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Chemical and Mental Health Services Transformation:

State Operated Services Redesign in Support of the Resilience & Recovery of the People We Serve

A Report

Mandated by Minnesota Session Laws, 2009, Chapter 79, Article 3, Section 18.

March 2010

Legislative Report

Minnesota Department of **Human Services**

Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience & Recovery of the People We Serve

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

March 2010

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Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience & Recovery of the People We Serve

State Operated Services Report to the 2010 Legislature

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I. EXECUTIVE SUMMARY

The Minnesota Department of Human Services Chemical and Mental Health Services (CMHS) administration 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 report lays out changes to be implemented in phases, which are centered on the goals of recovery and resilience, access and partnerships. Access to integrated psychiatric services will be improved through development of:

- **Level 1 psychiatric care centers in each region of the state.** These centers will provide the highest intensity of care for individuals with the greatest acuity and complexity and will involve 24 hours of staffed psychiatric coverage such as that now provided by Hennepin County Medical Center, Regions Hospital and Fairview University Hospital in the metro region. Lower Level 2 inpatient psychiatric care centers and Psychiatric Extensive Recovery Treatment Services also will be developed.
- **A new 24-hour Psychiatric Access Service.** This will provide consultation to emergency departments, primary care clinics, mobile crisis teams, jails and other mental health providers. Comprehensive assessments, triage services and referrals to appropriate levels of care will be provided. The access service will also include a new psychiatric emergency transportation system to be developed in consultation with consumers and advocates, law enforcement, providers and other stakeholders.

This transformative process will lead to a comprehensive, integrated system of care for each identified geographic area. This 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 we serve 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 SOS transformation will be aligned with these principles.

The assessment of needs and recommendations for transformation obtained in community meetings held across the state 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.

Planning began in late 2008 to redesign SOS as a specialty health care organization for people with highly complex needs. The 2009 Legislature subsequently directed DHS to transform services provided at the Anoka-Metro Regional Treatment Center and the Minnesota Extended Treatment Options. Meanwhile, budget pressures for SOS and the rest of state government have

mounted. Currently, SOS must reduce $17 million from its operating budget by the end of the biennium on June 30, 2011.

Due to these budget pressures and the need to transform the current care delivery system, changes will occur in phases that will result in the immediate reduction in expenditures while phasing in the changes leading to the transformation. Over the next 15 months a reduction of full-time positions and the closing or transforming of several current services will occur.

II. INTRODUCTION

During the 2009 calendar year the Chemical and Mental Health Services (CMHS) Administration of the Minnesota Department of Human Services (DHS) organized its resources around 7 goals of excellence. The four divisions of the CMHS administration, namely, the Children's Mental Health Division (CMHD), Adult Mental Health Division (AMHD), Alcohol & Drug Abuse Division (ADAD) and State Operated Services (SOS) are striving to achieve excellence by:

- Eradicating the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improving access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establishing best practices and quality standards of care and practice across all providers;
- Breaking down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reducing the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promoting and expanding those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reducing the severe wide-ranging consequences of mental illness and addictions.

CMHS, in evolving the public chemical and mental health system, is making the following commitments in the SOS redesign process:

- We will assure active engagement of CONSUMERS and FAMILIES in the planning and implementation decisions of this transformation.
- We will significantly improve ACCESS to chemical and mental health care.
- We will create MULTIPLE LEVELS OF CARE within the same facility whenever possible so that the individual in need may receive the right care at the right time in the right location.
- We will OPTIMIZE and LEVERAGE all appropriate and available funds to serve our clients.
- We will PARTNER with community health systems, community hospitals, community mental health centers, community primary care clinics, and health plans in order to create an INTEGRATED PARTNERED NETWORK of care.
- We will fulfill our leadership responsibility in the state and work to establish the QUALITY STANDARDS OF EXCELLENCE IN CARE for all providers in the state so that all consumers, no matter who they are or where they live, can be assured to receive the highest quality of care possible.

- We will continue to provide the Minnesota SAFETY NET for chemical and mental healthcare by assuring that CAPACITY is built through new partnerships and incentives.
- We pledge that ALL decisions in this transformation plan will ATTEMPT TO VALUE AND RETAIN employees to the best of our ability. We recognize that the EMPLOYEES of the Chemical and Mental Health Administration and especially those within State Operated Services are SKILLED, COMPASSIONATE AND DEDICATED individuals who provide care for those individuals with the most complex needs in the state.
- We will develop a bold, transformational plan that is MEANINGFUL AND SUSTAINABLE for our future.
- We pledge that the primary outcome of our transformation will dramatically impact the current reliance on inpatient psychiatric hospital beds and shift resources to further develop the community infrastructure as envisioned by the Minnesota Mental Health Action Group (MMHAG) and the Governor's task force on mental health.
- We pledge as public STEWARDS serving the people of Minnesota to be fiscally responsible, while using the aforementioned commitments, as we address a $17 million budget deficit projected for State Operated Services.

