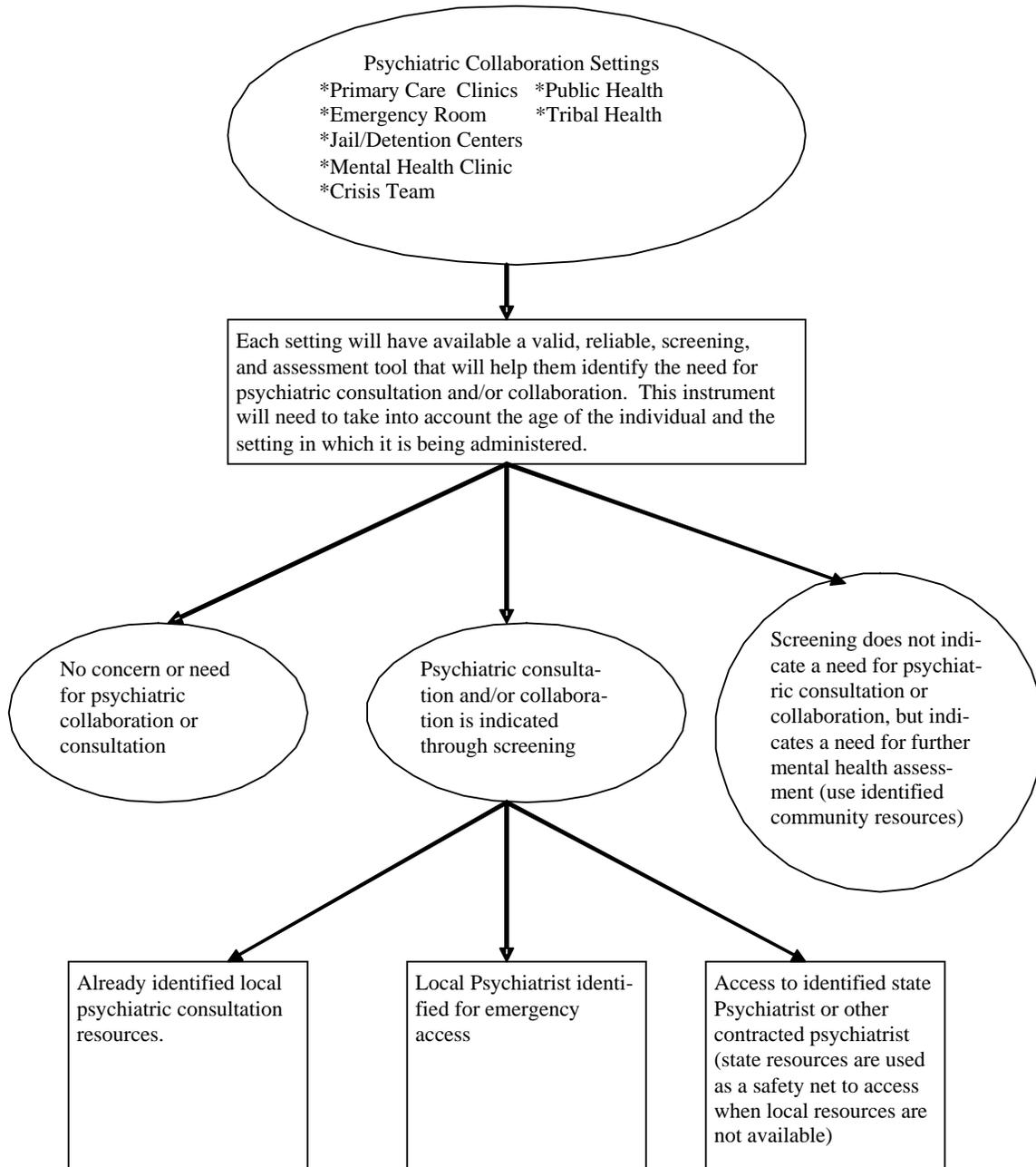
### **Group Recommendations:**

- Global screening, triage, and psychiatric consultation should be common practice for mental health services.
- Collaborative partnerships and relationships are the primary goal.
- Collaboration should also include education provided by the consulting psychiatrist.
- Psychiatrists provide consultation services for any patient referred from the identified providers (add possibly schools, law enforcement, and jails).
- A common simple screening tool will help determine the need for psychiatric consultation/collaboration (screening should be simple and fit the setting level of care and provide common language for collaboration).
- Collaborative care should be available psychiatrist to psychiatrist to bridge continuity of service and further service needs.
- Collaboration should exist from screening in a primary care setting to chronic and acute care in a variety of community settings.
- Collaboration should intervene ‘upstream’ to prevent the need for more expensive services.
- Existing examples of good collaboration should be used as role models.
- Integrating mental health care and primary care in service delivery and payment is a must to sustain any level of collaboration.
- Video technology is highly regarded as the solution.
- Collaboration should be available in local community settings that tend to be the first point of contact.

## Service Flow Chart

# Psychiatric Consultation/Collaboration

(A universal model that will be adapted to setting and local resources)



\* The same service model/flow chart can be used by primary care physicians prescribing mental health medication as identified by state statute #

**Outcome Measures:**

A tracking matrix will be used to:

1. Track the number of requests for psychiatric consultation and/or collaboration
2. Track to the number of people who get response to their requests
3. Track the type of consultation/collaboration (local or state)
4. Track the time it took to access psychiatric collaboration/consultation
  - \*60 to 120 minutes
  - \*within 72 hours
  - \*within two weeks
  - \*two weeks or more
5. Demographics
  - \*Who is requesting consultation or collaboration?
  - \*Age of identified patient
  - \*Location/setting of request

It is recommended that all participating resources track the above information.

**Summary:**

The group felt that the actual model was outlined very specifically in 245.4862 Subd. 4. Collaborative psychiatric consultation. However, some specific points were brought up that need to be clarified. As stated above, the consultation and collaboration need to be based on local client need and local resources. The service should be available at all levels of care from screening to acute care. Finally, the model needs to be financially sustainable for all providers who are involved in collaborative consultation.

## **Mental Health Urgent Care Sub-committee Summary**

As part of the Adult and Children's Mental Health Acts, counties have been required to provide or contract for enough emergency services within the county to meet the needs of children or adults in the county who are experiencing an emotional crisis, mental illness or emotional disturbance. As is true with all the requirements of both acts, this is not a strict mandate since there is a caveat that all sections of the acts are required to be done within available funding. It was not until 2005 for the metro area and 2007 for the rest of the state did we see crisis services covered under Minnesota's health care programs and direct funding available for the more full development of these services.

Two presentations were made by Mental Health Division staff so that the entire work group could understand the current state of crisis services in Minnesota. The information provided was very helpful in more fully understanding the scope of and state of crisis services.

### **Background**

In the adult system, counties have had emergency phone lines since 1988 which need to connect a caller to a mental health professional within 30 minutes and must be available 24/7. Using county funds, state grants and reimbursement from state and private health plans, additional crisis services – including mobile crisis - are now available in every county. These are generally regional crisis services with each region deciding how best to meet the mental health crisis needs of people in their area. In addition to screening, crisis services also include assessment, intervention, stabilization and community intervention. In many counties there is also access to residential crisis stabilization, health care navigator services, rapid access to psychiatry and transportation services.

In 2009, using data from the 20 grant funded programs, 4702 people were served with 43% served under a Minnesota health care program and 28% by another insurer. In addition, 35% of the people received services in their homes and 30% in a hospital emergency room. Suicidal ideation was the most common presenting problem (31%) followed by depression (26%) anxiety (12%) and psychosis (10%). Less than 11% were referred for hospitalization, roughly 30% were referred to outpatient mental health services and 12% were referred to a psychiatrist. Many were not in the mental health system, with 58% not receiving case management services.

In the children's system, counties also had emergency phone lines since 1988, and like the adult system when emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes. Thanks to the mental health initiative, 12 grants were provided for regional crisis services covering 57 counties. The components of the crisis system include assessment, intervention and stabilization.

In 2009, a total of 9861 children and their families received crisis phone line services and 3022 (31%) received mobile crisis visits. It is interesting to note that 60% were not in the mental health system. Many were under a Minnesota health care program (42%) or under a private health plan (32%). Suicidal ideation and out of control behavior were the main reasons for

referral (24% each) followed by situation (11%) and aggressive behavior (10%). After a mobile crisis team visit, 72% stayed in their home and only 14% were hospitalized and 25% were referred for therapy and 7% for medication management.

The subcommittee examined the requirements under both mental health acts, the Medical Assistance program and the grant requirements of the Mental Health Division in order to understand the full breadth of the current requirements for crisis services. There are numerous requirements related to staff qualifications, definitions of crisis and assessment, provider entity standards, components of a crisis treatment plan, supervision, records, and the scope of crisis stabilization services.

In addition the subcommittee developed a survey and distributed it to crisis teams. The survey asked questions regarding the type of mental health professionals on the crisis team (including psychiatrists, psychologists, etc.), the need for more mental health professionals on the team, if the crisis team goes into an emergency department, if staff are credentialed by the hospital, if the team works with the juvenile justice system or goes into the jail for crisis assessment, if they have Rapid Access Psychiatry, if they have adult crisis stabilization beds or crisis/respite beds for children, the types of screening assessment tools used, if the crisis team ever goes into the schools, and if they have a health navigator service.

The survey was sent to 38 teams with a 50% response rate. In looking at the professionals used on the teams only 16% had a psychiatrist on the team while nearly all had a licensed clinical social worker. Nearly half responded that they needed more mental health professionals on their team with 22% stating that they needed more nurses on the team but most mentioning the need for more Licensed Individual Clinical Social Workers. For children the teams used the Child and Adolescent Service Intensity Instrument (CASII) or Strengths and Difficulties Questionnaire (SDQ) but for the adults a variety of tools are used many developed by the teams themselves. Other interesting data include:

- 78% had staff credentialed by the hospital
- 39% conducted crisis assessments in jails
- 78% had rapid access to psychiatry
- 83% had adult crisis stabilization beds totaling 110 beds
- 16% had children's crisis stabilization beds or respite beds
- 33% had health care navigators and 75% of the ones that didn't want one
- 89% collaborate with law enforcement and 61% with Emergency Medical Technicians

In asking about unmet needs or unaddressed issues in their areas there were a range of responses. A common thread was the needs for crisis beds for children and addressing transportation issues. An additional issue for more rural areas was the difficulty with limited funds from being a true 24/7 service and access to medications on weekends.

Teams that are funded by the state are already required to submit data including:

- Referral source
- Primary reason for intervention
- Location of initial face-to-face assessment#
- Known/suspected alcohol or drug use at time of assessment#

- Services provided#
- Health care referrals
- Case management information
- New or repeat call
- Immediate disposition
- Mental Health crisis plan availability\*
- 12 month mental health history\*
- Demographic information\*

\*Children only

#Adult only

### **Challenges**

One of the biggest challenges is that crisis services are relatively new so not everyone knows about them. Much progress has been made in the past year with the teams providing publicity on their services including working with local hospitals, providers, 911 operators, police and mental health providers in order to increase referrals. Health plans have been involved in EMACS and MetrCCS along with making sure that their care coordinators understand crisis services and that their providers refer to crisis services as well. Two years ago the message on most mental health professionals' voice mail was to call 911 if it was an emergency. While we have not reached 100%, many more now leave the phone number of the mental health crisis team on their voice mail.

Other challenges include:

- Low population and greater distances to cover in some parts of Minnesota
- Lack of mental health professionals and practitioners willing to do crisis team work
- Assuring service quality and uniformity across all regions
- Lack of standardized training for all crisis workers
- Not enough state staff time to analyze data, monitor services, etc.
- Developing relationships with law enforcement, hospitals, service providers
- Billing for third party – private insurers
- Providing children's services through mainly an adult oriented team

Despite the challenges, the subcommittee felt that great progress has been made in a short amount of time. These services are evolving and appear to be responsive to making changes to meet the needs of people in the community. An example of this is MetrCCS contracting with an organization to provide training to families of children regarding the role and function of crisis teams and incorporating a feedback loop so that the teams could learn from the parents' experiences. The data show that people are entering the mental health system through the crisis teams and a large number are being diverted from hospitalization.

### **Recommendations**

The subcommittee in reviewing all the data, the survey results and carefully examining existing laws on the subject, makes the following recommendations:

- Address the difficulty of recruiting or attracting mental health professionals who are willing to work on crisis teams

- Develop a joint privacy release between the Minnesota Department of Education and the Department of Human Services so that families can provide advance approval for their children to receive crisis services in the schools
- Strengthen current law regarding the use of peer specialists on crisis teams
- Create a list of essential elements that should be used in any assessment tools used for adults
- Create and utilize a client satisfaction tool
- Clarify that crisis teams can go into emergency departments and distribute model and existing agreements
- Support adding funds so all teams can have health care navigators and create a list of key elements of a health care navigator.
- Identify clearly the lack of or barriers to accessing specific services post-crisis
- Create a separate funding stream to pay for crisis/respice beds for children
- Develop more crisis beds for adults in key regions of the state and look at creating a state funding “pool” in order to address the problem of crisis beds not being able to be used by people outside the county it is located in.
- Include in the definition of crisis services and plans the need to prevent future problems/crisis and action steps
- Firmly state that the values on which crisis services are based are: strengths based, recovery oriented and person centered services that are culturally appropriate, foster hope, encourage the development of natural supports and foster/support individual choice.
- Provide additional training to teams the provide services to both children and adults to ensure that they understand the parent perspective.
- Define integrated, collaboration, consultation and coordinated.
- Collect information from all teams, regardless of grant funding and change the reporting forms slightly so that the same or equivalent data is collected for both children and adults.
- Look at conducting follow-up surveys six months or a year later.
- Address the need for emergency and non-emergency transportation
- Ensure a steady continued funding stream to pay for the infrastructure costs and the costs of uninsured and underinsured individuals.

In regard to the legislation, the subcommittee was a bit stymied. Since these services are already developed – especially in the metro area – and we are looking at refining and expanding the existing services not starting them we could not come up with recommendations as to how to phase them in as part of the State Operated Services redesign. No one could generate examples as to how state staff could be utilized or placed on existing teams.

Access to Care Recommendations	Housing	Neuro-cognitive	Children	Transport-ation	Dental	Levels of Care	SOS AMRTC Redesign	SOS Cambridge Brainerd Redesign
<b>Rapid Access</b>								
<b>Credentialed psychiatric LIP's can be reached in 60-120 minutes.</b>								
There is a web-based system in place to record system utilization that allows us to measure use of service and response time to each call. As part of this system there is also a location for providers of the service to provide feedback on utilization of the system. Data is initially analyzed daily, weekly and monthly. Reports and analysis are on the web-based system for users to evaluate.								
<b>In each jail and detention center there is a phone number that when dialed provides individuals access to live or tele-presence psychiatric services.</b>								
A registry has been established that denotes what services each jail or detention center have. A regional system is in place to fill in the gaps. The registry questionnaire has been of assistance in organizing the registry process.								
<b>Robust mobile adult and children's crisis teams are accessible across the state.</b>								
There is a mobile crisis center in every region which is available/accessible to work with adults and children and provides, and upon request, collaborates with Emergency Departments, Jails and Detention Centers in the provision of crisis services. Data Source: CMHSA Divisions								
<b>Mobile Crisis Team Services are reimbursable when provided in ER's, Jails and Detention Centers.</b>								
A periodic assessment with Mobile Crisis Team Service Providers indicates that this group of service providers is being paid for their services in ER's, Jails and Detention Centers.								
<b>Shared care models that exist across the state have psychiatric collaboration.</b>								
Shared care is defined, definition written and consultation services are available upon request. Uses web-based system defined earlier.								
<b>People have confidence with the rapid access response process and it is tried and true.</b>								
Web based feedback has been shared, self-correcting module has addressed issues, feedback substantiates it is used and provider and user satisfaction with the system is evident.								
<b>Rapid access model is regionalized, with written regional plans that demonstrate regional linkages, etc. in the event of significant crisis or disasters. Plans incorporate collaboration with other regional health care partners (plan has mutual aide tied into the plan and is linked with county emergency disaster response team).</b>								
Plan is written and functional model exists within each								

Access to Care Recommendations	Housing	Neuro-cognitive	Children	Transport-ation	Dental	Levels of Care	SOS AMRTC Redesign	SOS Cambridge Brainerd Redesign
region of the state.								
<b>There are formal and ceremonial relationships between tribal independent nations and the state around rapid access to psychiatry.</b>								
Regional plans demonstrate tribal involvement in their development. Agreements between independent nations and the state have been formally and ceremonially executed and are in action.								
<b>Rapid Access Service is global (meaning across the State of Minnesota with equal access to this service regardless of where the person lives, Metro or Greater Minnesota).</b>								
Web-based data hits demonstrate access is equal and available.								
<b>Common language and assessment tool exists to access the need for urgent or emergent behavioral health care.</b>								
<b>There are ongoing communication, education and evaluation plans in place which have been implemented around the Rapid Access Service.</b>								
Web-based data is evaluated, web page is kept current, annual survey of users and providers are done, an education plan is present and multi-media communication strategy is implemented with measures quarterly.								
Around SOS, there would be a platform for the regional planning for this service. Participation may vary from region to region from no involvement to significant involvement which would be determined in the regional planning process.								
<b>Psychiatric Collaboration</b>								
<b>Global screening, triage and psychiatric consultation should be common practice for mental health services.</b>								
<b>Collaborative partnerships and relationships are the primary goal.</b>								
<b>Collaboration should also include education provided by the consulting psychiatrist.</b>								
<b>Psychiatrists provide consultation services for any patient referred from the identified providers (add possibly schools, law enforcement and jails).</b>								
<b>Collaborative care should be available psychiatrist to psychiatrist to bridge continuity of service and further service needs.</b>								
<b>Collaboration should exist from screening in a primary care setting to chronic and acute care in a variety of community settings.</b>								
<b>Collaboration should intervene “upstream” to prevent the need for more expensive services.</b>								
<b>Existing examples of good collaboration should be used as role models.</b>								
<b>Integrating mental health care and primary care in service delivery and payment is a must to sustain any</b>								

<b>Access to Care Recommendations</b>	<b>Housing</b>	<b>Neuro-cognitive</b>	<b>Children</b>	<b>Transport-ation</b>	<b>Dental</b>	<b>Levels of Care</b>	<b>SOS AMRTC Redesign</b>	<b>SOS Cambridge Brainerd Redesign</b>
<b>level of collaboration.</b>								
<b>Video technology is highly regarded as the solution.</b>								
<b>Collaboration should be available in local community settings that tend to be the first point of contact.</b>								
<b>Consultation and collaboration need to be based on local client need and local resources.</b>								
<b>Service should be available at all levels of care from screening to acute care.</b>								
<b>The model needs to be financially sustainable for all providers who are involved in collaborative consultation.</b>								
A tracking matrix will be used to track: number of requests for psychiatric consultation and/or collaboration; number of people who get response to their requests; the type of consultation/collaboration (local or state); the time it took to access psychiatric collaboration/consultation; demographics. All participating resources will track this information.								
<b>Mental Health Urgent Care</b>								
<b>Address the difficulty of recruiting or attracting mental health professionals who are willing to work on crisis teams.</b>								
<b>Develop a joint privacy release between the MN Dept of Education and DHS so that families can provide advance approval for their children to receive crisis services in the schools.</b>								
<b>Strengthen current law regarding the use of peer specialists on crisis teams.</b>								
<b>Create a list of essential elements that should be used in any assessment tools used for adults.</b>								
<b>Create and use a client satisfaction tool.</b>								
<b>Clarify that crisis teams can go into emergency departments and distribute model and existing agreements.</b>								
<b>Support adding funds so all teams can have health care navigators and create a list of key elements of a health care navigator.</b>								
<b>Identify clearly the lack of or barriers to accessing specific services post-crisis.</b>								
<b>Create a separate funding stream to pay for crisis/respice beds for children.</b>								
<b>Develop more crisis beds for adults in key regions of the state and look at creating a state funding “pool” in order to address the problem of crisis beds not being able to be used by people outside the county they are located in.</b>								
<b>Include in the definition of crisis services and plans the need to prevent future problems/crisis and action steps.</b>								
<b>Firmly state that the values on which crisis services are based are: strengths based, recovery oriented and person centered services that are culturally appropriate, foster</b>								

<b>Access to Care Recommendations</b>	<b>Housing</b>	<b>Neuro-cognitive</b>	<b>Children</b>	<b>Transport-ation</b>	<b>Dental</b>	<b>Levels of Care</b>	<b>SOS AMRTC Redesign</b>	<b>SOS Cambridge Brainerd Redesign</b>
<b>hope, encourage the development of natural supports and foster/support individual choice.</b>								
<b>Provide additional training to teams that provide services to both children and adults to ensure that they understand the parent perspective.</b>								
<b>Define integrated, collaboration, consultation and coordinated.</b>								
<b>Collect information from all teams, regardless of grant funding and change the reporting forms slightly so that the same or equivalent data is collected for both children and adults.</b>								
<b>Look at conducting follow-up surveys six months or a year later.</b>								
<b>Address the need for emergency and non-emergency transportation.</b>								
<b>Ensure a steading continued funding stream to pay for the infrastructure costs and the costs of uninsured and underinsured individuals.</b>								

## APPENDIX XII .

### CMHS Transformation Housing with Services Workgroup

#### Workgroup Charge

The Minnesota Department of Human Services Chemical and Mental Health Services (CMHS) administration is dedicated to transforming the Minnesota public chemical and mental health system in service to the resilience and recovery of youth and adults with mental illness and chemical dependency. By improving access, quality of care, and efficiency of care provision, CMHS will assure that individuals receive the appropriate level of care at the right place at the right time.

This transformative process will lead to a comprehensive, integrated system of care for each identified geographic area. The transformed system will assure that persons with the most complex chemical and mental health needs can obtain safety net services closest to their home community.

The Chemical and Mental Health Services administration is committed to the principle that the people served can become their own recovery experts who in turn can inform their treatment providers about what is effective and meaningful to their recovery journey. In this regard, CMHS embraces the principles of resilience and recovery, wellness, cultural competence, and best practices and assures that the State Operated Services (SOS) transformation will be aligned with these principles.

The Adult Mental Health Division (AMHD), part of the Chemical and Mental Health Services administration of the Department of Human Services, believes in recovery and mental wellness. "Recovery from mental illness is a personal journey of healing to attain satisfaction in life, work, home, and close relationships".

The CMHS Transformation Housing with Services Workgroup was specifically charged.

- To propose an overarching model and framework for providing housing with services to people with a

#### Target Population Example 1

Dorothy, age 57, was diagnosed with schizophrenia when she was 20. According to Dorothy she has heard voices since she was 15. Beginning about 24 years ago she had been hospitalized 6 times in two years for total of 18 out of 24 months. Her lifetime health insurance limit had been reached 4 years earlier. Her husband had paid over \$200,000 dollars out of pocket and owed another \$300,000 for her care.

Dorothy's voices periodically command her to drive her car into an oncoming semi, light her house on fire (which she once did), and run head first into the wall.

She now resides in a corporate foster home. She hears voices about half of the time. Dorothy continues to have command auditory hallucinations that tell her to run head first into the wall. It took two years of on the job staff training at the adult foster home before they eliminated the need for hospital stays to insure her safety when she is responding to her voices. Various medications have been tried and have not eliminated the command hallucinations. There have been repeated efforts to discover antecedent stressors and early warning signs that her auditory hallucinations were becoming more commanding without success. The command hallucinations that require careful redirection occur randomly approximately 2 to 3 days per month.

primary mental disorder, regardless of co-occurring disorder(s).

The workgroup finds that the “workgroup charge” by the CMHS administration has an underlying assumption of “one model or framework” which would limit the diverse housing with services needs of persons with serious mental illness.

The Workgroup identifies that the needs of person’s with a serious mental illness are as varied as those of the general population; thus “one model or framework” would ultimately constrain consumer choice and reduce the options available for developing housing with services that best meets recovery for a person living in the community.

The Workgroup believes that housing with services models need to include, but not be limited to, single family homes, townhomes, scattered and single site apartments, intentional and integrated communities, permanent and transitional housing, project and tenant-based rental assistance, rehabilitation and habilitation services, and treatment. Regardless of the model all housing with services should be affordable, safe, private, and the tenant’s choice.

### **Definitions**

There are a broad number of understandings and definitions for the various words related to housing which can be imprecise and create misunderstanding. The following definitions clarify how the terms are used within this report.

**Housing** is defined as a private residence within the community that is the person’s home which they lease or own in accordance with community rent or homeownership standards.

**With** is defined as “linked” to the housing for tenant use but is not required for tenancy.

**Service** is defined as wraparound and individualized direct services that address a broad variety of individual treatment, rehabilitation, health needs, and/or personal goals. A provider of service cannot also be the landlord or the landlord cannot also be the provider of service.

**Supportive Housing** 1) is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. (definition of the Corporation for Supportive Housing) 2) combines affordable housing with individualized health, counseling and employment services for persons with mental illness, chemical dependency, chronic health problems, or other challenges. (Definition of the Affordable Housing Consortium)

Besides the linkage of services, housing with services may also rely on housing supports which are integral to the person’s successful tenancy.

**Housing support** is defined as a core set of activities and resources that are available, but not required, for all the eligible housing tenants to facilitate tenant housing stability and retention.

**Serious mental illness** 1) is a diagnosis of mental illness that is a “disorder resulting in a functional impairment that substantially interferes with or limits one or more major life activities” or “would have met the functional impairment without the benefit of treatment or other support services.” (Definition of the Federal government). 2) pursuant to section 1912(c) of the Public Health Service Act, adults with serious mental illness are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness. (3) That has resulted in functional impairment, which substantially interferes with or limits one or more major life activities. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425. (Definition of State of Minnesota)

### **Parameters for housing with services**

In addition to the charge, the workgroup was provided with the following parameters for the discussion and this report.

1. Each workgroup must identify or develop metrics to evaluate effectiveness of the groups’ recommendations (answer begins on page 19 – Metric – Baseline – Target table);
2. Workgroups should begin with the SOS redesign stakeholder input information and proposals from that process (input begins on page 6 – CMHS administration SOS Redesign...);
3. Each workgroup’s deliberation process needs to account for people with multiple and complex needs, including any combination of mental illness, intellectual disability, chronic medical conditions (account begins on page 9 – Complex Need);
4. The deliberation process needs to include all the state’s residents, regardless of age, culture, or background (inclusion begins on page 9 – PATH project).

### **Description of the Housing with Services Problem**

The scope and complexity of housing with services for persons with serious mental illness is very broad. Housing, services, and housing supports encompasses multiple agencies and complex systems at the Federal, Tribal, State, County, and local levels. They involve coordination and partnership with a myriad of public, private, for-profit, and non-profit entities to align the housing with services and housing supports in an efficient and effective manner.

#### *Housing Analysis*

Housing is planned, developed, approved, marketed, and sold or rented using housing market analysis. It takes a minimum of several years to produce housing – new or rehabbed. There has been no housing market study for persons with a serious mental illness in the State of Minnesota. Housing with services market analysis is needed in order to provide a foundation for any frameworks or models that will be used to plan, develop, approve, fund, and rent or sell housing with services that serves the needs of persons with a serious mental illness in Minnesota.

1. **Recommendation:** A statewide housing with services analysis is needed that examines on a regional basis
  - a. the availability of supportive and affordable housing;
  - b. the service availability;
  - c. needs of persons with a serious mental illness in the region; and
  - d. the community capacity to develop, fund, and manage housing with services.

### *Service Needs*

Services needs or gaps are studied every two years when local mental health authorities (counties) are asked to report on them during the biennial Grant Application process in Minnesota. Services development takes certification, licensing and/or general State approval of budget proposals. A service can be funded much quicker than housing can be developed.

In October 2009, each County and Adult Mental Health Initiative was asked to report on the “unmet needs” and changes that will be made to the CY 2008-2009 Adult Mental Health Grant Application for person’s with a serious mental illness. County Boards have the responsibility, with the local mental health authority advisory council or subcommittee of existing advisory councils to develop a biennial adult mental health plan which considers the assessment of unmet needs. Twelve of sixteen Adult Mental Health Initiatives (AMHI) report housing or housing with services unmet needs. The following example statements were made about housing unmet needs and changes:

- Funding strategies for housing options for persons with a mental illness housing, particularly for individuals with felonies or bad credit histories remains a priority of consumers, and the Initiative Steering Committee;
- Housing and service options for persons who do not need the level of care of a foster home but are unable to maintain in independent housing even with community supports such as ARMHS, PCA or CSP. The Region continues to work with DHS and local providers with plans to apply for grants and develop housing with supports in the next year and a half;
- Housing needs: Access to permanent, crisis, and transitional housing including clients with criminal histories, chemical health histories, and/or clients with a need for specialized services due to medical or mental health symptoms. Need for more housing with supported services built into the housing services such as ILS, vocational support, medical care, etc.;
- Not all levels of support service are developed in our continuum. We have identified four sub-groups, medically fragile, high behavior issues with failed placements, borderline personality disorders, and short term transitional. We have developed housing with services for the high behavioral consumers. If successful and fiscally manageable we will pursue development for another sub-group. Changes with PCA and CADI funding will significantly impact this continuum and we need to be proactive in planning to fill the gaps that will surface;
- Increase total volume of housing alternatives for eligible homeless residents and significantly increase actual number of beds by over 150 for the past two years; and
- Our Initiative area has a lack of affordable housing and a shortage of rent subsidy. There is not a shelter in the Initiative area, which forces clients to double up with family or friends. Our Initiative has been active in seeking additional housing supports for the area.

Housing with services for persons with serious mental illness must allow access to a range of services and housing support resources that facilitate the development of personal and community supports, provide access to mainstream resources and highly intensive in-home services. Each service or housing support must be provided in a way that optimizes choice for the person and is scalable to their current level of need, adjusts to the person's strengths, and varies as personal recovery goals change. A range of housing, services and housing support, options, models, and frameworks will be needed to accomplish this goal.

#### *Permanent Supportive Housing Evidence Based Practice*

Recently the Substance Abuse and Mental Health Administration (SAMHSA) has released a new evidence based toolkit for Permanent Supportive Housing (PSH) outlined in Appendix A. This is intended to help mental health authorities, agency administrators, and Permanent Supportive Housing leaders think through and develop the structure of Permanent Supportive Housing programs. The toolkit has tips for:

- Funding
- Local and State Housing Plans
- Evaluating a Housing Market; and
- Phases of Housing Development

The toolkit was released on January 21, 2010 and sent to Minnesota during the Workgroup's meeting. The toolkit is one recommended framework for tailoring the PSH model to the local need and optimizing tenant choice of housing, services, and housing supports. But it does not cover all the options or models for supportive housing nor does the toolkit identify a specific model of PSH.

2. **Recommendation:** In planning and developing permanent supportive housing in Minnesota, the Chemical and Mental Health Services administration will use the SAMHSA toolkit and advise its usage by local mental health authorities, tribes, provider administrators and program leaders.

#### *SOS Redesign Stakeholder Input*

The CMHS administration SOS Redesign held 13 regional meetings to obtain stakeholder input, information and proposals. The meetings included input from nearly 1,000 Minnesotans representing stakeholders in service delivery to people with mental illness— consumers, family members, advocates, county and tribal officials, community hospitals, community mental health providers, in addition to SOS employees and state legislators. Twelve themes emerged from stakeholder meetings with the first and most important theme being “develop housing options”.

#### *SOS Consumer Focus Group*

A State Operated Services Consumer Focus Group conducted in May 2010 reported that 15 consumers suggested the need to develop housing as a part of an Action Plan. Two people identified that the housing needs to be focused on affordability, six people wanted more choice and options, two people wanted service coordination and supports, and four people wanted the housing for people with criminal history or other legal issues.

The scope of the need for housing with services for persons with serious mental illness is pervasive. In State Fiscal Year 2009 there were 214,148 adults with serious mental illness estimated by the Department of Health and Human Services (DHHS) to be residents of Minnesota. Each person with serious mental illness has a basic need for safe and affordable housing that provides them a stable home from which they can access necessary supports and services. Some are able to access and sustain their housing with the resources and supports available to them, while many need to rely on services from the public sector.

The number of people with a serious mental illness that received public mental health services through County and State resources in fiscal year 2009 was 55,112. Each person was eligible for County or State based services. Metro persons served in SFY09 were 16,161 as compared to 14,807 in rural counties, and 18,243 in rural counties with an urban center.

Persons that are eligible for county-based mental health services have fewer economic, healthcare, service, and housing resources available to them in order to meet their need for safe and affordable housing. Affordable housing waiting lists are limited, full, or not taking applications.

### *Bridges*

In 1991, the Minnesota Department of Human Services (DHS) received legislative funding to begin a housing initiative for persons with mental illness, modeled after the Section 8 program. Two years later, Minnesota Housing was authorized and appropriated state funds to operate the Bridges rental assistance program for persons with mental illness. Funds were later designated from Minnesota Housing's Ending Long Term Homeless Initiative Fund (ELHIF) to be used in the Bridges program for participants meeting both program requirements. Currently, both DHS and Minnesota Housing collaborate to oversee the Bridges program.

Bridges provides a rental subsidy for persons with serious mental illness who may or may not also be long-term homeless. Participants must become eligible to receive a Section 8 Housing Choice Voucher subsidy or currently be on a Section 8 waiting list. The Bridges program is administered to participants by the local housing agency in communities where the applicants live.

In State Fiscal Year 2009-2010, the Bridges program subsidies served 662 households, 1,159 people (212 children) and the Bridges ELHIF subsidies served 64 households, 104 people (18 children). The State legislature appropriated \$2,902,500 per year (\$5,805,000 for SFY 2009-2010). The average gross rent is \$781 in the Metro Region and \$575 in Greater Minnesota. The tenant on average paid \$253 a month in the Metro Region and \$222 in Greater Minnesota. The State subsidy paid the remainder of the rent which was on average \$528 in the Metro Region and in Greater Minnesota \$353.

The Bridges program is under serving the projected utilization in SFY 2011 because Section 8 is unavailable in many Bridges communities and people are unable to transition off the short term program onto permanent subsidies.

The Bridges model has been used by most of the AMHI to target Adult Mental Health grant dollars to pay for housing subsidies since 1995. In 2009 these Bridges II subsidies totaled \$7,399,404 (18% of total grant funds) were spent on housing rent, mortgage, and utilities.

#### *Adult Mental Health Initiative - Housing*

The Adult Mental Health Division works to ensure that programs and services are available throughout Minnesota. People may need assistance in a variety of areas, such as employment, housing, social connections, family relations and other co-occurring conditions. With the exception of the State Operated Services area of DHS and some state staff working with special county initiatives, the state does not provide direct services. However, the division does provide state and federal funding for mental health treatment. In Minnesota, the county is responsible for providing publicly funded mental health services with federal, state and county funding. In many parts of the state, counties contract with providers to deliver mental health services.

Since 1995, the AMHD has funded regional Adult Mental Health Initiatives (AMHI) that have planned to improve their adult mental health system. In 2009 the AMHI funding was almost \$69,000,000. The 16 AMHI spent \$7,399,404 (18%) on housing much of it using the criteria for spending identified in the Bridges temporary, modified Section 8 program.

#### *Crisis Housing Fund*

Since 1995, the AMHD has contracted with Minnesota Housing Partnership to administer the Crisis Housing Fund. The Crisis Housing Fund is a flexible pool of money that provides short-term housing assistance to persons with a serious and persistent mental illness while they are receiving inpatient psychiatric treatment (includes chemical dependency treatment) of 90 days or less. Crisis Housing Funds cover housing expenses that a person is no longer capable of paying because their income is being used to pay for treatment. The expense must be used to retain housing for the individual. Eligible expenses are payments towards: Rent, Mortgage, and Utilities.

In 2009, there were 298 individuals served by the Crisis Housing Fund (226 had never been served before). The statewide average individual payment made for rent, mortgage and utility is \$1,030. The total amount of Crisis Housing Fund dollars paid in 2009 was \$291,431.

#### *The Governor's 2007 Mental Health Initiative*

In 2007, the Legislature passed the Governor's 2007 Mental Health Initiative intended to create a range of housing with services options for persons with serious mental illness.

The Governor's DHS budget was approved for \$3.25 million for SFY 2007-2008 and \$1.5 million per year thereafter to develop and maintain a range of housing with supports options.

The first year was used for gap financing and alterations to pay for supports in current projects being considered for funding by the Minnesota Housing Finance Agency (MHFA). Second year funding of \$1.5 million was used for gap financing along with new applications that included housing costs and supports.

Funding is to be used to develop and maintain a range of housing with supports options. These options are needed to provide a place in the community for individuals with a serious mental illness who need on-site supports. These supports link the person to evidence-based rehabilitative services and treatment which is funded through other funding sources.

The housing options before SFY2007 were limited both by availability and by adequacy in meeting the needs of individuals with a serious mental illness. Housing developed from the new funds was to be used for multi-family style that was either newly developed or rehabbed. Funded supports from the infrastructure investment would include: front desk coverage, meal preparation, building maintenance and other relevant supports that could not be funded through other funding sources. Individuals receiving housing with supports would be linked to and offered rehabilitative services and treatment, but not required to accept that as a condition of the housing (unless this was required as part of a commitment order.)

The range of housing with supports was to include:

- Safe Haven - a type of supportive housing that served individuals who, perhaps because of their illness, have refused help or have been denied or removed from other programs serving people who are homeless. Individuals are not required to participate in treatment but, as they are ready, are expected to re-engage in services and move to permanent housing with supports
- Assisted Living Residence
- Intentional Community – a new concept in supportive housing for consumers of mental health services. This housing focuses not on buying bricks and mortar but rather on helping individuals create a community that supports them in staying out of the hospital and leading rich and fulfilled lives. Individuals receive subsidies to live in apartments scattered throughout the community and near a community organizer’s apartment. The organizer coordinates members’ activities, such as cooking communal meals, planning recreational activities and holding groups. Members use the organizer’s apartment as a site for meetings.
- Housing First - an approach that centers on providing people with housing quickly and then providing supports and services as needed, often but not necessarily in scattered sites.
- Project-based, small percentage of housing subsidies with supports in large apartment buildings.

The expected outcomes from the Governor’s 2007 Mental Health initiative was:

- A range of housing with supports that would help reduce backlogs in discharges from acute care inpatient setting and reduce re-admissions by 30 percent;
- Reduce the wait list for Bridges subsidies by one-fourth;
- Local mental health authorities would have more options to assist persons with their recovery – safe affordable housing being a key component of recovery.

Today, the Housing with Supports for Adults with Serious Mental Illness (HSASMI) funding provides \$1,500,000 per year in flexible AMHD funding to expand the housing infrastructure for persons with serious mental illness. Building on the established Bridges partnership with Minnesota Housing, the AMHD has awarded the HSASMI grants as housing support funding through the Minnesota Multifamily Rental Housing Common Application in order to link this support resource to well-designed housing projects. Since HSASMI was implemented the funds have provided access to a total of 1,040 units and are currently sustaining 624 of these units, with 91 new units projected to be developed in 2011.

### *Wilder Research 2009 Statewide Homeless Survey*

Regardless of these housing resources the lack of housing access has increased significantly for persons with serious mental illness over the past three years. This is particularly evident from the results of the point-in-time Wilder Research 2009 Statewide Survey. Since 2006 there has been a 25% increase in the number of persons that are homeless in Minnesota. While the percentage increase of persons with serious mental illness that are homeless continued its upward trend from 52% to 55%, the actual number of homeless adults with serious mental illness increased by 32% from 2,467 to 3,250 of the persons surveyed statewide. Many of these 3,250 individuals (69%) are also dealing with a co-occurring chronic health condition or substance abuse disorder, which further complicates the service resources needed in order to help them obtain and retain housing.

### *Project for Assistance in Transition from Homelessness*

Another indicator of the need for supportive housing options for persons with serious mental illness is the data from the Project for Assistance in Transition from Homelessness (PATH) program. This Federal program, along with a State match, provides funding for outreach services to people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at risk of becoming homeless.

In 2009 the ten PATH projects provided services in nine Minnesota counties (Anoka, Clay, Dakota, Hennepin, Polk, Ramsey, St. Louis, Stearns, and Washington). PATH providers served 1,793 adults with serious mental illness, 46% who met the stringent definition of being “literally homeless” living outdoors or in a short term shelter. The impact of homelessness on minority populations is disproportionately high as documented in both the Wilder 2009 Statewide Survey and the PATH data. Homeless persons with serious mental illness are in the basic need of housing with services in order to survive.

The need for housing with services is not restricted to persons that are homeless. Active community service participants with limited income and persons that have limited access to formal or informal services and/or supports are also in need. This includes people that are repeatedly moving in and through community mental health services, community hospitals, Community Behavioral Health Hospitals (CBHH), residential programs and the corrections, employment, veterans, and law enforcement systems.

### *Complex Needs*

Some individuals with serious mental illness have complex needs which are defined as:

**Complex need** includes but is not limited to: co-occurring substance and/or alcohol abuse; documented criminal activity; violent behavior; and chronic medical problems. These complex problems further disrupt their ability to acquire and retain housing and live successfully in the community.

### *Serious Mental Illness and Violent Behavior*

The Adult Mental Health Division, surveyed the Adult Mental Health Initiatives and Tribes in May 2008 about the number of people from October 2007 through March 2009 who had a serious mental illness and a violent behavior that the county or tribe were aware of. Forty seven

counties and one tribe responded. On average there were 52 people in a month who met the criteria chosen by the tribe or county of serious mental illness and violent behavior.

State Operated Services and the Adult Mental Health Division acknowledge “people with violent histories who are in need of acute psychiatric treatment and are currently violent” are one of the four complex need groups that they have not been effectively served in the community by the current SOS system. The other three complex need groups are: people with serious mental illness and substance disorder in need of detoxification; people with developmental disabilities, traumatic brain injuries or a cognitive disorder who are in behavioral crisis; and, people with serious mental illness and chronic medical conditions requiring convalescent or long term care. The high service usage and the related costs of these complex needs groups are matched by the disruption that unstable housing and insufficient services has on their lives and ability to live in the community before and after inpatient services.

This descriptive overview of the need and current programs for affordable and supportive housing gives only a partial understanding of the affordable and supportive housing needs of persons with serious mental illness in Minnesota. Since housing information is not consistently collected by CMHS this overview does not provide for example information on the level of need for persons that do not have direct contact with the mental health reporting systems, the impact of housing and service access on minority populations, the housing status of people as they move through the mental health system, or the access to affordable housing by any person with serious mental illness that lives on a limited income.

Recognizing that the full scope and complexity of housing is beyond what can be addressed within a short series of meetings, the Housing Workgroup agreed to focus on one part of the housing picture for persons with serious mental illness by addressing housing for persons with serious mental illness that have the most complex needs, but makes the following recommendation to address the full concern of the workgroup.