Through its transformation, CMHS will achieve the three priorities of RESILIENCE AND RECOVERY ORIENTED CARE, ACCESS and PARTNERSHIP:

1. **RESILIENCE AND RECOVERY ORIENTED CARE:**
   For the children and adolescents served by or through CMHS, recovery must be importantly accompanied by resilience. Resilience is the outcome of developmental processes which have been accomplished through individual, family and community contributions, creating youth who are capable, accomplished and well-prepared for the challenges of adult life. Resilient youth will be able to pursue the educational and vocational goals of their choosing, enjoy successful personal and family relationships, and be productively engaged in their communities.

   For adults, the recovery model places the individual or representative in a position of control, focusing on the person's need to understand and manage his or her own chemical and mental health care. In service to this model, CMHS will engage consumers and families in assuring that the transformation meets the intent of resilience and recovery oriented care. In support of a person's recovery journey, the chemical and mental health care system must provide these essential activities:
   - Engagement and welcoming
   - Person-centered planning and goal-driven services
   - Sharing decision-making and building self responsibility
   - Rehabilitation - building skills and supports
   - Recovery-based medication services
   - Peer support and self help
   - Adapting and integrating therapy and healing
   - Trauma-informed care
   - Individual's spirituality
   - Community integration and quality of life support services
   - Graduation and self-reliance

The ultimate goal is **Wellness** which is a focus on the whole person, addressing the individual's physical health, mental health, social health, and spiritual health congruently.

2. **ACCESS:**
   We will work to develop a Psychiatric Access Service that will provide comprehensive assessments, consultation, triage and referrals. Psychiatric consultation will be available to emergency departments, primary care clinics, mobile crisis teams, jails and other mental health providers. The ACCESS service will also include the development of a new psychiatric emergency transportation system.

3. **PARTNERSHIP:**
   We will create a process by which geographic areas can collaborate to respond to partnership proposals requested by the state. These proposals will seek to identify a combination of community agencies (community hospital, community mental health center, community primary care clinics, and health plans) willing to partner in a new business and clinical care model within the designated geographic areas. The proposals will provide for Level 1 Psychiatric Care Centers, Level 2 Psychiatric Care Centers or Psychiatric Extensive Recovery Treatment Services (PERTS). As a result, each geographic area of greater Minnesota (northeast, northwest, central, southeast, southwest), in addition to the metropolitan region will have access to a Level 1 Psychiatric Care Centers.

In service to this transformation, CMHS will be closing services that have a minimal impact on patient care or could be delivered in a more comprehensive, effective, and efficient manner. The transformation will be conducted in three phases.

Phase one adjustments occurring over the next 15 months will include:

- Permanent closure of the Community Behavioral Health Hospital (CBHH) -Cold Spring, which has not been operating since October 2009.
- Transfer crisis beds to the nearby CBHH-St. Peter in order to close the 10-bed Mankato Crisis Center.
- Replace community transition beds with a new adult therapeutic transitional foster care facility in northeastern Minnesota in order to close the state-operated adult mental health recovery facility in Eveleth.
- Transition of state-operated dental services for people with disabilities to another service model.
- Establish a SOS psychiatric nursing facility in St. Peter and transition one unit at Anoka-Metro Regional Treatment Center (AMRTC) to this facility. Remaining units at AMRTC would be operated in partnership with current Level 1 psychiatric care centers in the Twin Cities metropolitan area.
- Establish a 24 hour psychiatric access service.
- Temporary conversion of CBHH's in Willmar and Wadena to psychiatric extensive recovery treatment facilities. Community stakeholders will be asked to partner and respond with proposals for psychiatric facilities with levels of care matching the community's needs.
- Conversion of Minnesota Neurorehabilitation Services (MNS) in Brainerd to a 16-bed neurocognitive psychiatric extensive recovery treatment program for people with traumatic brain injury and intensive transitional treatment foster homes.