3. **Recommendation:** That the affordable and supportive housing need is too important for the basic health and welfare of persons with serious mental illness to end with this Phase I report and that in order to be effective the discussion must continue into Phase II
  - a. with a review of the housing with services analysis of the housing needs of persons with serious mental illness; and
  - b. the development of a comprehensive strategic plan for addressing the housing needs of all persons with serious mental illness

There was clear concern expressed that the focus on a small population not detract from addressing the significant and varied housing needs for persons with serious mental illness across the state. It was also identified that the supports and services to retain housing are not static and will change over time as a person’s symptoms, needs, strengths, and recovery goals change.

### **Principles for housing with services**

The following four principles were provided for and utilized by the workgroup.

1. The products of the workgroups need to be consistent with the principles of Person-Centered Thinking, assuring attention to what is important to consumers;

2. Recommendations should include evidence-based practices and best practices;
3. Service design must be consistent with the expectation of recovery and resilience, and include family involvement when it works for the consumer;
4. Recommendations should include the efficient and effective use of resources and sensitivity to local preferences.

These principles were applied in a manner that was consistent with the housing mission for all adults with mental illness that was established in 1989 as part of the Minnesota Comprehensive Adult Mental Health Act, 245.461 Subd.4.

***Housing mission:*** *The commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system:*

- (1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;*
- (2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and*
- (3) provide necessary support regardless of where persons with mental illness choose to live. (State Statute 245.461, Subdivision 4.)*

### **Housing Workgroup Process**

The participants in the Housing Workgroup were drawn from a broad collection of stakeholders that had familiarity and expertise with affordable and supportive housing development, experience with mental health services and linkage to homeless or housing resources, or were consumers and consumer advocates. Workgroup members represented Federal agencies, State agencies, private profit and non-profit agencies, and advisory groups. Participants from metro and greater Minnesota were sought out and incorporated into the discussion via video conference. The participation of minority communities and organizations was significantly under represented on the workgroup. The list of the workgroup members and the organizations they are affiliated with are listed in Appendix B.

The meetings were conducted as a series of five video conferences. There were nine video conference sites, one located in St. Paul and the remaining eight distributed across greater Minnesota. The greater Minnesota sites were located in southwest, south central, southeast, central, northwest, north central, and northeast Minnesota. The co-chairs facilitating the meetings were located in St. Paul and Rochester. Each meeting was provided with a focus that worked toward the charge and parameters of the group, which are listed below and will be used to provide the workgroups findings:

July 1, 2010	Introductions and The Goal
July 17	The Problem
July 28	The Ideas
August 13	The Solution
August 24	The Plan

The workgroup introduced a range of the stakeholders and identified the charge, principles, and parameters of the group. Information about existing housing programs, resources, and funding utilization administered by the AMHD in partnership with counties, Adult Mental Health Initiatives, Minnesota Housing, and private agencies was provided as background. The programs and related funding are summarized:

Bridges	\$2,902,500
Crisis Housing	\$291,431
Housing with Services	\$1,500,000
<u>County/AMHI Housing</u>	<u>\$7,399,404 (18% of \$68,802,408 total grant funds)</u>
Total	\$12,093,335

These are the total State dollars dedicated to housing for persons with serious mental illness in 2009 and projected for 2010.

Given the broad range of perspectives of the group, identifying a common understanding of how to categorize housing need and formulate a direction for addressing the need was complex. The varied approaches and insight of each stakeholder created many different ways to consider the issue of supportive housing, housing with services, and how it relates to persons with serious mental illness and helping them to obtain and retain housing. The workgroup recognizing the range of housing issues and needs decided to focus on the charge in two phases. Phase I has addressed the immediate CMHS and SOS redesign objectives, and Phase II which will review the broader assessment of housing needs for persons with serious mental illness and develop the comprehensive strategic planning objectives to address housing need.

## I. Phase I

The scope of the housing question is large and targeting resources or funding in one area for a particular group of consumers has the distinct potential of limiting resources for other consumers that would be best served by a different housing model or option. The workgroup makes the following recommendation for the Phase I target population with the understanding that there is a continued obligation to examine and evaluate the ramifications of any changes as the planning for supportive housing moves forward.

### A. Target Population

4. **Recommendation:** The Phase I Target Population should be individuals with serious mental illness and complex needs and must meet the following diagnostic, service, and housing criteria:
  - a. mental health service Level of Care Utilization System for Psychiatric and

**Target Population Example 2**

Dave has a diagnosis of schizophrenia with a co-occurring medical condition of brittle diabetes. As a result of his medical condition Dave is insulin dependent and at significant health risk if the insulin is incorrectly managed. Dave's identified baseline psychiatric symptoms include being extremely delusional with little to no insight into mental illness or recognition of symptoms. The documented history of Dave identifies recurring incidents of not taking psychiatric or diabetic medication consistently, eloping within hours of program placement, and on occasion traveling cross country upon doing so. Dave's elderly parents are a principle natural support for Dave. Previous engagement by the parents in Dave's mental health services or supporting Dave's utilization of medications and services has been very limited.

- Addiction Services (LOCUS) rating of 4 or 5; and
- b. the individual does not meet medical necessity for inpatient hospitalization; and
- c. has complex, or multiple, service and support needs that are essential to be met in order for the person to obtain and retain housing; and
- d. the individual has a demonstrated history of being unable to retain housing; or
- e. there is a documented history that makes the person ineligible for a housing subsidy, rental voucher, or unable to obtain affordable housing

A portion of the phase I targeted population may meet the homeless or long term homeless definitions.

After a great deal of debate regarding scope and need of supportive housing for adults with serious mental illness the workgroup agreed to focus upon a specific target population in order to meet the charge within the time frame available for the discussion. The population was selected because:

1. there is an identifiable estimate 100 people that meet the criteria;
2. the group utilizes a disproportionate share of the inpatient mental health resources;
3. they have very limited access to housing or service resources that can meet their needs and help them to retain housing;
4. estimated cost to the mental health system (services and resources) are extremely high
  - a. Costs that need to be considered are
    - i. community hospitalization,
    - ii. state hospitalization,
    - iii. emergency care,
    - iv. law enforcement,
    - v. community treatment programs, and
    - vi. residential housing services,
  - b. Consumers cycle through all of these systems
  - c. Stable housing in the community would cost far less per day.

### **Target Population Example 3**

Carl is a veteran diagnosed with major depression, poly-substance dependency, a history of hypochondria and conversion disorder vs. somatoform pain disorder, and borderline personality traits. The behaviors that impact Carl's treatment and his access to housing are a history of medication seeking behavior, self-injurious behavior, suicide attempts, and aggression. The treatment history for Carl includes multiple chemical dependency treatments with relapse shortly after completion. Financial issues create problems for Carl with resource and service eligibility. Carl's personal strengths are being educated, very intelligent, and having a family that is concerned and involved.

### **B. Housing with Service and Housing Support Design**

The Phase I design of housing with service and housing support is composed of three principle components that need to be addressed in order to assure a person's choices: housing, service, and housing support.

The term tenant will be used throughout the design to highlight that housing with service and housing supports is based upon a person's rights as a tenant of the housing. Tenancy is inclusive of both rental and homeownership roles and rights for the individual. In order to assure tenant choice a final design objective is to assure that housing, service and housing

support eligibility and access are not restricted based upon health insurance coverage or economic barriers. The following are all components and objectives of housing with service and housing support design:

1. **Housing** component is defined as a private residence within the community that is the tenant's home which they lease or own in accordance with community rent or homeownership standards. The housing component is comprised of the following objectives.
  - a. a range of housing models that include, but are not limited to: home ownership, rental (scattered site and site based), shared housing, safe haven, permanent and transitional (24 months or less);
  - b. occupancy is voluntary and based upon community tenancy and housing standards;
  - c. integrated into the community, city, county, State, and Tribe;
  - d. "links" the tenant to community resources;
  - e. maximizes community acceptance as a person;
  - f. intentionally promotes the development of the tenant's chosen community;
  - g. physical design features that allows for on-site resources needed to support the skill development, rehabilitation, and recovery goals for the tenant's successful independent living;
  - h. tenant choice to move to housing that is reflective of the individual's personal choice, rehabilitation and recovery goals, or their improved skills and not lose access to services;
  - i. access to housing resources, support, and service options that will help the tenant to transition or chose other permanent affordable housing;
  - j. choice of whom to live with;
  - k. individual units are composed of a living and sleeping space, cooking area, and bathroom;
  - l. Each unit must have an exterior window;
  - m. fully lockable by the tenant and in compliance with Minnesota Housing standards;
  - n. preservation of housing while hospitalized or in treatment must provide reasonable accommodation for the retention of tenant housing; and
  - o. safe environment for those living in the housing and the surrounding neighborhood.
  
2. **Service** component is defined as wraparound and individualized direct services that address a broad variety of individual treatment, rehabilitation, health needs, and personal goals. The service component is inclusive of these objectives.
  - a. provided wherever the person choses to receive them including on site and within the community including:
    - i. Assertive Community Treatment (ACT) teams;
    - ii. Intensive Community Recovery Services (ICRS); and
    - iii. State waiver programs;
  - b. linked to the individual;
  - c. not dependent upon tenancy;

- d. services accompany the individual or can be transitioned to an alternate provider in order to best facilitate the individual’s goals and the provision of service;
  - e. core focus of outreach and engagement of the individual and helping them to establish and maintain housing and community stability;
  - f. flexible funding of resources that can pay for maintenance services;
  - g. staff who are flexible to meet with people when they need them;
  - h. staff skill and training resources must reflect the complex service needs of the tenants;
  - i. based upon best practice and evidence-based practice standards – especially
    - i. Integrated Dual Diagnosis Treatment;
    - ii. Certified Peer Support;
    - iii. Illness Management and Recovery;
    - iv. Permanent Supportive Housing; and
    - v. Supported Employment;
  - j. connection to rehabilitation, nursing, tenancy support, employment, behavior modification, etc.; and
  - k. culturally competent and inclusive.
3. **Housing Support** component is defined as a core set of activities and resources that are available to all eligible housing project tenants to facilitate tenant housing stability and retention. The support component has the following objectives.
- a. voluntary and accessed at the tenant’s discretion;
  - b. will facilitate the development of an intentional community;
  - c. support staff work space should be integrated into the housing design and re-useable as housing;
  - d. positive and proactive relationship with law enforcement;
  - e. core focus of engaging the individual and helping them to establish and maintain housing and community stability;
  - f. facilitate “linkage” to services and to the tenant’s natural support systems, such as family, friends, and cultural supports;
  - g. includes but are not limited to staff provided activities, tenant service coordination, housing subsidies, and technology assists for retaining housing, such as on site medical support, building security, and safety alerts; and
  - h. culturally competent and inclusive.

### **C. Funding Resources**

The funding resources need to be flexible and address each of the component areas of housing, services and housing supports. While funding can be drawn in from or leverage a range of financial resources for the three components, the housing with service and housing support funding also needs available dedicated flexible funding that can support individual projects and the tenants they serve. Fiscal resource should include finding ways to foster tenant equity and economic improvement. Funding resources will need to be tailored for each project and should utilize the full range of existing housing, services, and housing support resources available to develop, implement, and sustain the project. Funding resources fall into three categories which correspond approximately with the design

categories. The categories of capital, service funding, and operating subsidy are defined below and matched to the housing with service and housing support component it funds:

1. **Capital funding (housing)** is defined as cost related to the development, construction, rehabilitation, and structural maintenance of the housing. Capital funding resources includes but is not limited to:
  - a. U.S. Department of Housing and Urban Development (HUD) and the administrators of their funding:
    - i. Housing Redevelopment Agencies (HRA), and
    - ii. Community Development Agencies (CDA)
    - iii. Indian Housing
  - b. Internal Revenue Department - Tax Credits
  - c. U.S. Department of Agriculture
  - d. Veteran's Administration
  - e. Tribal Housing
  - f. Minnesota Housing
  - g. Minnesota Department of Employment and Economic Development
  - h. Local Government
  - i. Family Housing Fund
  - j. Greater Minnesota Housing Fund
  - k. Metropolitan Council
  - l. Foundations, and
  - m. private investment
  
2. **Service funding** is a broad array of person-centered direct services that provide wraparound services to support the person in the community, in their recovery, and their housing stability. Service resources include but are not limited to:
  - a. Healthcare, waivers, grants, or certified or licensed State programs that include ARMHS, ACT, and ICRS.
  - b. County or Adult Mental Health Initiatives;
  - c. SAMHSA grant funding,
  - d. Veteran's Administration grant funding;
  - e. Tribal resources;
  - f. Group Residential Housing and Shelter Needy; or
  - g. targeted project funding.
  
3. **Operating subsidy funding (housing support)** is defined as costs incurred due to serving the targeted population(s) for which the project was developed. Operating subsidy funding falls into three types, revenue shortfall, unique costs, and supports. There are very few funding resources available to pay for operating subsidies:
  - a. Revenue shortfall which provides supplementary funding to cover the project operating costs that remain once tenant income-based payments have been collected;
  - b. unique costs are project operating or maintenance expenses that are vital to the fiscal sustainability of the building and the welfare of the population(s);
  - c. supports are non-reimbursable activities that are provided on-site at the project to facilitate tenant housing retention of the target population(s); or

- d. Housing with Supports for Adults with Serious Mental illness (HSASMI) is the only operating subsidy funding available to develop housing supports for persons with serious mental illness.

**D. Recommendations and Evaluation Metrics**

The Phase I evaluation metrics are specific to serving the identified population of adults with serious mental illness and complex needs. The metrics also need to identify and collect both output and outcomes based data in order to demonstrate effectiveness of housing, supports, and services. The evaluation of the fiscal impact of housing with supports and the relation to housing stability needs to be monitored to assure that it is a cost effective use of State resources.

**II. Phase II**

Based on Recommendation 3 (this will be the first phase in a comprehensive strategic approach to addressing the housing and support needs of persons with serious mental illness) being accepted by the Advisory Task Force, Phase II will be a continuation of the Housing with Services Workgroup. The Workgroup members have already expressed their desire to continue to meet and one of the current chairs, Jim Behrends will be joined by Gary Travis to call the group together and to come up with recommendations on proposing other overarching models and frameworks for providing housing with services to people with a primary mental disorder, regardless of co-occurring disorder(s).

<b>CMHS Housing with Services Work Group Recommendations</b>
1. <b>Recommendation:</b> A statewide housing with services analysis is needed that examines on a regional basis <ul style="list-style-type: none"> <li>a. the availability of supportive and affordable housing;</li> <li>b. the service availability;</li> <li>c. needs of persons with a serious mental illness in the region; and</li> <li>d. the community capacity to develop, fund, and manage housing with services.</li> </ul>
2. <b>Recommendation:</b> In planning and developing permanent supportive housing in Minnesota, the Chemical and Mental Health Services administration will use the SAMHSA toolkit and advise its usage by local mental health authorities, tribes, provider administrators and program leaders.
3. <b>Recommendation:</b> That the affordable and supportive housing need is too important for the basic health and welfare of persons with serious mental illness to end with this Phase I report and that in order to be effective the discussion must continue into Phase II <ul style="list-style-type: none"> <li>a. with a review of the housing with services analysis of the housing needs of persons with serious mental illness; and</li> <li>b. the development of a comprehensive strategic plan for addressing the housing needs of all persons with serious mental illness</li> </ul>
4. <b>Recommendation:</b> The Phase I Target Population should be individuals with serious mental illness and complex needs must meet the following diagnostic, service, and housing criteria: <ul style="list-style-type: none"> <li>a. mental health service Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) rating of 4 or 5; and</li> <li>b. the individual does not meet medical necessity for inpatient hospitalization; and</li> <li>c. has complex, or multiple, service and support needs that are essential to be met in order for the person to obtain and retain housing; and</li> </ul>

- d. the individual has a demonstrated history of being unable to retain housing; or
- e. there is a documented history that makes the person ineligible for a housing subsidy, rental voucher, or unable to obtain affordable housing

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
<b>Target population:</b> Identify the number of eligible individuals through statewide housing study	100 estimated	100 – 300 individuals
<b>Target population:</b> Develop and utilize consistent assessment tools to determine need	Diagnostic eligibility, LOCUS, and current housing status	Uniform tool for assessment and tracking of housing status across State programs

<b>Housing component:</b> Develop and create supportive housing for the target population	16 units	100 - 300 units of tenant based supportive housing
<b>Housing Support component:</b> Develop and sustain onsite supports that have the capacity and expertise to assist the target population retain housing	Limited supportive housing resources available (Bridges, Housing with Supports for Adults with SMI, and the Crisis Housing Fund)	Expand supportive housing resources to meet and sustain the target of 100 - 300 units and individuals
<b>Service component:</b> Consolidate existing service resources to target the population of adults with SMI and intensive needs	DHS has disparate service resources and eligibility criteria that limit client access to needed service	Consolidate service resources in order to target intensive in-home wraparound services for 100 – 300 eligible individuals
<b>Service component:</b> Develop service funding to cover needed services that are outside of existing funding resources	Housing with Intensive Community Recovery Supports (HICRS) pilot projects	Expand service capacity to meet the intensive need of 100 - 300 individuals

<b>Capital funding:</b> Partner with capital funders and agencies to coordinate and target resources to develop a broad range of housing	Capital funding resources for affordable or supportive housing are targeted at a broad range of populations and housing needs.	Coordinate and secure capital funding to obtain, rehab, or build 100 – 300 units of supportive housing that are integrated into the local community
<b>Operating subsidy funding:</b> Develop a stable funding resource that can sustain a broad range of individualized supports that are needed for	HSASMI operating subsidy funding is available up to two years.	A stable funding resource to sustain 100 – 300 project linked and client selected supports

<b>Metric</b>	<b>Baseline</b>	<b>Target</b>
tenants to retain housing		
<b>Service funding:</b> Consolidate existing service funding and develop fiscal resources to cover service needs specific to the target population	Existing DHS funding streams are not coordinated to effectively provide service to the target population. Funding streams have specific service outcome objectives that do not address the full range of the population service needs. Funding for non-covered services draws on limited State resources.	A client directed service budget based upon client need that maximizes access to critical services for 100 – 300 individuals
<b>Service funding:</b> Utilize existing SOS staffing resources and mental health service expertise	Existing SOS staffing resources and service expertise is primarily facility based	Provide SOS staff retraining in order to assure community based and housing focused mental health services

## Appendix A

### SAMHSA Permanent Supportive Housing Evidence-Based Practice Toolkit Summary

- **Evidence-Based Practices**
  - Services that have consistently demonstrated their effectiveness in helping people with mental illnesses achieve their desired goals.
  - Effectiveness was established by different people who conducted rigorous studies and obtained similar outcomes.
  - Consumers and families have a right to information about effective treatments and, in areas where EBPs exist, they have a right to access effective services.
  - Mental health services should have the goal of helping people achieve their personal recovery goals; develop resilience; and live, work, learn, and participate in the community.
- **Permanent Supportive Housing**
  - Decent, safe, and affordable community-based housing that provides residents the rights of tenancy under state and local landlord-tenant laws.
  - The housing is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences.
- **Central to the approach**
  - A belief that people with psychiatric disabilities should have the right to live in a home of their own, without any special rules or service requirements.
- **Components of Permanent Supportive Housing**
  - Choice in housing and living arrangements
  - Functional separation of housing and services
  - Decent, safe, and affordable housing
  - Community integration and rights of tenancy
  - Access to housing and privacy
  - Flexible, voluntary, and recovery-focused services

The Permanent Supportive Housing Toolkit is available at:

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/housing/>

## Appendix B

### Housing Workgroup Membership

<b>Member</b>	<b>Affiliation</b>
Dave Schultz (co-chair)	Chemical and Mental Health Services Administration, Adult Mental Health Division
Jim Behrends (co-chair)	Olmsted County, CREST, and MACSSA
Senta Gorrie	Amherst H. Wilder Foundation, Supportive Housing & Employment Services
Pat Boyer	Becker, Clay, Otter Tail, Wilkin (BCOW) Adult Mental Health Initiative
Nancy Cashman	Center City Housing
Gary Travis	Chemical and Mental Health Services Administration, Adult Mental Health Division
Paul Heyl	Chemical and Mental Health Services Administration, Adult Mental Health Division
Steve Luzar	Chemical and Mental Health Services Administration, Adult Mental Health Division and Childrens Mental Health Division
Dianne Wilson	Chemical and Mental Health Services Administration, Alcohol and Drug Abuse Division
Richard S. Amado	Chemical and Mental Health Services Administration, Office for Innovations in Clinical & Person Centered Excellence
Janel Bush	Children and Family Services, Community Partnerships
Craig Fladeboe	Community Services Program Specialist, Southwestern Minnesota Adult Mental Health Consortium
Melanie Fry	Continuing Care, Disability Services
Amy Wicklund	Fond du Lac Reservation
Kim Lutes	Consumer Volunteer
Joel Pribnow	Hennepin County
Ruth McVay	Hennepin County
Dan Moore	Human Development Center, Duluth
Jim Gruba	Human Development Center, Duluth
Patrice O'leary	Lutheran Social Service, Brainerd
Ed Eide	Mental Health Association of Minnesota

<b>Member</b>	<b>Affiliation</b>
Patricia Siebert	Minnesota Disability Law Center, Mental Health Legislative Network
Susan Haugen	Minnesota Housing Finance Agency
Chip Halbach	Minnesota Housing Partnership
Nancy Bokelmann	Owatonna Housing and Redevelopment Authority
Sharon Geiger	Ramsey County
Angela Youngerberg	South Central Community Based Initiative
Terese Emmen	Southwest 18 Adult Mental Health Initiative
Monica Nilsson	St. Stephen's Human Services
Annie Pierre	State Advisory Council on Mental Health
Wendy Rea	State Advisory Council on Mental Health
Kevin Turnquist	Touchstone Mental Health
Martha Lantz	Touchstone Mental Health
Ben Osborn	U.S. Department of Housing and Urban Development, Minneapolis Field Office

## APPENDIX XIII.

### **Getting There With Dignity Psychiatric Transportation Workgroup State Operated Services Redesign**

#### Mission/Charge

The workgroup was tasked with the responsibility to:

- study the way that emergency psychiatric transportation is currently provided across the state;
- identify problems and unmet needs related to emergency psychiatric transportation;
- identify best practices and innovations;
- identify potential barriers to implementing effective solutions (funding, regulations, inter- governmental and inter-agency coordination/cooperation);
- consider all effective solutions; and
- develop recommendations to implement system-wide changes.

#### Values

Psychiatric Transportation – should be:

- person-centered;
- delivered in a manner which does not add to the trauma that an individual experiences during an acute psychiatric emergency;
- delivered as a mental health service and carried out with the involvement of mental health staff;
- an element in the array of transportation alternatives ranging from natural supports, volunteer drivers, common carriers, special transportation services, ambulance and transportation by law enforcement;
- based upon the individual's need – transportation delivered by law enforcement and by ambulance services should only occur when there is a public safety issue or a medical need;
- all providers of psychiatric transportation should receive mental health crisis training appropriate to their role; and
- mental health crisis intervention services and psychiatric transportation should be delivered in a way that promotes resolution of the crisis, diversion, or if necessary, a voluntary admission.

#### Issues/Best Practices/Recommendations

##### I. Crisis Intervention Training

Crisis Intervention Training (CIT) is a training program developed in a number of U.S. states to provide law enforcement officers with the knowledge and skills that would enable them to react more effectively in crisis situations involving mental illness.

##### II. Law Enforcement

Minnesota, like many other states, utilizes Law Enforcement as a primary method for providing transports for persons involved in psychiatric crises. This occurs often by default whether or not a public safety risk is present. Officers spoke of sometimes being used as a glorified taxi service. The role of Law Enforcement often includes long waits in emergency rooms, crossing the state to bring a person to a treatment facility and transportation to and from commitment hearings. This has the effect of making Law Enforcement personnel unavailable for other vital and important activities.

From the perspective of mental health consumers, they recounted experiences of being handcuffed and confined in the back of squad cars. They spoke of the embarrassment, anxiety and trauma that they experienced being taken into custody. It was pointed out that “rarely, do individuals experiencing other medical conditions get dealt with in this manner. “ Many provided input about the value of providing officers with training related to handling mental health emergencies, such as the Crisis Intervention Training (CIT) which has been made available in the past few years. Some county sheriff’s offices and local police routinely utilize officers in plain clothes and unmarked cars when responding to mental health related calls. These “best practices” have been supported by many both within and outside of the law enforcement community. Some of these standards already appear in statute: “Whenever possible, a peace officer who provides the transportation shall not be in uniform and shall not use a vehicle visibly marked as a police vehicle. (M.S. 253B.10, Subd. 2.)”

Best Practices for law enforcement assistance:

- Should not be the default method for transporting persons with mental illnesses to inpatient settings, but should only be used in situations where there is an imminent and identifiable public safety and security risk;
- Should be provided by personnel who have received CIT training, or with the assistance of a mental health practitioner or professional with a background in MH Crisis Intervention;
- Should be provided in a manner which is sensitive to stigma issues, plain clothes, unmarked cars; and
- Should be provided in a manner which does not increase the trauma associated with a psychiatric emergency and protects the dignity of the individual.

Although there was general consensus about the best practices described above, the law enforcement participants did not want to see the best practices become outright mandates.

### **Recommendation:**

The transportation services provided by law enforcement continues to be needed and valued. In an effort to make transportation by law enforcement more effective and less traumatic to individuals experiencing a mental health crisis, it is important that a mental health component be added. It is recommended that the statute be expanded to include:

“Whenever possible, a peace officer who provides the transportation should have mental health crisis intervention training or seek the assistance of a mental health crisis intervention practitioner or professional, shall not be in uniform and shall not use a vehicle visibly marked as a police vehicle.

The state should develop CIT training which is continuously available across Minnesota, to psychiatric responders.

### III. Ambulance Emergency Medical Transportation

In the presentation by the providers of ambulance services it was noted that these services were also often inappropriately used and that mental health transports also were time consuming and often resulted in a lack of coverage in a community or region.

Consumers indicated that they were often more likely to prefer to be transported by law enforcement, rather than strapped down on a gurney.

Workgroup member expressed the opinion that there exists a significant potential to have a less costly and more relevant service developed that would involve the use of special transportation services and a qualified escort or attendant as an alternative to emergency medical transportation.

#### Best Practices for Emergency Medical Transportation

- Should not be used when less restrictive approaches to psychiatric transportation are available;
- Is best used when there is an identifiable medical need.

IV. EMT and Paramedics should receive adequate training and orientation related to addressing the needs of individuals who are experiencing an acute psychiatric emergency, or have the immediate availability of someone qualified to provide mobile MH crisis intervention.

### V. Special “Psychiatric” Transportation

The workgroup received a significant amount of input about the need for a “middle tier” service where transportation services would be paired with Crisis Response Services. This will utilize the existing STS provider network. Providers would receive additional training to assist the transportation driver to deal with the unique issues of an individual experiencing a mental health crisis situation.

The service could be used for initial transport in a mental health crisis situation and when the individual is being transported between health services (emergency rooms, psychiatric hospitals, CBHHs, Crisis Residential). The service is not reimbursable under Minnesota Health Care Programs for transportation to and from court hearings.

This option has a number of advantages because the service:

- is reimbursable for individuals eligible for Minnesota Health Care Programs
- reduces the pressure on Ambulance and Law Enforcement provided transports
- expands the range of appropriate transportation alternatives
- can be used for site to site transports (emergency room to psychiatric hospital)
- would be established to allow for payment of an attendant
- represents a reduced cost compared to ambulance and law enforcement services
- would be expected to be less stigmatizing and less traumatic for the individual experiencing a mental health crisis

Best Practices:

- providers of special psychiatric transportation should receive training which relates to serving individuals who are experiencing a mental health crisis;
- drivers would be responsible to deliver a station to station service and assistance as needed;
- most crisis situations will require an additional attendant or escort: ideally, in responding to the initial crisis, the attendant should be from the Mental Health Mobil Crisis Team or a Certified Peer Specialist
- the transport should be restraint free
- providers would be subject to background checks

#### Barriers:

- Medical Assistance pre-authorization process may not be responsive enough to make the service work; this process should be evaluated for ways to make it more flexible
- does not pay for transports between health facility and court
- may not be a service covered by third party payors

#### **Recommendations:**

The state and counties should pursue the development of Special Psychiatric Transportation as an effective and cost-saving alternative.

- collaboration should occur with MCOs serving public pay clients and commercial plans to make this service available to their recipients
- courts and counties should consider this option in lieu of using law enforcement when transporting to court hearings
- the state should allow Crisis Intervention Practitioners and Professionals to authorize the special psychiatric transportation services and an additional attendant if needed.

In order to allow for the evaluation and consideration of various approaches to this service, the state should fund a handful of demonstration projects to be designed and implemented by Adult Mental Health Initiatives.

#### VI. Crisis Intervention Practitioner or Professional as Health Officer

Over the past few years Mental Health Mobile Crisis Intervention Services have been emerging across the state. Data shows that these teams have been very successful in de-escalating mental health emergencies and creating situations where individuals have been diverted from needing acute psychiatric inpatient services. If we want to be successful in de-emphasizing the use of law enforcement in mental health emergencies, it seems important to expand the role of the crisis team members as Health Officers empowered to place individuals on a temporary hold.

The proposed change to the Civil Commitment Act is provided here:

*Subd. 9. Health officer. "Health officer" means a licensed physician, licensed psychologist, licensed social worker, registered nurse working in an emergency room of a hospital, or psychiatric or public health nurse as defined in section 145A.02, subdivision 18, or an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3, or a Mental*

Health Practitioner or Mental Health Professional providing Mental Health Mobile Crisis Intervention Services as described as 256B.0624 and formally designated members of a prepetition screening unit established by section 253B.07.

#### VII. Access Transportation

This category includes taxis, buses and volunteer drivers. A potential exists to use these options in situations where the individual needing transportation to a mental health service is not experiencing a situation with significant risk. ATS services are coordinated and reimbursed through the local county human/social service agencies.

This transportation category would also allow for the involvement of Crisis Intervention Practitioners and Professions as well as Certified Peer Specialists.

#### VIII. Natural Supports

Just like many of us, mental health consumers frequently get to the hospital by way of friends and family. There are many mental health crisis situations where this form of transportation is extremely appropriate and preferred by the individual. In order that this preference be recognized, it is advisable that the consumer make his/her wishes known through the development of an advance psychiatric directive or crisis prevention plan.

This transportation category would also allow for the involvement of Crisis Intervention Practitioners and Professions as well as Certified Peer Specialists.

#### IX. Non-emergency Transportation related to commitment and hearings

- Should not default automatically to law enforcement, unless a security or public safety issue is identified;
- Current legislation allows for alternative forms of transportation to meet this need – County Social Services and Courts should be encouraged to develop and utilize a broader range of options (MS253B.10 Sud 2.)

#### X. Emergency Room

One of the issues raised by work group members representing law enforcement was the extended time they needed to spend in emergency rooms. Their presence is necessary to address safety and security issues that might arise relating to the mental health patient in crisis. In hospitals and emergency rooms with on-site security, officers are often free to leave as soon as the individual is dropped off.

Another issue raised relating to Emergency Room has to do with the Emergency Medical Treatment and Active Labor Act (EMTALA). The methods for transferring the individual from one medical facility to another should include alternatives beyond ambulance and law enforcement transports. EMTALA is often cited as the reason that hospitals and emergency rooms do not consider a broader range of options. The transfer must be effected through qualified personnel and the appropriate mode of transportation. This does not always mean an ambulance. Having a transportation service staffed with Mental Health Practitioners that are clinically supervised, may address the concerns of emergency room physicians. If not, there is still the option for the patient, with informed consent, to decline the hospital's mode of transportation in lieu of an alternative more in keeping with their preference (e.g. family member, Access Transportation with a Certified Peer Specialist escort). If the patient decides to exercise their option to refuse medical transport, they should not have to give up the other

requirements that go into an EMTALA compliant transfer such as a release of records and the coordination of activities performed between facilities.

**Recommendation:**

There should be at least one hospital in each region with a sufficient amount of on-site security that would allow for law enforcement to disengage after transport.

Technical assistance should be sought by hospitals and emergency rooms to understand the parameters they must adhere to.

**XI. Health Plans**

In looking at Health Plans as possible funders of psychiatric transportation, it appeared that they might be willing to consider funding less expensive transportation alternatives. It was recommended that the commercial plans be drawn into the discussion. More universal buy-in would make the service more viable.

**XII. Certified Peer Specialist Role**

The workgroup received input about the role of Certified Peer Specialist Services in providing crisis intervention and psychiatric transportation services. CPS services have been emerging in Minnesota since 2007 when the legislature authorized the service to be provided along with rehabilitations services (e.g. Intensive Residential Treatment, Assertive Community Treatment, Adult MH Rehabilitative Services and Crisis Stabilization Services). To date, CPS has been provided in all the settings listed here and has recently become a part of the emergency room services at Regions Hospital and is being planned for the CBHHs.

**Certified Peer Specialist Services:**

- could potentially be involved in all phases of transportation and in the crisis intervention
- Should have crisis intervention training
- Should not be designated as health officers
- could reduce potential for trauma,
- would be able to advocate for client
- assist in seeing that advance directives are honored

CPS staff can provide a valuable service accompanying individuals to emergency rooms or psychiatric inpatient services, and riding along when special transportation service is being provided.

**Recommendation:**

The statutory language relating to CPS services should be expanded to allow CPS staff to participate in mental health mobile crisis intervention services.:

*Subd. 3. Eligibility. Peer support services may be made available to consumers of (1) the intensive rehabilitative mental health services under section 256B.0622; (2) adult rehabilitative mental health services under section 256B.0623; and (3) mental health mobile crisis intervention services and crisis stabilization services under section 256B.0624 (d) and (e).*

**XIII. Geography Issues and the Use of ITV**

Individuals are currently subjected to transfers from one end of the state to another. This has increased the need for psychiatric transportation services and has had a significant impact upon

local sheriff office resources. Although it is felt that some of the impact could be mitigated through the use of telemedicine and ITV for court hearings, the better answer is to have regionally available crisis mental health and inpatient service capacity.

**Barriers:**

- There is a requirement that the client's attorney and the client be present together at the same site. Sometimes the court appointed attorney is willing to travel to court but not to the ITV site.

**Recommendation:**

- The use of ITV to conduct commitment hearings should be better optimized but the decision to use ITV should be weighted by consumer preference

**XIV. Clarifying County Responsibility**

A major issue identified by the workgroup was the lack of clarity in state law with regards to who is responsible to provide psychiatric transportation. Historically, it has been generally understood that the county was responsible for providing transportation services for uninsured persons needing to go to an inpatient setting. M.S. §261.22, gives counties authority to pay hospital costs for indigent persons and specifies: "The county board shall provide for transportation of the person to the hospital." But, in tough financial times counties are looking at reducing costs and administrators and commissioners are asking questions about what is truly expected of local government.

The workgroup felt strongly that the matter needed to be addressed and that leaving things vague will only result in individuals in mental health crisis being even more traumatized by the uncertainties about who is responsible to pay. In principle, the individual with means or the individual's health benefit should be responsible for payment. The county should serve as payor of last resort.

The county already has a responsibility to assure the "Availability of Acute Care Inpatient Services" (MS 245.473). It seems reasonable to assume that transportation would be a necessary aspect to meeting the requirement of making Acute Care Inpatient Services available. In addition, this requirement should be extended to include Mental Health Services that are used in lieu of Acute Care Inpatient Services. The workgroup recommends that the following language be added to the Mental Health Act. M.S. §245.473, Subd 5 should be added to read: Subd. 5 Psychiatric Transportation Services. The county board shall ensure that persons having a psychiatric crisis are provided with psychiatric transportation services to and from emergency hospital services, acute care hospital treatment, crisis residential stabilization services, Community Behavioral Health Hospitals and mental health related court hearings. Access to these transportation services shall not be limited to persons who have been placed on a hold.

A definition of Psychiatric Transportation Services should be added to the Mental Health Act as well as basic standards:

Psychiatric Transportation Services – Involves the transporting of persons who are experiencing a mental health crisis to an appropriate setting to have their condition assessed and to receive mental health treatment if needed. Those providing psychiatric

transportation services should have received crisis intervention treatment training or seek the assistance of a mental health crisis intervention practitioner or professional.

## The Role of mobile crisis intervention team clarified relative to Psychiatric Transportation

The role of the mobile crisis intervention team should be clarified to include assessing the individual's need for emergency hospital services, acute care hospital treatment, crisis residential stabilization services, or Community Behavioral Health Hospital services and determine the most appropriate means of transportation to get the individual to the service.

### XV. First Responder Round Table

Eventually all those involved in transporting persons who need psychiatric care have come to realize that there is no way to operate an effective system without ongoing communication. All regions should establish a psychiatric responder round table which would promote collaboration between ambulance services, law enforcement, mental health mobile crisis intervention services and other transportation entities involved in the medical transportation of persons who need quick access to mental health treatment.

### State Operated Services

The question has been asked – “What role could State Operated Services play in assisting with the psychiatric transportation needs of the regions?” There was a time in the past where many of the Regional Treatment Centers did provide some transportation services. But, as the system changed transporting clients was largely discontinued. SOS is in the unique position to meet a significant amount of the need for psychiatric transportation:

SOS has

- a state-wide presence;
- a fleet of vehicles;
- qualified staff; and;
- operates services that are closely related to MH Crisis Intervention.

Many of the AMHIs would welcome the development of a regional SOS psychiatric transportation services.

Attachment A: Getting There with Dignity Workgroup Process  
Meetings and Topics

In order to be responsive to the timelines and needs of the State Operated Services Transformation Stakeholder Group the Psychiatric Transportation stepped up its frequency of meetings and the length of time for each meeting. The initial meeting was held in Brainerd as a face-to-face event with the subsequent meetings conducted through interactive televideo and telephone conferencing from approximately 12 locations around the state.

Date	Topic
June 4, 2010	Welcome, background, mission, charge, work plan development
July 9, 2010	DHS Administered/Funded Transportation, and planning for future meetings
July 23, 2010	Law Enforcement, Non-Emergency Transportation, begin discussion on best practices
August 13, 2010	Emergency Medical Transportation, Legal Issue, continued discussion on best practices
August 20, 2010	Consumer Issues, Natural Supports and Certified Peer Specialist Involvement, continued discussion on best practices and recommendations
September 3, 2010	Input on report and recommendations
October 1, 2010	Review and approval of report and recommendations

The Department of Human Services would like to recognize and thank the many individuals who participated and contributed to this workgroup. Their efforts are greatly appreciated and proved to be valuable in advising the Department about the issue of psychiatric transportation.

**Participants**

Jim Lucachick	Tri-Lead – Beltrami County Board of Commissioners
Joyce Pesch	Tri-Lead – Region 4 South Adult MH Initiative
John A. Anderson	Tri-Lead – DHS Adult MH Division
Jode Freyholtz-London	Consumer Survivor Network of MN
Henry Dailey	Advocate
Roger Schwab	Office of the Ombudsman
Paul Heyl	DHS Adult Mental Health
Sgt. Dave Fischer	Crow Wing County Sheriff's Office Law Enforcement
Terry DeMars	MeritCare/Sanford - Hospital
Linda Sjoberg	Southwest 18 – Adult MH Initiative
Sgt. Eric Herschberger	Anoka County Sheriff - Law Enforcement
Terese Amazi	Mower County Sheriff - Law Enforcement
Bob Ries	DHS/Medical Transportation
Arthur Saunders	Hennepin County Sheriff - Law Enforcement
Luke Foley	Consumer
Debra Phelps-Boone	Consumer
Hazel Campbell	Consumer
Jeanette Hall	Consumer
Rose Dahlvang	Consumer
Jeff King	Consumer
Dennis Henkel	Lake County Social Services

Heather Bjork	Hennepin County Social Services
Dalaine Remes	Disability Law Center - Advocate
Claire McLean	NAMI - Advocate
George French	Pine County Social Services
Dawn Hoffner	Prairie St Johns - Hospital
Thomas Jensen	SMDC Medical Center, Duluth
Dr. Peter Henry	St Joseph's Medical Center, Brainerd
Maureen Marrin	Consumer survivor Network of MN
Jim Franklin	MN Sheriffs' Assn. - Law Enforcement
Daryl Bessler	Hubbard County Social Services
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Mike Sletta	Upper Mississippi Mental Health Center
Alison Wolbeck	State Advisory Council
Catherine Lee	PrimeWest - Health Plan
Marcie Vickerman	PrimeWest - Health Plan
Randy Tieg	DHS - State Operated Services
OJ Doyle	MN Ambulance Association
Michael Weidner	MN Paratransit Association Providers
Rachel Voller	Certified Peer Specialist
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Debra Hartman,	Beltrami County Health and Human Services
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Robert Fraik	Beltrami County Sheriff's Department
Amy Bardwell	Stellar Human Services
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Jana Bromenshenkel	North County Regional Hospital, Nursing Services Director
Tim Hall	North County Regional Hospital, Emergency Services Director
Malotte Becker	Director, Clearwater County Human Services
Buck McAlpin	EMT and Ambulance Providers
Rick Amado	DHS – CMHS Administration
Shelly White	DHS – Adult Mental Health Division
Sgt. Jennifer Cho	Dakota County Sheriff – Transport Div.
Matt Schepers	Dakota County Sheriff – Transport Div.

## APPENDIX XIV.

### Dental Services Workgroup

#### Background

Dental services for underserved and difficult-to-serve populations in Minnesota have historically, been fragmented, often far away from the need and limited by funding questions and concerns. This was the initial drive for the development of State Operated Services Dental Clinics. SOS began by serving persons with developmental disabilities (with the closing of state institutions), then added others on Medical Assistance and finally added persons with mental illness because of a lack of access for these individuals. The shortage of dental providers (especially in rural MN), the inconsistency of funding for dental services and the need for enhanced training for the provision of appropriate dental services to difficult-to-serve populations (DD, MI, etc.) has created gaps in access to necessary services. Lack of coordination in the treatment of both health and dental conditions for difficult-to-serve populations further fragments care.

#### Charge

With a focus on underserved populations (challenging behaviors, uninsured, underinsured) the Work Group will develop recommendations on potential solutions that would provide access to underserved dental clients across Minnesota. It's expected this group will review utilization data from across the state, gather information on the reasons for barriers to access, compare reimbursement rates in MN vs. other states in the country and identify provider shortage areas across the state.

The group will recommend potential solutions to the fragmented system which may include enhanced funding, re-directed funding, creative provider enhancements and perhaps "specialty" dental services closely aligned with general dentistry community-based private practices.

#### Timeline

The work group will have an initial analysis of the issues on the table by the end of August 2010 and a series of recommendations for implementation by the end of September 2010.

#### Membership

-Attached-

#### Efforts

The group met six times over two and a half months utilizing a mixture of in-person and video conferencing technologies. The composition of the group represented various provider types, stakeholders, and public service organizations. Some group members did not attend all sessions and many sent alternates to represent them. Some members were added as appropriate as meetings progressed.

#### I Target Population

- **Target Populations:** Difficult-to-serve adults with
  - Developmental Disabilities
  - Serious and Persistent Mental Illness
  - Traumatic Brain Injury
  - Chemical Dependency (receiving services in residential treatment facility)

- POTENTIAL FUTURE TARGET GROUP: Children with disabilities

## **II Service Barriers**

### **1) Continuum of Care** (issues with connecting home, clinic, and hospital services)

*“She cannot tell me what hurts. Is it a headache, a toothache or something else? Do I take her to the dentist or to the doctor? My personal dentist can’t handle her in their office. Her physician can’t examine her in their office. I take her to the emergency room...”*

- a) Lack of clarity and confusion around what the true service need is across Minnesota
- b) Lack of coordination among different levels of dental providers as to who serves this population and how to make appropriate referrals
- c) Lack of understanding around difficult behaviors the target population may exhibit, the severity of those behaviors in the office setting, and the impact of these behaviors on service delivery
- d) Credentialing/legal barriers prevent a continuum from being developed that could lead to a more seamless service array
- e) Lack of a systematic approach as to where care sites are established in greater Minnesota
- f) Lack of coordination of dental care with medical care in the management of overall health conditions

## **III Provider Barriers**

### **1) Access** (cited by some dental providers for seeing a limited number of the target populations)

*“He cannot communicate and exhibits maladaptive behavior; yelling, flailing and swinging his head on a consistent basis...”*

- a) Embarrassment/discomfort with serving the targeted populations in a practice setting
- b) Fear of behaviors making other patients uncomfortable in practice setting
- c) Concern about potential for disruption in waiting area and in scheduled appointments related to serving target population
- d) Low reimbursement (in the community practice setting & in the hospital setting)
- e) Lack of provider skills necessary to effectively treat target populations
- f) Culture and language disconnects between patient and dental provider
- g) Significant MN budget constraints resulted in a reduction in the adult benefit set (effective 1/1/10) that impacted the target populations. Recipients in these target populations are in need of some of the services eliminated (i.e. full mouth dental radiographs, hospital outpatient surgery with general anesthesia, IV sedation, etc.)
- h) Providers and patients are often unaware of community clinics that provide services on a sliding scale or free basis
- i) Lack of knowledge and skills necessary to treat adults with developmental disabilities, severe and persistent mental illness, those with traumatic brain injuries, and those who are chemically dependent and receiving services in residential treatment facilities for the disabled
- j) Special needs clients often require additional time for site preparation, procedure, care management during the visit, and follow-up care coordination with patients/families/guardians/care providers

### **2) Access** (cited by some providers who **do serve** the target populations)

*“Because of his condition, he should be seen on three-four month intervals just to maintain a stable periodontal condition. Current allowable benefit will provide care on an annual basis only and does not cover periodontal maintenance.”*

- a) Significant MN budget constraints have resulted in a reduction in the adult benefit set that negatively impact, more significantly, special needs populations. Recipients in these target populations are in need of some of the services eliminated
- b) There is no general agreement on a minimum set of core services necessary to best serve the target populations
- c) Redefining Critical Access Sites has financially threatened providers who have traditionally served the target populations
- d) Access to Operating Room (OR) time is limited
- e) Services that a provider would like to render are outside of the Minnesota Health Care Programs (MHCP) limited adult benefit set
- f) Dental services will often lose in competition for OR time with higher volume/higher reimbursement services

#### **IV Consumer Barriers**

##### **1) Failure to seek dental services**

*“There are three staff people who try to help me hold still and not get up or slide down. But all I want to do is get off that chair and get away from there...”*

- a) Patients/clients are often afraid to be treated in a dental office (fear of the sights, sounds and smells of dental sites can trigger behavior outbursts)
- b) Previously difficult dental visits can cause patients and caregivers to stop seeking dental care
- c) In some cases, the target population may be unable to self-report dental symptoms and caregivers may not be able to recognize dental issues as they arise
- d) Fear of dental clinics and dental care can be increased when it is medically necessary for services to be provided in a hospital setting
- e) Many potential patients simply don't seek preventive care in midst of other significant life challenges
- f) Patients are dependent on others to schedule and transport to appointments and travel distances may be excessive for routine and/or preventive care

#### **V Transportation Barriers**

- 1) There is no recognized standard for how far patients, families, caregivers should travel for dental services (note: The US Department of Health and Human Services standard for analyzing areas for designation as Dental Health Professional Shortage Areas is 40 minutes or 40 miles. MN has not adopted a standard for access to dental services for difficult-to-serve populations)
- 2) There is no standard for who transports patients and required skills during transportation or in handling post-treatment patients
- 3) Costs for transportation and reimbursement levels are inconsistent, often inadequate and difficult to access

#### **VI Legal Barriers**

- 1) Need for enhanced professional standards and educational programs focused on serving target populations
- 2) If guardian is uninformed, barriers to seeking service can occur

- 3) General Consent for dental treatment needs to be broad when applied to special needs patients in the event multiple dental problems are diagnosed during an OR or IV sedation procedure due to the risks associated with extended or repeated anesthesia procedures.
- 4) Provider time needed to inform patient/guardian/family (Education) substantially exceeds that for a traditional patient population

## **VII Opportunities**

*“PrimeWest’s program to improve dental access has resulted in contracts with 66 dental clinics and other dentists to serve MA clients on a case-by-case basis. That is up from three contracts in 2003.” (note: dental services were provided to 1,110 unique members in the first quarter of 2004 trending up to 4,190 unique members receiving services in the fourth quarter of 2009)*

- 1) Northern third of state-Sanford Health, North Country Hospital and private practice dentists appear willing to partner with just a small infusion of equipment and leadership
- 2) Engage hospitals regarding OR time for oral services-some dentists are willing to treat but can’t get OR time
- 3) Collaboration between dental providers, behavior therapists and staff caregivers on an individual patient level, using proven techniques can lessen behaviors that get in the way of effective treatment
- 4) Encourage further development of the role of dental hygienists practicing under limited supervision to provide services within their scope of practice for the target population in residences and hospitals
- 5) Need to develop “best practices” recommendations and standards for MN
- 6) Clarification around delivery of dental services using portable equipment -if and where this service may be utilized/needed is not clear
  - i) Is there a need for coordination of such services? Is so, who should coordinate?
  - ii) Mobile Clinic
    - (1) Can be scary as it has all the trappings of a typical dental office
    - (2) Simply dental office on wheels
    - (3) Economies of scale related to this method of service delivery requires further assessment
  - iii) In-home services utilizing portable dental equipment
    - (1) Less scary scenario for many patients because of familiarity, proximity to caregiver, no dental clinic smell, etc
    - (2) More personal/comfortable for the patient than a dental office or hospital setting
- 7) Explore utilization of existing care coordinators to assist clients with accessing transportation and care
- 8) By developing better information and continuums of care, behaviors can be matched more effectively to sites willing/able to manage behaviors during oral treatment
- 9) Mapping of group home demographics and congregate living centers can create a better understanding of the need for proper geographic distribution of specialized services
- 10) Engage with Indian Health Services and tribal agencies regarding barriers/opportunities to service
- 11) Explore grant possibilities for development and pilot testing of more/ better integrated models of care delivery

## **I Work Group Recommendations for 2011**

### **1) Develop and implement a Comprehensive Assessment of Dental Needs in Minnesota utilizing a representative sample of the target populations, recognized oral health indicators and validated metrics.**

**The assessment should be done in coordination and partnership with MN Department of Health Oral Health Program, Office of Rural Health and Primary Care, MN Dental Association, MN Board of Dentistry, MN Dental Hygienists' Association, MN DD Nurses' Association, Safety Net Coalition, and other interested parties.**

Assessment should include:

1. Involvement of patients, families, guardians, social workers and care givers
2. Assess necessary dental treatment needs: regular, episodic; primary, secondary, tertiary
3. Analyze where services are needed and where services are currently provided (where is the target population density)
4. Analysis of current system capacity and potential capacity
5. Analyze existing data sets to develop a picture of the utilization patterns, needs and opportunities for enhanced access to services
6. Current spending on dental and hospital care for target population (public and private)
7. Develop a standard for what is meant by proper access
8. The assessment should include a description of activity in other states
9. Develop a MN standard for a minimum benefit set to meet the needs of the target populations
10. Develop a MN standard for Best Dental Practices to meet the needs of the target populations

### **2) Develop a comprehensive analysis of SOS clinics**

- a) Analysis/Assessment of clinics, including
  - i) Billing and reimbursement practices
  - ii) Business management
    - (1) Staffing Ratios
    - (2) Chair turnover rate
- b) Develop plan for enhanced utilization of clinics with clear roles and functions
- c) Needs assessment
  - i) Necessary additional equipment/staffing
  - ii) Necessary equipment upgrades
  - iii) Potential for expansion

### **3) Development and recognition of a clear role for SOS Clinics in serving the target populations**

- i. Marketing of Clinics to providers, care coordinators and client communities regarding appropriate care coordination and referrals

- ii. Development of partnership to serve as training sites and to recruit dental professionals
- iii. Develop partnership with educational institutions for rotation of students/residents

**4) Development and implementation of measures to gauge effectiveness**

- a) Utilize claims data to measure services being rendered to target population vs. a baseline (2009 vs. 2010. vs. 2011)
- b) Utilize claims data to measure impact of services under previous adult benefit set vs. 2010 adult benefit set
- c) Consumer survey of perception of access to service (better or worse)
- d) Provider survey of awareness of access to continuum of care (better or worse)\

**5) Dental training possibilities**

*Identify potential project partners (i.e. Univ of MN, HCMC, Central Lakes Community College, Normandale Community College, Apple Tree Dental, etc)*

- b) Develop courses on special needs services
- c) Additional training after dental school
- d) Training on medical issues
- e) Develop clinical competencies/standards around special needs services
- f) Develop rotations around special needs populations
- g) Develop an assessment of General Practice Residency graduates and what they are doing now
- h) Bring dental assistant students into SOS space for further educational experience around disabled populations
- i) Develop model for loan forgiveness for dental providers serving special populations

**6) Potential Project Partners**

*Minnesota Dental Association & All Dental Providers*

- a) Educate members on SOS clinics
- b) Educate on how to partner with SOS to utilize services appropriately
- c) Educate members on potential utilization of mid-level practitioners (how to collaborate and how to utilize)
- d) Keep legislators informed
- e) Develop grass roots supports to enhance ut members opportunity to shape the future of dentistry in MN
- f) Coordinate the development of a “continuum of care” model
- g) Seek enhanced participation by members

*Minnesota Board of Dentistry*

- a) General Consent needs to be broad and more streamlined to provide better service in single setting/visit
- b) Require serving disabled groups to gain CE
- c) Deeper links to Universities and educational opportunities

*Minnesota Dental Hygienists' Association*

- a) Educate members on SOS clinics
- b) Educate on how to partner with SOS to utilize services appropriately
- c) Educate members on potential opportunities for hygienists practicing under limited authorization and Advanced Dental Therapists
- d) Keep legislators informed
- e) Develop grass roots support to enhance members opportunity to shape the future of dentistry in Minnesota
- f) Assist in the development of a “continuum of care model”
- g) Seek enhanced participation by members

## **II Work Group Recommendations for 2011-2012**

- 7) *Model Development-what would a community wide “continuum-of-care look like”?*
- 8) *Potential for multi-service clinical sites (dental, physical, behavioral)*
- 9) *Model for dispersed training sites and clinical rotations serving disabled populations*
- 10) *Explore potential for revised/enhanced funding streams*
- 11) *Utilization of dental hygienists, dental therapists and advanced dental therapists*
- 12) *Partnering roles-develop a “linked” network of providers with clear understanding of who serves whom*
- 13) *Model development for medical/dental care coordination to manage chronic conditions*

## **III Attachments**

- 1) Membership
- 2) State Operated Services
  - a) Anecdotal comments and overview
  - b) Background information
- 3) Limited information on some Work Group members
- 4) Hennepin County Medical Center provided information
- 5) FQHC Data
- 6) MA Benefit Set Overview-2010
- 7) MDA “Flash” survey

# Child and Adolescent Intensive Services Workgroup DRAFT Listening Session Summaries and Recommendations

DRAFT DATE: 12/02/10

## Question 1: Description of children and adolescents for whom it is difficult to access appropriate, intensive services

- **Diagnostic complexity:** more than one mental illness diagnosis; mental illness and disabilities; mental illness and cognitive disability; comorbid substance abuse; harmful to self or others, or highly aggressive; specific diagnoses including Autism Spectrum; Fetal Alcohol syndrome/Effect; Reactive Attachment Disorder
- **Demographic factors:**
  - Age: groups  $\leq 8$  and transition age (14-21) highlighted
  - Underserved populations, with highlighting of specific needs:
    - Immigrant groups
    - Deaf and Hard-of-Hearing children and adolescents, who may have either hearing or DHH parents
    - Native Americans, both on reservations and in urban areas, particularly in dealing with historical trauma, complex trauma and multiple losses
    - U.S.-born cultural, racial and/or ethnic groups, who may be underserved or not receiving appropriate services
  - Geographic variation: presentation of greatest needs related to what community currently has available, e.g., more focus on facility needs in areas most distant from metro area
- **Juvenile justice-involved youth:** those with criminal or other court involvement; gang affiliations; sexual behaviors/offenders
- **Contextual factors:** under- and uninsured; homeless children and runaways; transportation and other family social or economic needs

## Question 2: Intensive services needed to effectively treat identified children and adolescents

- **Expanded crisis services:**
  - Mobile crisis not available statewide, and/or immediacy suffers due to distances
  - Continuity needed between immediate crisis intervention and stabilization, continued services
  - More training for crisis staff to work effectively with parents of children and adolescents
- **Continuity between/among intensive service providers, even within same agency**
  - Networks organized to minimize or ease transitions, especially for youth leaving inpatient or residential programs
- **Increased inpatient hospital beds and/or psychiatric residential beds, particularly in northern Minnesota**
- **Increased access to psychiatric services, perhaps using expanded range of providers**

- **Increased access to day treatment and partial hospitalization programs**
- **Increased capacity to serve youth with co-occurring MI/CD disorders**
- **Standardization of level-of-care decisions**
- **Greater family involvement at all levels of service planning and utilization, including:**
  - Enhanced support/flexibility by providers to enable families to be involved in services
  - Increased availability of and emphasis on services to caregivers who may also have mental health, chemical dependency or other treatment needs
- **More respite care, with trained providers**
- **Continuity of providers whenever possible, particularly in planning for transitions**

### **Question 3: Critical care components**

- **Don't send children and adolescents away from their home communities for treatment**
  - Increase access to intensive community-based interventions shown to avert placements
  - If there is a residential treatment need, it needs to be readily accessible in the local community
  - As new treatment options are designed, assure access for all children and adolescents
- **Collaborative/cooperative communication and care/treatment planning across systems**
  - Schools, juvenile justice, county human services, families, providers
    - School collaboration needs particular focus to assure success for children and adolescents with most critical needs
    - Youth in juvenile justice also need specific attention to assure care and treatment needs met
  - Make transitions easy, especially across service system discontinuities
- **Build core community capacity rather than more specialized services**
  - Holistic approach to assessment and treatment
  - Primary care capacity and connections to behavioral health services
  - School-based services
  - Build in cultural expertise
  - Use telehealth not only for individual consultation, but for specialized knowledge dissemination
- **Build increased capacity for respite and short-term crisis placements**
- **Sustain therapeutic gains made in inpatient and residential programs by increasing the availability and utilization of aftercare services and supports**
- **Establish standards of care for all providers**
- **Increase supports for families**
  - Increase availability of parent-to-parent support and parent education
  - Create and sustain mechanisms to help families assure safety of children with complex needs in their homes
- **Determine how to make all infrastructure enhancements affordable and sustainable**

#### **Question 4: New Ideas**

- **Better supported and understood families, utilized as resources at all levels of planning and service delivery**
- **Create incentives for local collaboration, i.e., “local think tanks”**
- **Master plan/master case manager to coordinate services**
- **Infuse psychoeducation throughout system: in-home services, public awareness, professional training**
- **Expand technological supports/extenders for service delivery**
- **Supplement or enhance traditional treatment services with other interventions and supports, e.g.,**
  - job training and support, independent living skills training and support, youth and parent mentoring, etc.
  - holistic/culturally validated treatment approaches and training for providers serving culturally-specific populations

#### **PRELIMINARY RECOMMENDATIONS**

##### **1. Public Safety Net**

Although not required to do so by statute, the State of Minnesota has traditionally served a “safety net” function for children and adolescents with severe mental health difficulties by providing psychiatric hospital care for those youth who require such intensive services and are unable to get their treatment needs met in other settings; such youth are currently served through the CABHS program at Willmar and the YAAP program at St. Peter. CAISW believes the state has a responsibility to continue providing a “safety net” for this population and recommend that State Operated Services (SOS) continue to fulfill this obligation by maintaining its capacity to serve youth who require inpatient psychiatric care but whose treatment needs cannot be met in a community setting.

However, maintaining this capacity does not necessarily mean providing services to these youth in a state-operated facility. Alternative approaches to serving this population, such as contracting for psychiatric beds in community hospitals or supporting the development of psychiatric residential treatment facilities (PRTFs) should also be explored. CAISW members noted, however, that alternatives developed within private facilities and/or through public-private partnerships must be designed to be able to meet the needs of all children and adolescents who present for the most intensive level of care.

##### **2. Contract beds**

CAISW recommends that the Chemical and Mental Health Services Administration of DHS begin exploring the possibility of contracting with community hospitals in Minnesota and adjacent trade areas in neighboring states for extended-stay inpatient psychiatric beds for children and adolescents with intensive service needs.

This recommendation, in combination with 1. (above) leads to the following proposed action steps:

- Determine an appropriate portion of the state appropriation for the CABHS program which could be allocated to an RFP for contract beds in a metro-area community

- hospital(s) with current child and adolescent psychiatric inpatient programming. Contract(s) must specify core components of programming to fit the service to the population described earlier in this document as “difficult to treat.”
- Develop a second RFP for contract beds in a community-based hospital in northern Minnesota (or adjacent trade area), with the same requirements for core programming components fitted to the difficult to serve population.

### **3. Intermediate levels of care**

CAISW noted intense interest in some parts of the state in developing a level of care which could be considered more intense than most current children’s residential treatment, but less intensive than inpatient psychiatric hospitalization. Various perspectives on the nature of this type of facility-based care were expressed, including uses ranging from hospital diversion to transition from hospitalization back to community; public versus private capacity development; licensure type; and funding model. Specific discussion with a range of stakeholders, including hospitals and residential treatment providers, was recommended. CAISW members also noted the need for clarification from CMS regarding specific requirements for PRTFs which could impede development of this model, viz., facility requirements and Medicaid coverage status for children served.

This recommendation leads to the following proposed action steps:

- Coincident with establishing contract psychiatric bed capacity in the metro region and northern Minnesota, conduct feasibility study of conversion of CABHS Willmar campus to PRTF level of care. The campus meets current CMS facility requirements, abbreviating the potential impediments to conversion.
- Assuming clarification of other CMS requirements, determine other current or projected facilities which might be candidates for conversion to PRTF, as well as the staffing, technical assistance or material support which would be needed to accomplish conversion.

### **4. Accountable Care Organization Development to meet Child and Adolescent Needs**

In response to stakeholder feedback regarding the need for care coordination, continuity of services and improved access to the right level of care and intensity of intervention, CAISW initiated a discussion of the merits of establishing a formal connection among providers of the inpatient, outpatient and rehabilitation service continuum. CAISW recommends establishing of subgroup to explore the feasibility of a pilot(s) to develop this connection as an Accountable Care Organization.

This recommendation leads to the following proposed action steps:

- Establish a working group charged with creating a design for ACOs which would unite hospital, residential treatment and community service providers jointly responsible for the successful treatment of children and adolescents with intensive service needs in a specified geographic area. The group should report to CAISW on specifications for one pilot in the metro area and one in a greater Minnesota location.

## **5. Standards for Levels of Care and Transitions Among Levels of Care**

Stakeholder feedback identified a number of ways in which the development of specific standards for levels of care would improve children's and families' experience of care. Of particular concern was the need for clear communication among providers, care/case managers, families and youth at points of transition between levels of care, e.g., within a care system, from hospital to community-based services, and between residential treatment and community service providers.

This recommendation leads to the following proposed action steps:

- Establish a subgroup within CAISW to develop proposed level of care guidelines in order to differentiate and coordinate intensive services. This work can expand on current implementation of the Child and Adolescent Service Intensity Instrument (CASII), as well as coordinating with parallel work in the adult mental health system.
- The subgroup should also develop proposed communication guidelines for care transitions. Families and youth representatives should also be added to this group, with their transition experiences helping to shape guidelines and proposed formats for planned transitions.

## **6. Local “think tanks”**

Regional variation in responses to the CAISW listening sessions was noted, leading to a suggestion that a small amount of funding, possibly developed from both public and private sources, be made available to local or regional groups ready to begin planning for the needs identified in their areas. Composition of local planning groups should focus on families and include at least all of the diversity currently represented in CAISW; current local planning structures (LACs, LCCs, etc.) could be eligible, or new groupings could be created to respond to a request for interest. “Think tanks” should be ready to do much more than just thinking, but would be prepared to take the ideas and suggestions that have been gathered, particularly in their specific areas, and determine how to implement them locally. Through their understanding of local systems, they would be uniquely able to seek and find ways to overcome barriers and move more quickly to secure the services needed.

## **7. Supporting Families**

Numerous listening session comments regarding family needs and the valuable role of families in children's treatment were reinforced by data from more than 30 parents and other caregivers who responded to an on-line survey sponsored by NAMI-MN and the Minnesota Association for Children's Mental Health (MACMH) during the same time period. Parents and caregivers expressed considerable frustration with the difficulties they experienced finding out what resources might be available for their children, and how these could be accessed. While a number of actions can progressively be taken to assure better and easier participation for parents in system planning (cf. local “think tanks,” above) and family-centered interventions, one of the most basic needs is for statewide dissemination of information for families about how to access services as early as they may have a concern. These materials could be customized locally to facilitate

access to appropriate services, and could be distributed by family, advocacy and provider groups to assure a common knowledge base of available services. Additional suggestions for supporting families included the development of parent-to-parent or other parent support groups in every county.

Family feedback and survey information also called for care coordination which crosses all systems touching the lives of children and families, perceived as broader in scope than current case management.

This recommendation leads to the following proposed action steps:

- In cooperation with family and advocacy organizations, DHS Children's Mental Health should prepare information adaptable to a variety of formats regarding service access. The materials should be reviewed by CAISW and other stakeholder groups and made available to families by spring, 2011.
- DHS should explore mechanisms for funding care coordination activities by providers which could ease access and transition issues for children, youth and families, and report on these to CAISW.

## **8. Integrated Systems and Services for Youth With Dual Mental Health and Chemical Dependency Needs**

Systemic structural barriers were identified through listening sessions and CAISW member input, and these were described as hampering access to integrated, concurrent services for youth with dual mental health and chemical dependency disorders. Separate funding and regulatory mechanisms act to prevent the development of services which would more effectively respond to the needs of the adolescent and most efficiently utilize scarce resources. Youth and families are subject to sequential sets of services, "bouncing" them between care teams based on either side of the mental health and chemical dependency divide or leading to the juvenile justice system. This fragmentation within the system is costly on every level, and can foster failure of service intervention, wasted time and resources, and missed or inadequate communication and undermining of important therapeutic relationships. Providers who attempt to provide dual interventions struggle with an endless debate about clinical documentation, adequacy of treatment plans, justifying of care often having reimbursement denied by one side of the system or the other. The State should provide leadership to determine how these structural barriers at both state and national level can be addressed to promote an integrated, single system of care for dually diagnosed mental health and chemically dependent youth.

## **9. Workforce Needs**

A theme in the feedback from stakeholders was the lack of consistent resources for youth with intensive service needs. Some providers noted that their inability to serve youth with violent behaviors was at least in part due to staffing levels in their programs, e.g., funding for residential treatment centers does not allow for the level of staffing needed when multiple residents require one-to-one staffing to remain safe. The well-known shortage of mental health professionals can affect this population in particular, especially in greater Minnesota, as families may not have ready access to psychiatry or a crisis response team

with experience with children and adolescents. Training, particularly in trauma informed care, could be expanded to crisis teams, day treatment and respite providers. Broader use of telemedicine could improve access to mental health professionals. Feedback from families stressed the need for parent mentors who could help families navigate the complicated mental health system.

## **10. Continuity of Planning**

CAISW should be maintained as a planning and review group to assist DHS, provider organizations and family and advocacy organizations in improved service delivery for youth with intensive service needs and their families. Continued meetings through June, 2011 (or later) are recommended.

**APPENDIX XVI.**

**Chemical and Mental Health Services  
Transformation Advisory Task Force:  
Anoka Metro Regional Treatment Center Redesign**

**A Report**

Mandated by Minnesota Session Laws, 2010, 1<sup>st</sup> Special Session, Chapter 1, Article 19, Section 4 and Section 19.

December 2010

**Chemical and Mental Health Services Transformation Advisory Task Force:  
Anoka Metro Regional Treatment Center Redesign**

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

**Chemical and Mental Health Services Administration, Minnesota Department of Human Services**

**December 2010**

This information is available in other forms to people with disabilities by contacting the Chemical and Mental Health Services Administration, Department of Human Services, at (651) 431-2225 (voice). TTY/TDD users can call the Minnesota Relay at 711 or (800) 627-3529. For Speech-to-Speech Relay, call (877) 627-3848.

**COST TO PREPARE REPORT**

**Minnesota Statutes, section 3.197, requires disclosure of the cost to prepare reports. The cost of preparing this report was less than \$10,000.**

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# Chemical and Mental Health Services Transformation Advisory Task Force: Anoka Metro Regional Treatment Center Redesign

## Report to the 2010 Legislature

### TABLE OF CONTENTS

I.	Executive Summary.....	Page 246
II.	Introduction.....	Page 248
III.	Discussion.....	Page 250
IV.	Recommendations.....	Page 253
V.	Appendices.....	Page 256
	Appendices include ( <i>20 pages</i> ):	
	• Request for Information.....	Page 256
	• DHS Response to County Questions.....	Page 261
	• County letter to Adult Mental Health Division.....	Page 269
	• Department letter to Counties.....	Page 274

## I. EXECUTIVE SUMMARY

The Chemical and Mental Health Services (CMHS) Transformation Advisory Task was established to make recommendations to the Commissioner of the Minnesota Department of Human Services and to the Minnesota Legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, and specifically reduce cost and improve efficiency of services including those provided by the state through State Operated Services. The Task Force was convened in June 2010 and was made up of members representing consumers, family members, advocates, advocacy organizations; service providers and professional organizations; unions representing public employees; state and local government with administrative and policy responsibilities for these services; state legislators; and academic programs conducting research and preparing behavioral health professionals.

The Task Force met a total of ten times to hear presentations of recommendations from the following seven CMHS workgroups: 1) Levels of Care; 2) Access to Care; 3) Neurocognitive Services; 4) Housing with Services; 5) Psychiatric Emergency Transportation Services; 6) Child and Adolescent Intensive Services; and 7) Dental Services. Each work group was instructed to assess current needs and provide recommendations to the Task Force on what role State Operated Services should serve in addressing these needs. Each work group then went on to provide recommendations and long range goals for the broader system of care. The Task Force members instructed each work group to respond to specific questions and provide more information. Task Force members then voted on each of the recommendations.

The results of the voting on these recommendations is contained within a broad Task Force report entitled, *“Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services”*. Besides the recommendations on the broader system, the Task Force was specifically charged by the Minnesota Legislature to provide recommendations to the Commissioner of the Department of Human Services and to the Minnesota Legislature on a redesign of the Anoka Metro Regional Treatment Center.

The Task Force heard presentations from the Department on approaches to developing pilot models in partnership with counties and community providers concerning Anoka Metro Regional Treatment Services in October 2010. In order to achieve the legislatively mandated goal of the Task Force, the Department proposed releasing a formal Request for Proposal on March 1, 2011 that will require response by May 1, 2011 to develop at least one pilot initiative in the metro region that will provide an array of services as an alternative to hospitalization at Anoka Metro Regional Treatment Center.

The Task Force also heard a proposal from State Operated Services to temporarily create a sub-acute service in Bloomington, Minnesota while the RFP process was underway. The Task Force responded with caution to this proposal, expressing that the expense of closing a unit and opening a new unit in another location may be prohibitive and did not fit the charge to the Advisory Task Force to provide recommendations that were “transformational” by addressing how State Operated Services fits into the a transformed broader system of care for adults with severe mental illness and complex needs in the metro region.

The Task Force not only expressed concerns with the temporary proposal presented by SOS, but it also expressed concerns pertaining to the lack of adequate time needed to assess service delivery in the metropolitan region, the needs of the persons receiving services at AMRTC, and the best methods to improve service delivery for these persons, include additional redesign of the system.

Despite these concerns, the Task Force did not object to the Department proceeding with the process it outlined, which would include:

1. Staff of the Chemical and Mental Health Services Administration should meet with directors from the seven-county metropolitan area prior to January, 2011 to discuss an agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders.
2. The process mutually agreed on above should be employed during January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members and advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a RFP to be developed by DHS. DHS will cover the cost of facilitator services to run and coordinate these meetings.
3. DHS should issue an RFP consistent with recommendations of the CMHS Transformation Advisory Task Force, input from the local process outlined above and the requirements in Laws of Minnesota 2010, First Special Session Chapter 1, Article 19 section 19 by March 1, 2011 with a projected due date of May 1, 2011 for local responses.
4. The Chemical and Mental Health Services Transformational Advisory Task Force should appoint a subcommittee to evaluate and advise the Department's implementation of the recommendations above. Initially, and through the completion of the RFP process, the subcommittee will be composed of members who are representing advocacy organizations, consumers & family members, and the statutorily established advisory bodies for chemical and mental health services. The subcommittee will convene at least once to hear stakeholder presentations and advice on its task prior to the drafting of the RFP. In the event that the RFP process does not produce a plan for alternative services, the subcommittee will evaluate and advise any further action taken by DHS to plan and implement alternative services. The membership of the subcommittee overseeing the development and implementation of alternative services should expand once the RFP process is concluded to include key stakeholders initially excluded due to conflict of interest limitations.

While the RFP is being issued it was felt that the Department could prepare the Bloomington building for new services and await opening until it was determined if the RFP process is not successful in yielding results for the redesign of services out of AMRTC. At that point the Department could proceed with the development of the Bloomington site.

## II. INTRODUCTION

As directed by the Laws of Minnesota 2010, First Special Session, Chapter 1, Article 19, Section 4 and Section 19, the Chemical and Mental Health Services (CMHS) Transformation Advisory Task Force, established under Laws of Minnesota 2010, First Special Session, Chapter 1, Article 19, Section 4, was required to make recommendations to the commissioner of human services and the legislature on the *“transformation needed to improve service delivery and provide a continuum of care, such as transition of current facilities, closure of current facilities, or the development of new models of care, including the redesign of the Anoka-Metro Regional Treatment Center.”* In addition, under Section 19, *“the Task Force was required to recommend an array of community-based services in the metro area to transform the current services now provided to patients at AMRTC. The community-based services may be established in partnership with private and public hospital organizations, community mental health centers and other mental health community services providers, and community partnerships, and must be staffed by state employees.”*

This report supplements a 2009 Legislative report, [\*Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience & Recovery of the People\*](#), on the redesign of the public chemical and mental health system in Minnesota and its associated budget proposal and implementation plan. That report discussed the underutilization of the available beds within the State-Operated Community Behavioral Health Hospitals (CBHHs) and the inappropriate placement of persons with mental illness in inpatient hospital settings at the CBHHs and the Anoka Metro Regional Treatment Center. The report also discussed the process utilized to assess the needs and recommendations for system transformation obtained in community meetings held across the state and included input from nearly 1,000 Minnesotans representing those with most at stake in service delivery to people with mental illness— consumers, family members, advocates, county and tribal officials, community hospitals, community mental health providers, in addition to SOS employees and state legislators. The report resulted from a directive from the 2009 Legislature to transform services provided at the Anoka-Metro Regional Treatment Center and the Minnesota Extended Treatment Options.

As directed by the 2009 Legislature, the transformation of the Anoka-Metro Regional Treatment Center (AMRTC) was targeted at initiating a transformation of the manner in which services are provided to individuals served at AMRTC and within the metropolitan region. The effort was intended to reap similar cost efficiencies and system improvements as did the system redesign that was initiated in greater Minnesota almost a decade earlier. With the adoption of the 2003 Human Services Budget, the Legislature furthered the community-based development for Adult Mental Health Services in greater Minnesota. Continuing with the vision described in the Minnesota Comprehensive Adult Mental Health Act of 1987, the Legislature leveraged the utilization of all 87 Minnesota Counties as the local planning authority for mental health services. The Counties organized themselves into 11 Regional Planning Workgroups, including the Adult Mental Health Initiatives, as they began the process of determining the additional community-based mental health services for their regions.

The Workgroup consisted of County representatives, including:

- Board members, directors & staff;
- Adult Mental Health Initiative Staff;

- Private Providers;
- Advocacy Organizations; and
- Citizen Groups.

Each Regional Planning Workgroup reviewed their current mental health system, proposed and adopted system changes that lead to the delivery of additional and improved services within their regions. The services adopted by each regional included:

- Adult Rehabilitative Mental Health Services (ARMHS);
- Assertive Community Treatment Services (ACT);
- Intensive Residential Treatment Services (IRTS);
- Crisis Services; and
- Community Alternatives for Disabled Individuals (CADI) slots.

During this resign, each region also identified a need for the continued presence of State Operated Services to provide care for the State's most difficult to serve and highly complex individuals. The regions asked SOS to develop ten, 16-bed Community Behavioral Health Hospitals (CBHHs) that were geographically dispersed throughout the state. These hospitals were charged to provide acute psychiatric inpatient care for adults 18 years and older using evidence-based practices, which are methods of treatment that research has demonstrated are effective in supporting people with mental illness in their recovery. The goals of each CBHH were to provide care in smaller settings, closer to individuals' communities, homes and natural supports of family and friends.

Along with an array of other community-based mental health services, the hospitals soon replaced bed capacity at the Regional Treatment Centers (RTCs) in Brainerd, Fergus Falls, St. Peter, and Willmar. In August 2008, this transformation of State Operated Services was completed. As part of the transformation, services from six of seven institutional settings in Greater Minnesota were moved to smaller community-based facilities.

Like in 2003, 2009 Minnesota Legislature adopted laws (Laws 2009, Chapter 78, Article 3, sections 17 & 18) requiring the Commissioner of Human Services to develop expanded and improved delivery of community-based mental health services for patients served by the state in the metropolitan region and write the fore-mentioned report on the design of those services. In tandem to these legislative objectives, the Governor also unallotted funding for the 2010/2011 biennium with the goal of initiating this transformation plan more quickly.

Between adjournment of the 2009 Legislature and the beginning of the 2010 Legislative Session, budget pressures for State Operated Services (SOS) and the rest of state government mounted and SOS identified that it needed to reduce its operating budget by \$17 million by the end of the biennium on June 30, 2011. The 2009 report was intended to be an immediate response to those budget pressures and the simultaneous need to transform the current care delivery system. The report outlined a phased-in approach over a 15 month time period resulting in a reduction of full-time positions and the closing or transforming of several SOS services. The 2010 Legislature responded to the report and plan by creating the CMHS Transformation Advisory Task Force, by allowing certain SOS services to close or transition to another alternative, and by providing enough funds to delay the ultimate reduction of specific state-operated services. In addition the

2010 Legislature amended the original law requiring the development of community-based mental health services for patients committed to AMRTC (*Laws 2009, Chapter 79, Article 3, Section 18*)

## II. DISCUSSION

In order to adhere to the law, the Department of Human Services, initiated the process of the redesign of services at the Anoka Metro Regional Treatment Center by issuing a Request for Information (RFI) in October 2010. The stated purpose of the RFI was to “solicit recommendations and proposed models from potential responders to a Request for Proposals to serve approximately 100 adults who have multiple disabilities and multiple diagnoses with poorly managed chronic medical conditions and /or behavioral dysfunction and chronic functional deficits who have been treated by AMRTC or are at risk of being committed to the commissioner of human services for treatment at AMRTC.” The objective of the RFI was “to begin the transition at AMRTC by reducing initial capacity at the facility by up to two units and to design the full array of quality mental health services from acute care to housing with supports in the community using, in part, staff from AMRTC who will continue to be state employees.” The RFI “envisioned that these networks with formalized service agreement will be a precursor to the Accountable Care Organization (ACO) proposed in the future under health care reform.”

The RFI, requested information from the seven counties served by the AMRTC and its array of service providers on:

- formal, collaborative models for delivering care;
- opportunities and challenges the models would present;
- requirements of resources, policy changes, and funding;
- the use of existing state staff to deliver services (*as prescribed by the law*); and
- the associated timeline for implementation.

While completely voluntary, participation was considered a precursor to a future Request for Proposals (RFP) requiring the development of formalized, collaborative partnerships from providers that would cover the full service array from acute care settings to the wide range of community-based mental health services including housing with supports in order to meet the needs of the target population.

Within the RFI, responders were requested to address the following:

1. Indicate the specific community hospital(s) with acute psychiatric care units and the community-based providers that will establish the formalized partnerships and what enhanced or expanded services will be provided.
2. Indicate the proposed fiscal agent for the partnership.
3. Indicate how consumers, family members, advocates and other key stakeholders will be included in the planning, development, implementation and monitoring of new service models.
4. Indicate the mechanism(s) by which individuals are allowed to voluntarily participate in this pilot partnership alternative or choose to be served traditionally at AMRTC.

5. Indicate the proposed numbers and qualifications of state staff currently working as AMRTC that will be needed to support the partnership and proposed models and any training and potential administrative costs associated with incorporating additional staff into the service mix.
6. Indicate the methods by which quality monitoring and oversight will be implemented to evaluate the efficacy and cost-effectiveness of the proposed partnership and proposed new models.
7. Indicate a proposed timeline that addresses planning, development and implementation.
8. Indicate any supports, technical assistance and other additional resources that are needed to meet the proposed timeline for implementation scheduled to occur on or before January 1, 2012.
9. Indicate how any proposed partnerships or models will comply with existing statutory or other legal requirements, including any requirements related to state employment or if any changes in current law would be necessary to effectuate the proposed partnerships or models.

Responses to the RFI were requested to be received by 4:00pm (CST) on November 17, 2010.

The seven-county metropolitan region initially responded to the RFI by submitting a series of questions and the Department of Human Services replied by provided responses on October 29, 2010. (Questions and Responses can be found in appendix II of this report.) Concurrently, the Counties submitted a letter dated October 29, 2010 (see appendix 3) unanimously affirming that:

- “Support *of* the objective of transitioning citizens out of AMRTC and back into the community. However, each county needs additional information regarding its citizens placed at AMRTC to determine what level of supports would be needed to accomplish this;
- Individuals in question have significant multiple disabilities, diagnoses, and upon transition would continue to be at very high risk for re-commitment to the Commissioner;
- A willingness to consider multi-county models to accomplish the objective;
- Confirmation that a significant waiting list at AMRTC compromises the availability of needed services;
- Appreciation that responses to the RFI are voluntary in nature; and
- Agreement that responses should detail a full service array.

Despite these points, the Counties urged the “Department not to move hastily to downsize the AMRTC without adequate planning...” and that “the Metro Counties do not want to see our residents disproportionately experience poverty and homelessness due to failures of the service delivery system.”

As a result of this caution, the Metro Counties agreed “that to produce a thoughtful, comprehensive, multi-county response to *the* RFI with merely 28 business days from publication to due date is unrealistic, for the following reasons:

- The RFI essentially asked counties to accomplish the next step in de-institutionalizing people with serious and persistent mental illness. This is a major systems transition. The scope of work encompassed in the RFI was daunting and cannot be adequately assessed in the time frames provided. Simply put, if the answer to moving more people out of AMRTC was so straightforward that Counties could provide it to you in 28 days, those counties would have accomplished it already.

- The RFI asks the Counties to identify how consumers, family members, advocates, and other key stakeholders will be included in the planning, development, implementation, and monitoring of new service models. Ideally, those individuals should be involved from the very beginning – the RFI stage – but this time frame did not realistically allow for more than their token involvement.
- The RFI further required identification of the mechanism(s) by which individuals can choose to receive service at AMRTC over whatever model(s) developed. There are many problems with being able to respond to this item within the time frame provided. First of all, such a mechanism may actually require a change in the Commitment Act, which of course cannot be accomplished by November 17. In addition, it will likely require the creation or identification of risk protocols that are currently not in use. Again, this task is not likely to be complete by November.
- The RFI requested that Counties indicate specifically the numbers and qualifications of state staff required to effectuate the model. This strikes us as an extremely detailed question to respond to within the first four weeks of planning for a major system transition.”

The Counties furthered that, “beyond the low quality submissions DHS would likely receive in such an abbreviated time frame, it simply may not be logistically realistic for county governments to process a response so quickly. County Boards of Commissioners typically require policy discussion and subsequent board approval in order for local social service agencies to submit RFI responses, a process which is not possible given the time required to complete the response drafting. In addition, it is possible county attorneys will advise us not to respond as multi-county entities without the existence of an underlying legal framework, such as a Joint Powers Agreement.”

In response to the receipt of this letter, the Department responded with a letter dated November 3, 2010 (see Appendix 4). The letter indicated that the RFI was to “solicit suggestions, potential proposals and any recommendations that would assist the department with issuing a RFP that incorporated ideas at the local level.” Responding to the Counties concerns about level of response necessary and the Counties inability to respond in a thorough fashion by the specified timeframes, the Department outlined the following alternative approach:

- “1. Staff of the Chemical and Mental Health Services Administration will meet with directors from the seven-county metropolitan area in December 2010 to discuss a less formalized and mutually agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders;
2. Meetings would be convened in January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members and advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a RFP to developed by DHS. DHS would be willing to consider covering the cost of facilitator services to run and coordinate these meetings.
3. DHS will issue a RFP on March 1, 2011 with a projected due date of May 1, 2011 for submission.”

The letter also indicated that, “because the last legislative session included budget savings that must be realized by State Operated Services, the department will likely need to proceed with some temporary changes at AMRTC to meet the budget pressures being encountered. It is the

department's intent that any changes be temporary in nature until a workable design is developed and implemented in 2011."

The patients served at Anoka have multiple diagnosis and multiple disabilities. They present complex cases and have co-occurring disorders. Of the total population served at Anoka, approximately 70% have a psychotic disorder, 25% have a bipolar disorder, 18% have major depressive disorder, 75% have a substance use disorder and 30% have a personality disorder.

On November 22, 2010, State Operated Services presented the CMHS Transformation Advisory Task Force with a temporary plan to re-design and move two units out of AMRTC until a more permanent solution identified through the RFP process could be initiated. As has been stated previously, approximately 30-40 patients being served at AMRTC are being served at a hospital level of care which is a higher level of care than the individuals need. This number has been consistent for two years. It is believed this population could be moved from Anoka to a lesser level of care that would serve as an Intensive Residential Treatment Service (IRTS) plus or a "sub-acute" level of care to better meet their needs in a more appropriate setting. While respecting the timelines of the metro-wide RFP process, SOS felt that it needed to respond to current budget pressures and the inappropriate utilization of 30-40 beds.

The temporary proposal submitted by SOS was to convert the vacant Bloomington unit in Minneapolis to a sub-acute unit by May 2011. In addition, SOS would open a second sub-acute unit on the Anoka Campus and relocate it to a yet to be determined community site by July 2011. Both of these sites would then need to be integrated with the existing primary care and behavioral health care community structures.

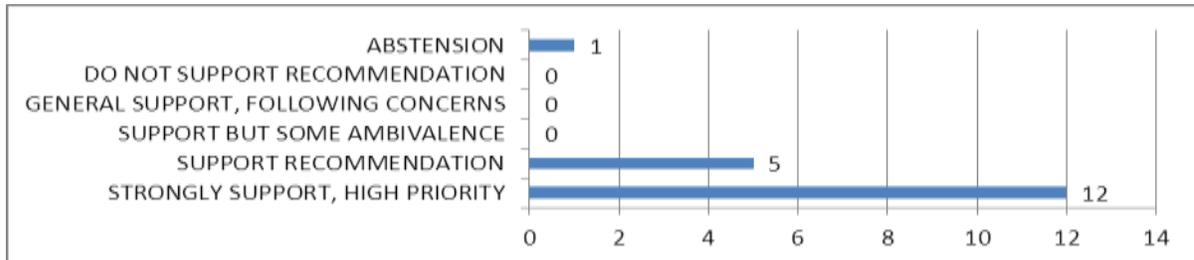
The Taskforce expressed concerns with this temporary proposal. Taskforce members indicated that they were concerned that care coordination and service delivery would not be improved and that the timeline was overly aggressive. Specific concerns expressed by consumers included a request to improve communication regarding discharge planning with consumers to avoid stress caused by the unknown. In addition, the Task Force expressed concerns pertaining to the lack of adequate time needed to assess service delivery in the metropolitan region, the needs of the persons receiving services at AMRTC, and the best methods for improving service delivery for these persons, including additional redesign of the system needed to support these individuals.

## **II. RECOMMENDATIONS**

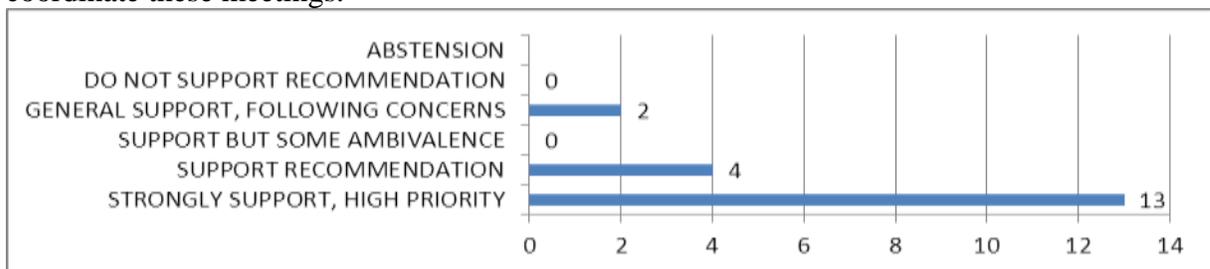
The details presented in this report are in addition to the recommendations presented in the report, *Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services*.

The process used to determine recommendations for the resign of services provided at the Anoka Metro Regional Treatment Center was unlike the workgroup process used for the previous recommendations. As discussed earlier, the Department issued an RFI and due to the resulting response the department recommended the following the Task Force. The Task Force then proceeded to vote on those recommendations.

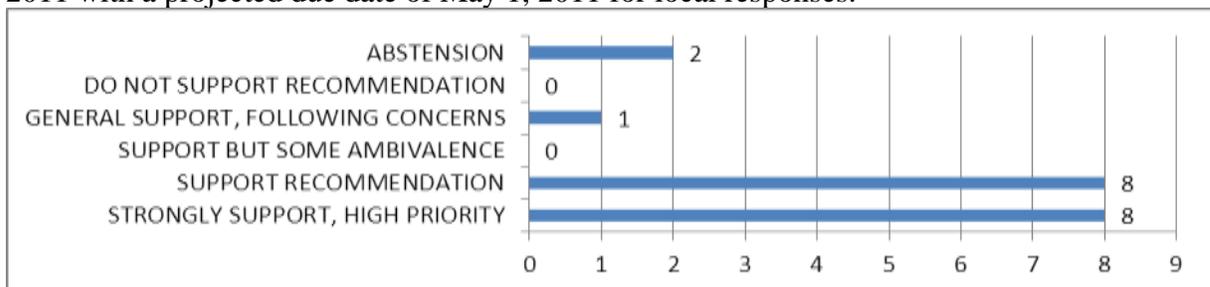
1. Staff of the Chemical and Mental Health Services Administration should meet with directors from the seven-county metropolitan area prior to January, 2011 to discuss an agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders.



2. The process mutually agreed on above should be employed during January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members and advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a RFP to be developed by DHS. DHS will cover the cost of facilitator services to run and coordinate these meetings.



3. DHS should issue an RFP consistent with recommendations of the CMHS Transformation Advisory Task Force, input from the local process outlined above and the requirements in Laws of Minnesota 2010, First Special Session Chapter 1, Article 19 section 19 by March 1, 2011 with a projected due date of May 1, 2011 for local responses.



4. The Chemical and Mental Health Services Transformational Advisory Task Force should appoint a subcommittee to evaluate and advise the Department's implementation of the recommendations above. Initially, and through the completion of the RFP process, the subcommittee will be composed of members who are representing advocacy organizations, consumers & family members, and the statutorily established advisory bodies for chemical and mental health services. The subcommittee will convene at least once to hear stakeholder presentations and advice on its task prior to the drafting of the RFP. In the event that the RFP process does not produce a plan for alternative services, the subcommittee will evaluate and advise any further action taken by DHS to plan and implement alternative services. The

membership of the subcommittee overseeing the development and implementation of alternative services should expand once the RFP process is concluded to include key stakeholders initially excluded due to conflict of interest limitations.



While the RFP is being issued it was felt that the Department could prepare the Bloomington building for new services and await opening until it was determined if the RFP process is not successful in yielding results for the redesign of services out of AMRTC. At that point the Department could proceed with the development of the Bloomington site.

## **APPENDIX 1.**

### **REQUEST FOR INFORMATION (RFI)**

#### **Recommendations for the development of alternative service models in the seven - county metropolitan region to transform the current services now provided to individuals served at the Anoka Metro Regional Treatment Center (AMRTC)**

#### **Minnesota Department of Human Services Chemical and Mental Health Services Administration**

#### **Purpose and Objective**

The purpose of the Request for Information (RFI) is to solicit recommendations and proposed models from potential responders to a Request for Proposals to serve approximately 100 adults who have multiple disabilities and multiple diagnoses with poorly managed chronic medical conditions and /or behavioral dysfunction and chronic functional deficits who have been treated by AMRTC or are at risk of being committed to the commissioner of human services for treatment at AMRTC. For example, we estimate that between 60-80 percent of the target population have a dual disorder of serious mental illness and substance use disorder. We also estimate that many of these individuals have co-morbid medical conditions and are at increased risk of premature death. An analyses of Minnesota data found that adults with schizophrenia, schizoaffective disorder or bipolar disorder are dying prematurely at 24 years sooner than adults without these diagnoses.

The objective is to begin the transition at AMRTC by reducing initial capacity at the facility by up to two units and to design the full array of quality mental health services from acute care to housing with supports in the community using, in part, staff from AMRTC who will continue to be state employees. It is envisioned that these networks with formalized service agreement will be a precursor to the Accountable Care Organization (ACO) proposed in the future under health care reform.

The Minnesota Department of Human Services (DHS) is interested in gaining information from the seven counties served by AMRTC and its array of service providers regarding what formalized collaborative models are feasible in both the short and long term, what opportunities and challenges these models would present and what assistance ( support resources, policy changes and funding), in addition to the direct service state employees, these models would require of DHS to be successful and provide high quality services to the target population. The time frame for actual implementation of these collaborative models is between July 2011 and January 1, 2012. DHS is interested in recommendations for regional models involving more than one or more counties and multiple providers that build on current successful partnerships. The opportunity for two or more pilots is possible depending upon the proposed models and timelines.

Responses to this Request for Information (RFI) are completely voluntary but are a prerequisite for submission of a response to the STATE's anticipated future Request for Proposals (RFP) for the development of formalized collaborative partnerships from providers that will cover the

full service array from acute care settings to the wide range of community-based mental health services including housing with supports in order to meet the needs of the target population. This RFI does not obligate the STATE to pursue formalized collaborative models nor does a potential Responder's response to this RFI obligate such responder to a related future RFP. Responders are responsible for all costs associated with the preparation and submission of responses to this RFI.

### **Trade Secret Information:**

All materials submitted in response to this RFI will become the property of the State and will become public record in accordance with Minnesota Statutes, section 13.591. If the Responder submits information that it believes to be trade secret/confidential materials, as defined by the Minnesota Government Data Practices Act, Minn. Stat. §13.37, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this Response, the Responder must:

- a. clearly mark every page of trade secret materials in its response with the words "**TRADE SECRET**" or "**CONFIDENTIAL**" in capitalized, underlined and bolded type that is at least 20 pt.; the State does not assume liability for the use or disclosure of unmarked or unclearly marked trade secret/confidential data;
- b. fill out and submit the attached "*Trade Secret/Confidential Information Notification Form*", specifying the pages of the response which are to be restricted and justifying the trade secret designation for each item. If no material is being designated as protected, a statement of "None" should be listed on the form;
- c. satisfy the burden to justify any claim of trade secret/confidential information. Use of generic trade secret/confidential language encompassing substantial portions of the response or simple assertions of trade secret interest without substantive explanation of the basis therefore will be regarded as nonresponsive requests for trade secret/confidential exception and will not be considered by the State in the event of a data request is received for response information; and
- d. defend any action seeking release of the materials it believes to be trade secret and/or confidential, and indemnify and hold harmless the State, its agents and employees, from any judgments awarded against the State in favor of the party requesting the materials, and any and all costs connected with that defense. This indemnification survives the State's award of a contract. In submitting a response to this RFI, the Responder agrees that this indemnification survives as long as the trade secret materials are in the possession of the State. The State is required to keep all the basic documents related to its contracts, including selected responses to RFIs or RFPs, for a minimum of six years after the end of the contract.

The State reserves the right to reject a claim if it determines Responder has not met the burden of establishing that the information constitutes a trade secret or is confidential. **The State will not consider prices or costs submitted by the Responder to be trade secret materials.** Any decision by the State to disclose information designated by the Responder as trade

secret/confidential will be made consistent with the Minnesota Government Data Practices Act and other relevant laws and regulations. If certain information is found to constitute a trade secret/confidential, the remainder of the response will become public; only the trade secret/confidential information will be removed and remain nonpublic.

The State also retains the right to use any or all system ideas presented in any response received in response to this RFI unless the Responder presents a positive statement of objection in the response. Exceptions to such Responder objections include: (1) public data, (2) ideas which were known to the State before submission of such response, or (3) ideas which properly became known to the State thereafter through other sources or through acceptance of the response.

If the STATE should decide to issue an RFP and award a contract based on any information received from responses to this RFI, all public information, including the identity of the responders, will be disclosed upon request subsequent to an executed contract.

**Timelines:**

Responses to this RFI must be submitted by 4:00 p.m. Central Standard Time (CST) on Wednesday, November 17, 2010. The recommendations and proposed service models will be summarized, shared with and informed by the legislatively required Advisory Task Force for inclusion in a legislative report due November 30, 2010. If the STATE chooses to issue a Request for Proposals, the RFP will be issued with the intent that it be published by January 15, 2011.

**Background:**

Anoka Metro Regional Treatment Center (AMRTC) is a State Operated psychiatric hospital with a 120 operating bed capacity, serving adults primarily from the seven-county metropolitan region who have been committed to the Commissioner for psychiatric care and treatment. Approximately 540 individuals are served each year at AMRTC with an average length of stay of 100 days. There is often a significant waiting list of three or four weeks for admittance to AMRTC and often AMRTC experiences significant delays with discharge to an appropriate community based service for those in the target population who no longer require acute inpatient psychiatric care.

AMRTC is the last remaining large state operated non-forensic facility for adults who have a mental illness and who are committed to the Commissioner of Human Services for psychiatric care and treatment. Based upon the success of downsizing and ultimately closing the large state psychiatric facilities in Greater Minnesota, there is an interest on the part of the legislature to replicate this effort in the metropolitan seven counties that would involve a phased transition of AMRTC to alternative community-based models. The 2010 legislative session passed language requiring the Department of Human Services to submit a report to the legislature by November 30, 2010:

“ detailing the transition plan, services that will be provided including incorporating peer specialists where appropriate, the location of the services and the number of patients that will be served”.

The legislation further states that the:

“community based services may be established in partnership with private and public hospital organizations, community mental health centers and other mental health community services providers and community partnerships and must be staffed by staff employees.”

Approximately \$3.5 million representing the cost of state funded professional, direct care and support staff is available. Savings generated as a result of transitioning individuals from the Anoka Metro Regional Treatment Center to community-based services may be used to fund supportive housing staffed by state employees.

The STATE is also committed to providing resources for a facilitator to help with the planning and development of proposals and recommendations for this RFI. If the STATE chooses to proceed with a Request for Proposals, the STATE will consider the feasibility of providing funds to cover future costs associated with securing the services of a project manager for the selected and approved pilots.

### **Content of Response to the RFI**

Responders should address the following:

1. Indicate the specific community hospital(s) with acute psychiatric care units and the community-based providers that will establish the formalized partnerships and what enhanced or expanded services will be provided.
2. Indicate the proposed fiscal agent for the partnership.
3. Indicate how consumers, family members, advocates and other key stakeholders will be included in the planning, development, implementation and monitoring of new service models.
4. Indicate the mechanism(s) by which individuals are allowed to voluntarily participate in this pilot partnership alternative or choose to be served traditionally at AMRTC.
5. Indicate the proposed numbers and qualifications of state staff currently working as AMRTC that will be needed to support the partnership and proposed models and any training and potential administrative costs associated with incorporating additional staff into the service mix.
6. Indicate the methods by which quality monitoring and oversight will be implemented to evaluate the efficacy and cost-effectiveness of the proposed partnership and proposed new models.
7. Indicate a proposed timeline that addresses planning, development and implementation.
8. Indicate any supports, technical assistance and other additional resources that are needed to meet the proposed timeline for implementation scheduled to occur on or before January 1, 2012.
9. Indicate how any proposed partnerships or models will comply with existing statutory or other legal requirements, including any requirements related to state employment or if any changes in current law would be necessary to effectuate the proposed partnerships or models.

**Information submitted in response to the Request for Information must be received by 4:00pm (CST) on November 17, 2010 addressed as follows:**

**Attention: Sharon Autio, Director**  
Adult Mental Health Division  
Department of Human Services  
444 Lafayette Rd. N. St. Paul, MN. 55155  
Phone (651) 431-2228  
Email: Sharon.autio@state.mn.us

Only counties in the seven- county metropolitan region, as the Local Mental Health Authority, are authorized to submit a response to this RFI. It is expected that the response(s) will identify the full range of partner agencies which will form the proposed new model(s). All submissions, questions, concerns or communications regarding this RFI should be addressed to Sharon Autio, Director, Adult Mental Health Division. Questions received by Sharon Autio through October 22, 2010 will be posted along with the answers on October 29, 2010 on the DHS website in the same location as the RFI.

Late responses will not be considered and will be returned unopened to the submitting party.  
**Faxed or emailed information will not be accepted.**

Responses should not exceed twenty (20) pages. Provide six (6) copies of your responses in hard copy. Include a name, title, address, telephone number and e-mail address of the person to contact in the event there are questions regarding your submission.

This request does not obligate the STATE to complete the work contemplated in this notice. The STATE reserves the right to cancel this solicitation. All expenses incurred in responding to this notice, with the exception of potential limited funding for a facilitator, are solely the responsibility of the Responder.

## APPENDIX 2.

### DHS RESPONSES TO QUESTIONS REGARDING THE RFI FOR DEVELOPMENT OF ALTERNATIVE SERVICE MODELS IN THE SEVEN-COUNTY METROPOLITAN REGION TO TRANSFORM THE CURRENT SERVICES NOW PROVIDED TO INDIVIDUALS SERVED AT THE ANOKA-METRO REGIONAL TREATMENT CENTER (AMRTC)

Date October 29, 2010

1. The RFI only allows counties to apply. What is the rationale for not allowing community providers to apply?

**Response:** The Comprehensive Mental Health Act identifies counties as the Local Mental Health Authority. It has been standard practice to have the county/ies respond to Requests for Information/ Proposals. Counties contribute local funds for mental health and adjunctive support services such as housing, employment support and also reimburse providers for services for adults who are uninsured. Counties are not required to be the fiscal agent for the partnerships described in the RFI. It is expected that the counties will engage the full array of mental health service providers, consumers, families and advocates and other key stakeholders in discussions about models and/or recommended strategies for consideration by DHS.

2. Please describe the current racial/ethnic breakdown of adults experiencing a mental illness who have been treated at AMRTC?

**Response:** For state fiscal years 2006 through 6/30/2010- the racial/ethnic breakdown is as follows: The total number of adults treated for that time period equals 2918. Of the total: 75 (2.5%) were American Indian/Native Alaskan; 127 (4.%) Asian; 574 (20%) Black/ African American; 76 (3%) Latino/Hispanic; 2,002 (67%) Caucasian and 64 (2%) other/no entry.

3. Please clarify the distinction between a Request for Information and a Request for Proposals.

**Response:** A Request for Information is issued to solicit information in a more formalized manner from individuals with knowledge and expertise in the field to help inform the DHS staff in proceeding with issuing a Request for Proposals if the department chooses to proceed. Submissions to RFIs do not obligate responders.

#### **Analysis of Need:**

4. What are the DHS policy goals for closing 40 beds? What is the vision and purpose?

**Response:** An analyses of utilization data indicate that, on average, 40 beds are being occupied by individuals who no longer meet criteria for acute psychiatric inpatient care and could be better served in less restrictive settings.

The long range vision is to provide a comprehensive array of services as close to the person's home as possible and to create greater coordination and collaboration across the array of services from acute care to long term community-based services and supports. The ultimate goal is to develop a system that fosters early identification and intervention and reduces the over-reliance on institutional care.

5. Based on analysis of data/needs, what is the evidence that the two units at AMRTC are not needed? Which two units at AMRTC are intended to be closed?

**Response:** As stated above, 40 or so patients at Anoka have not met criteria for needing a hospital level of care. The predominant population at Anoka not meeting this criteria are those who fall into two categories: a) individuals in need of a service that falls between hospital and Intensive Residential Treatment (IRT) that is not currently available and b) individuals in need of skilled nursing services (not necessarily nursing facility) because of their chronic medical and psychiatric conditions.

6. What has the State learned from the CBHH experience that supports replicating this effort for the AMRTC redesign?

**Response:** It is critically important to develop new formalized partnerships across the service delivery system. We have learned that stand alone services do not provide sound clinical outcomes for individuals experiencing a mental illness.

7. If the plan is for AMRTC to continue to serve people: 1.) On Rule 20's; 2.) Needing nursing home level of care; and 3.) With severe behavioral issues, please describe the 100 people to whom this RFI refers, specifically:

a. How do they differ from the above populations in a way that will not allow them to be served at AMRTC? Or have the plans for Anoka changed?

b. How do individual counties plan for people without knowing how many each county is financially responsible for? Or are we to plan for the full population regardless of who is CFR?

**Response:** Persons who are on Rule 20's will be served at St. Peter and individuals needing medical care in addition to their psychiatric disorder will be served on a medical/psychiatric unit. It is assumed that county case managers are aware of the individuals who are currently residing at AMRTC since there are regular discharge planning conferences between staff from the counties and the hospital. Counties should plan for the individuals who are residents of their county although regional service planning is also encouraged since individuals have the freedom to move across county boundaries.

**Policy:**

8. Given the foster care moratorium, are we able to add new foster care beds as part of developing alternative models?

**Response:** The purpose of the RFI is for counties and their local community-based mental health provider networks including hospitals with acute care psychiatric capacity to propose models or specific recommendations for serving a subset of the adult population that is served by or is at risk of being served by Anoka Metro Regional Treatment Center (AMRTC). It is premature to respond to questions about specific service components when these discussions have not begun. The intent of the RFI is, based on the clinical needs of this population, to creatively determine how a service model could be designed to meet these needs. It would be important to not only consider what is currently available that has not appeared to be meeting the needs of this population but also new or enhanced services.

9. How does this RFI fit into the overall SOS redesign?

**Response:** Across SOS, we are monitoring the utilization of the system. Occupancy, length of stay, meeting admission and continued stay criteria are examples that we are watching to ensure patients get proper care and efficiency of operations. Expected changes in the AMRTC services should be responsive to these types of indicators.

10. Could the physical space at AMRTC be used to create alternatives (e.g. 15 beds for medically complex)?

**Response:** As a hospital, it would still be an Institution for Mental Diseases (IMD) and not eligible for Medicaid reimbursement. Even if we had another provider run the unit, the Center for Medicare and Medicaid Services (CMS) would likely not approve such an arrangement. It is also inconsistent with best practice to create a lesser level of care on a hospital campus; rather the service should be provided closest to the individuals' home community, natural supports and local resources.

11. In the RFI it says networks "will be a precursor to the Accountable Care Organization proposed in the future under health care reform." Is DHS thinking the Counties would become an ACO? Or is DHS thinking SOS would be an ACO? According to RWJ policy brief (October 2009) an Accountable Care Organization is comprised of local health plans/payors and a related set of providers; yet this RFI does not include any local healthcare organizations in the identified partner organizations. Who/how will those HC skill sets and capabilities be represented in these pilot projects without the inclusion of healthcare organizations?

**Response:** The intent of this statement was not to assume that counties or State Operated Services (SOS) would become an Accountable Care Organization. Rather, the intent was to begin the dialogue and establishment of formalized mental health partnerships/networks across the full array of mental health services to position the mental health system to be a viable and important player in the proposed new health care delivery system.

12. Depending on the outcome of the elections, Congress may look significantly different than it does today. Any change in the makeup of Congress could result in changes to Health Care Reform, including ACO's. If enabling legislation around ACO's is changed or repealed, what are DHS's plans relative to any ACO-type models which have evolved in the meantime to serve this population?

**Response:** Please refer to the response to the preceding question #11 above.

13. Will the State support a waiver to allow stays longer than the current 90 day limit at IRTS facilities?

**Response:** There is **NOT** a 90 day limit on stays at Intensive Residential Treatment (IRT) facilities. To again reiterate, an individual who meets medical necessity and is admitted to an IRT can remain in that setting for up to 90 days. If additional days are medically necessary, the provider must seek prior authorization. The current average length of stay at the IRTs statewide is 56 days. IRTs are a treatment setting and not a housing option.

14. Will more than 4 unrelated persons living under the same roof be able to utilize a HCBS waiver program if it is determined that such services should be developed to help facilitate housing for people in this pilot?

**Response:** The intent of the RFI is, based on clinical needs of the population, to creatively determine how a service model would be designed to meet these needs. It is premature to respond to specific services until there have been discussions with representatives from the full array of service providers and other key stakeholders. It is important to not only consider what is currently available that has not appeared to be meeting the needs of the target population but also to propose new or enhanced services.

15. We would like to see presumptive eligibility every 6 months for MA for clients if they are participating in this pilot. Would DHS support us in this endeavor?

**Response:** If, after meetings with the community based providers, this is an area that you wish to recommend, it should be included in the response to the RFI. It would be important to include a statement indicating why this is needed.

16. We would like to see enhanced GRH rates for clients that are moving through this system of care to assist with available housing options. Would DHS support us in this endeavor?

**Response:** Please refer to the response to question 14 above.

17. Could we create a new kind of waiver, possibly equivalent of the CAC waiver (hospital level of care) but for psychiatry rather than medical needs. Alternatively, would an “enhanced” CADI wavier, much like the TBI-NB waiver is to the regular TBI waiver?

**Response:** If, after a determination of the service needs of the target population and proposed models have been discussed with the community providers and key stakeholders, that recommendation should be included in the response to the RFI. Please keep in mind that waivers take a considerable amount of time to develop, submit to CMS for review and receive approval before the waiver can begin to be implemented.

### **Consumer Input/Choice:**

18. What has the State initiated to date and what is the ongoing plan to engage “prosumers” to include input from individuals as to what they need; their personal preferences for long-term living arrangements and location; what characteristics are desired, etc.?

**Response:** It is expected and assumed that the case managers for the individuals in the target group are already knowledgeable about and have engaged their prosumers in this discussion.

19. Please give further explanation on expectations around consumer choice. It is assumed that clients involved in this will have been through the commitment process. How do you embed voluntary choice in this pilot with a population deemed by the court system to require involuntary services to get their needs met? How can we offer choice when resources at AMRTC are being reduced and the option of going there may not be available due to more limited bed space?

**Response:** One of the overriding goals of quality mental health services is to engage the individual in developing a plan of care and treatment that is person centered and individualized. Commitment when used as a vehicle to access treatment could be prevented through earlier intervention and greater access to the right service at the right time.

### **Funding:**

20. What is the overall funding/reimbursement schema? How will it accommodate people who are not on MA? What funding is envisioned for housing and related expenses; for meeting healthcare expenses; and for employment services?

**Response :** Funding will depend on the provider status and the services being provided. The use of State staff in the development of new services is required under the language adopted during the 2010 session. The cost of the staff will be reimbursed to the State up to the value covered by the generation of revenues with the remaining costs offset by the State appropriation. The net savings to the State under this model will be directed to a State special revenue account to be used for supported housing. Access to these funds will be legislatively directed.

21. Given the limited waiver funds and the high cost of State staff, how could we create resources with costs that are sustainable?

**Response:** We are encouraging a dialogue that is not limited by services currently available. If there are, after discussions with the full array of service providers and other key stakeholders, specific recommendations, the department would welcome them.

22. How will the evaluation component be funded? Will the State be sponsoring their own evaluation? Or will pilot projects be expected to "self-evaluate"?

**Response:** Any program/project that is committed to quality service delivery should have in place a mechanism to evaluate efficacy and effectiveness of the services that are being provided. An independent evaluation with attention to clinical outcomes is also under discussion.

23. By legislative requirement, SOS must achieve \$1.8 million in savings by 2013. How can they achieve this savings and keep this pilot sustainable?

**Response:** It is expected that the savings will not come from this pilot.

24. If service continuum gaps are identified and "new services" developed who will pay for new services?

**Response:** It would be important to first identify the service and then proceed with exploring funding. It is not feasible to answer this question without specific examples of services.

**Staffing:**

25. What is the make-up of State staff that will be deployed to as part of the transition (psychiatrists, mental health professionals, nursing, mental health practitioners, etc.)? Based on credentials would staff be eligible to bill MA for services?

**Response:** A typical unit staffing pattern in FTEs includes 9 FTE registered nurses, 2 Part Time registered nurses, one FTE advanced practice nurse; 8 FTE licensed practical nurses; 11 FTE and 2 PTE human services technicians, 1 behavioral analyst, 2FTE social workers, 1 FTE occupational therapist, 1 PT recreational therapist and 1 FTE office and administration assistants. Psychiatrists are not assigned to a unit nor included in the staff complement. If prescriber services are needed, the response to the RFI should so indicate what is needed. .

26. If services are reimbursable and if State staff are claiming, where would the revenue go (to the State or local providers)?

**Response:** See response to question 20.

27. The RFI states that approximately \$3.5 million for direct and care and support staff is available. Are these dollars available up-front? Does this include the value of State staff to be deployed or are these additional dollars? Will the value of staff adjust with increases in cost of living and benefit expenses?

**Response:** The approximately \$3.5 million is the value of the staff available to be deployed. The process to provide the funding will be determined during the contracting process and will be specific to the cost of the staff being used by the provider. The value will be adjusted for cost of living or benefit expenses based on approved funding increases by the legislature for salary or benefit levels.

28. Will the lead agency be able to appoint their own project manager? Or will one be appointed by DHS? Will the project manager support be on-going or limited to project start-up?

**Response:** If the state proceeds with a Request for Proposals and there are available resources, the approved applicants can appoint a project manager. At this time, the proposed fiscal support

will likely be for start-up only. The DHS would entertain recommendations for why this should be on-going.

29. As State staff leave the system in the future, will the money stay with the project and will agencies be able to hire their own staff, or will they need to be replaced by other state staff? Will there be an option to not re-hire for the vacated position? Is there an option to fill the position with a non-state staff but have the funding allocated for the position?

**Response:** Language passed during the last session states the new services must be staffed by state employees.

30. What is the long term commitment to maintaining the funding for these positions?

**Response:** The intent of the legislation is to maintain funding. The Department can not guarantee any state funds it receives into the future. All decisions regarding continued funding rests with the legislature and the Governor.

31. Will there be an administrative fee charged to the fiscal agent for processing state administrative/overhead costs and will the fiscal agent need to assume the burden of costs for these fees ?

**Response:** SOS is required to bill the full cost to the State when providing a service or staff under a contract. How this will be handled between the fiscal agent and the providers will need to be determined through their contracting process.

32. Are counties required to accept state staff as part of this proposal, or is it possible to decline them?

**Response:** The available additional resources for this effort are the state staff. If the counties feel they can accomplish this without additional resources, please state this intent in the response to the RFI.

33. Who will have authority to decide key operational issues relative to state staff and the program or facility they work in, such as:

- a. Admissions criteria; **Response:** the provider agency will decide
- b. Hiring, firing, discipline of staff; **Response:** This rests with the State. This will be done in consultation with the community provider.
- c. Day to day program operations of the program; **Response:** The provider agency
- d. Physical space issues – rent, renovation, safety, etc. **Response:** This will need to be negotiated with the provider.

**Risk:**

34. What is the vehicle to hold the counties harmless (both in terms of finances and clinical risk)?

**Response:** The contracting process between the State, counties and providers will be the vehicle to address these issues.

35. Given the plan to close 40 beds, what does the state see as its role as a safety net in the Mental Health system?

**Response:** The state will continue to be a partner in this new service design and will maintain its safety net role. AMRTC will continue to serve individuals in need of acute care psychiatric treatment.

36. Have the County Attorney association been consulted on the RFI on alternatives to commitment and associated risks?

**Response:** Counties should feel free to contact their local county attorney. We are more than willing to also have a dialogue with the County Attorney association.

37. Are there assurances that future savings will not come at the expense of the entities that have been selected for these pilots?

**Response:** The intention of the RFI and current legislation is to establish new ways to redesign AMRTC and to create sustainable services.

**Timelines/Submission Requirements:**

38. What type of agreements/commitments from partners and providers must be in place before the RFI deadline?

**Response:** No formal agreements or commitments are required to respond to the RFI. It would be important to indicate what is under consideration for a formalized written agreement document.

39. Can we list potential partners (or categories of partners), versus partners that have agreed to be part of a response?

**Response:** The RFI should include in the body or as an attachment, the names and respective agencies that have been involved in meetings prior to the submission of the response to the RFI. If there are potential partners, they should be identified as such under a separate heading and listed by name and affiliation not by category

40. What is meant by "full range" of partner agencies on page 5 of the announcement? What types of agencies?

**Response:** A “full range” means hospitals with inpatient psychiatric capacity, the array of current mental health service providers, housing with support providers and any other provider with whom the county has a relationship. It is also important that providers who serve minority communities are at the table to provide their expert knowledge. All services must be sensitive to and address how they will be culturally competent in serving diverse communities.

41. How specific must we be about services?

**Response:** A detailed and complete listing of all services is not required. The intent of the RFI is to propose models and/or make recommendations to the department. Greater specificity will be expected with responses to the Request for Proposals if the department decides to proceed in that direction.

### **APPENDIX 3.**

October 28, 2010

Sharon Autio, Director  
Adult Mental Health Division  
Department of Human Services  
444 Lafayette Road North  
St. Paul, MN 55155

Dear Ms. Autio:

Please accept this letter in response to the Request for Information (RFI) “Recommendations for the development of alternative service models in the seven-county metropolitan region to transform the current services now provided to individuals served at the Anoka Metro Regional Treatment Center (AMRTC)” published in the State Register earlier this month. This submission is made on behalf of all seven counties in the Metropolitan area: Hennepin, Ramsey, Dakota, Anoka, Washington, Scott, and Carver.

We affirm numerous points stated within the text of the RFI. The seven Metro counties unanimously:

- Support the objective of transitioning citizens out of AMRTC and back into the community. However, each county needs additional information regarding its citizens placed at AMRTC to determine what level of supports would be needed to accomplish this.
- Agree that the individuals in question have significant multiple disabilities, diagnoses, and upon transition would continue to be at very high risk for re-commitment to the Commissioner.
- Are willing to consider multi-county models to accomplish the objective.
- Confirm that a significant waiting list at AMRTC compromises the availability of needed services.
- Appreciate that responses to the RFI are voluntary in nature.
- Agree that responses should detail a full service array.

Despite the budget crisis in which the state finds itself, we urge the Department not to move hastily to downsize AMRTC without adequate planning. While the RFI speaks of previous success of downsizing, many would question the degree of success. Our colleagues in Greater Minnesota have spoken to their experience of being essentially left without adequate service options for a number of individuals, and an unacceptable level of risk borne by counties. The Metro Counties do not want to see our residents disproportionately experience poverty and homelessness due to failures of the service delivery system.

As a group, the Metro Counties are unanimously in agreement that to produce a thoughtful, comprehensive, multi-county response to this RFI with merely 28 business days from publication to due date is unrealistic, for the following reasons:

- The RFI essentially asks counties to accomplish the next step in de-institutionalizing people with serious and persistent mental illness. This is a major systems transition. The scope of

work encompassed in the RFI is daunting and cannot be adequately assessed in the time frames provided. Simply put, if the answer to moving more people out of AMRTC was so straightforward that we could provide it to you in 28 days, we would have accomplished it already.

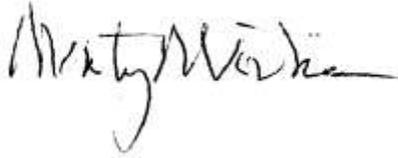
- The RFI asks us to identify how consumers, family members, advocates, and other key stakeholders will be included in the planning, development, implementation, and monitoring of new service models. Ideally, they should be involved from the very beginning – the RFI stage – but this time frame does not realistically allow for more than their token involvement.
- The RFI further requires identification of the mechanism(s) by which individuals can choose to receive service at AMRTC over whatever model(s) we develop. There are many problems with being able to respond to this item within the time frame provided. First of all, we think that such a mechanism may actually require a change in the Commitment Act, which of course cannot be accomplished by November 17. In addition, it will likely require the creation or identification of risk protocols that are currently not in use. Again, this task is not likely to be complete by November.
- The RFI requests that we indicate specifically the numbers and qualifications of state staff required to effectuate our model. This strikes us as an extremely detailed question to respond to within the first four weeks of planning for a major system transition.

Beyond the low quality submissions DHS would likely receive in such an abbreviated time frame, it simply may not be logistically realistic for county governments to process a response so quickly. County Boards of Commissioners typically require policy discussion and subsequent board approval in order for local social service agencies to submit RFI responses, a process which is not possible given the time required to complete the response drafting. In addition, it is possible county attorneys will advise us not to respond as multi-county entities without the existence of an underlying legal framework, such as a Joint Powers Agreement.

Consistent with the RFI requirements, Metro counties submitted a lengthy list of questions by the October 22 deadline. It is necessary to receive thorough responses to these questions prior to formulating a submission to the RFI. Please accept the questions and this letter as they are intended: as an indication of our desire to respond and partner in this process. We believe with adequate information and time, we can assess whether sufficient resources and assurances are in place to allow us to do so. Based on the responses to these questions, with guidance from our policymaking elected Boards, Metro counties will individually determine whether the risk parameters are sufficiently narrow in order to allow our participation. We anticipate with a swift response from DHS to our questions, these decisions of whether or not to respond to the RFI could be made by the end of 2010. Once this is accomplished, planning could commence in 2011, with a response to the RFI by May 31, 2011. If an RFP can be issued by July 1, a response could be expected by October 1, 2011. This would allow time for project(s) to begin rollout as early as January of 2012. We request your acceptance of these terms that we believe are more realistic in order to achieve the high quality response our consumers deserve. Please notify us in writing by November 3 if you are in agreement with these changes.

In closing, we respectfully request that this letter be incorporated in its entirety within the required report to the legislature on this subject.

Sincerely,



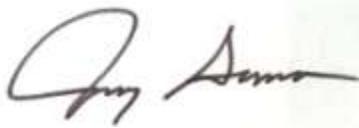
Monty Martin, Director  
Ramsey County Community Human Services



Daniel E. Engstrom, Director  
Hennepin County Human Services and Public Health Department



Kelly Harder, Director  
Dakota County Community Services



Jerry Soma, Division Manager  
Anoka County Human Services



Daniel J. Papin, Director  
Washington County Community Services



Timothy B. Walsh, Director  
Scott County Health and Human Services

A handwritten signature in black ink that reads "Gary Bork". The letters are cursive and fluid, with a prominent loop on the 'y' and a long tail on the 'k'.

Gary Bork, Director  
Carver County Community Social Services

Cc: Commissioner Cal Ludeman  
Senator Linda Berglin  
Representative Tom Huntley

## APPENDIX 4.



### Minnesota Department of **Human Services**

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November 3, 2010

Gary Bork, Director  
Carver County Community Social Services  
602 East Fourth Street  
Chaska, MN 55318

Daniel E. Engstrom, Director  
Hennepin County Human Services and  
Public Health Department  
Hennepin County Government Center A-  
2303  
300 South Sixth Street  
Minneapolis, MN 55487-0233

Kelly Harder, Director  
Dakota County Community Services  
1 Mendota Road West, Suite 500  
West ST. Paul, MN 55118-4773

Monty Martin, Director  
Ramsey County Community Human  
Services  
160 E. Kellogg Boulevard  
St. Paul, MN 55101-1494

Daniel J. Papin, Director  
Washington County Community Services  
14900 - 62<sup>nd</sup> Street North  
P.O. Box 30  
Stillwater, MN 55082-0030

Jerry Soma, Division Manager  
Anoka County Human Services  
Anoka County Government Center  
2100 Third Avenue  
Anoka, MN 55303-2264

Timothy B. Walsh, Director  
Scott County Health and Human Services  
Government Center, Room 300  
200 Fourth Avenue West  
Shakopee, MN 55370

Dear Human Services Directors:

I am responding, on behalf of the Chemical and Mental Health Services Administration, to your October 28, 2010 letter regarding the Request for Information (RFI) that was issued on October 11, 2010 to seek "Recommendations for the development of alternative service models in the seven-county metropolitan region to transform the current services now provided to individuals served at the Anoka Metro Regional Treatment (AMRTC)".

As background, when a decision was made in mid- September 2010 to proceed with either a Request for Information (RFI) or a Request for Proposals (RFP), it was determined that there was not adequate time to both develop, submit for internal review and publish a RFP that would allow adequate time for the staff of the seven counties to convene stakeholders to assist with proposals. Additionally, we realized that any responses to a RFP would require County Board approval prior to submission. To that end, it was decided to proceed with a RFI with the intent to solicit suggestions, potential proposals and any recommendations that would assist the

Human Services Directors

Page 2

November 3, 2010

department with issuing a RFP that incorporated ideas at the local level. We did not believe that responses would require County Board approval since we were not obligating the counties to either what was submitted as responses to the RFI or to respond to a RFP if one was issued.

We appreciate that your October 28, 2010 letter does reaffirm and support a number of the statements contained within the RFI. We also agree that we need to be thoughtful and deliberate in moving forward with any changes to AMRTC while, at the same time, assuring that we are providing the full array of quality mental health services to adults experiencing a mental illness. We also need to jointly challenge ourselves to be creative and innovative in designing a service system that does not rely on current services but first considers the clinical and social service needs of the population. In many areas of the state, the regional and inclusive planning and implementation that occurred with the Adult Mental Health Initiatives resulted in new and innovative models that have reduced reliance on unnecessary and restrictive institutional treatment.

As stated in the RFI, the responses to the questions that were received by October 22, 2010 were posted on the DHS website, [www.dhs.state.mn.us/MHDivision](http://www.dhs.state.mn.us/MHDivision) on Friday October 29, 2010. Your letter did indicate that you would not be able to respond to the RFI on the due date of November 17, 2010. Since the RFI states that only the counties can respond to the RFI, we are proposing the following alternative approach:

1. Staff of the Chemical and Mental Health Services Administration will meet with the directors from the seven-county metropolitan area in December 2010 to discuss a less formalized and mutually agreed upon process to solicit any ideas, recommendations and potential models from the broad range of stakeholders.
2. Meetings would be convened in January and February 2011 at the county and/or multi-county level with the full range of stakeholders including hospitals, community providers, consumers, family members advocates and any other relevant stakeholders to solicit recommendations, service models, etc. for possible inclusion in a Request for Proposals to be developed by DHS. DHS would be willing to consider covering the cost of facilitator services to run and coordinate these meetings. We envision that there would be no more than three meetings during this time frame and the discussion would be geared to the target population described in the October 11, 2010 Request for Information.
3. DHS will issue a Request for Proposals on March 1, 2011 with a projected due date on May 1, 2011 for submission. That allows an additional month for submission.

We feel this is a workable alternative and addresses the concerns you raise in your letter. Because the last legislative session included budget savings that must be realized by State

Human Services Directors

Page 3

November 3, 2010

Operated Services, the department will likely need to proceed with some temporary changes at AMRTC to meet the budget pressures they are encountering. It is the department's intent that any changes be temporary in nature until a workable design is developed and implemented in 2011.

Per your request, your letter and the DHS response will be incorporated within the required report to the legislature on this subject.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sharon Autio".

Sharon Autio, Director  
Adult Mental Health Division

C: Commissioner Cal Ludeman  
Assistant Commissioner, L. Read Sulik, M.D.  
Senator Linda Berglin  
Representative Tom Huntley