- Conversion of Minnesota Extended Treatment Options (METO) in Cambridge to a 16-bed neurocognitive psychiatric extensive recovery treatment program for people with developmental disability and intensive transitional treatment foster homes.
- Conversion of Child and Adolescent Behavioral Health Services (CABHS) in Willmar to two child and adolescent psychiatric extensive recovery treatment services at the current site in Willmar and with a second program at a site in the northern area of the state, such as Bemidji.
- These activities will result in the loss of approximately 200 full-time positions.

In **Phase two**, SOS will development integrated community partnerships with community hospitals, community mental health centers, other health providers, and health plans across the state. Identification of and negotiation with willing partners is intended to support a comprehensive, continuous, integrated network of care for collaborating communities.

Phase three is the full implementation of the integrated care networks, psychiatric access service, and psychiatric transportation system. The intention is to demonstrate a reduction in total cost of inpatient psychiatric hospitalization and system reliance on inpatient beds.

III. DISCUSSION

CMHS presented the 7 Goals of Excellence to the 2009 Legislature as it struggled to solve a projected $4.6 billion budget deficit for the FY2010-11 biennium. In addition to these goals, the administration presented to the Legislature a concept to define SOS, the department's chemical and mental health care provider, as a specialty health care system serving persons with the most clinically complex and highest acuity needs. This vision for State Operated Services proposed that SOS should be a network of collaborative partnerships serving those individuals providing a broad array of care where the right level of care is delivered at the right time.

As part of implementing this vision and adopting a partial solution to the state budget deficit, CMHS provided technical assistance to the State Legislature as it developed a plan to redesign how adult mental health services were provided by the Anoka Metro Regional Treatment Center (AMRTC) in the seven county metropolitan area and how services were provided by the Minnesota Extended Treatment Options (METO). The concept behind the redesign of adult mental health services provided at AMRTC called for greater collaboration with community hospitals and providers in the metro area. On May 15, 2009, the Governor signed into law legislation that called for the redesign of those services under Laws 2009, Chapter 79, Article 3, Sections 17 and 18. This law was anticipated to reduce State expenditures of SOS by $700,000 in FY2011 with greater reductions in expenditures occurring during the FY2012/13 biennium.

After the 2009 Legislature adjourned, the Governor announced $2.7 billion in unallotments to balance the state budget for the FY2010-11 biennium. The unallotments included a $236 million General Fund reduction for the Department of Human Services (DHS). Included in the $236 million reduction was a plan to continue efforts to transform State Operated Services (SOS) Adult Mental Health Services into a statewide specialty health care system. This transformation of SOS would redesign the current operation of the CBHHs located in greater Minnesota and would yield State expenditure reductions of $422,000 in FY2010 and $4.588 million in FY2011.

In addition to these specific actions other legislatively mandated cuts were made for the FY2010-11 biennium. Also, the DHS identified cost pressures related to SOS with increases in labor costs and deficits associated with the continued operation of state operated dental clinics and the Brainerd Regional Human Services Center (BRHSC) campus. With the submission of the Governor's 2010 Supplemental Budget to the State Legislature, an additional budget reduction in SOS was recommended for the FY2010-11 biennium. The total result of all of these budget pressures will leave SOS operations with a projected budget deficit approximating $17 million for the FY2010-2011 biennium.

In addition to the budget pressures, the plan to redesign SOS services comes at a time when utilization patterns have demonstrated that SOS inpatient beds are being inappropriately utilized or underutilized because of a lack of appropriate placement alternatives available for persons to receive care and treatment. This lack of alternatives for discharge has resulted in thirty to fifty percent of patients remaining in SOS inpatient beds beyond the time that is medically necessary for their inpatient care and treatment. The Community Behavioral Health Hospitals (CBHHs) have been underutilized at approximately 50% of the planned capacity.

In order to involve all stakeholders in the redesign of SOS, the administration began the stakeholder feedback process by implementing a series of open forums to listen to and gather feedback on stakeholder concerns and recommendations. The purpose of these meetings was to explore the options, concerns, and barriers in redesigning SOS. The purpose of these meetings allowed CMHS to obtain background information from a statewide perspective and to better understand the strengths and needs of each region. Attendees were asked to redesign SOS in a way that would enhance outcomes for those served while making the most of community resources and envisioning a different role for SOS. Innovation, systems change, and creative partnerships with community providers and stakeholders were encouraged. These meetings identified broad, systemic issues that hinder access and limit outcomes.

The stakeholders who were invited to participate in this process include:

- Persons: families and consumers; advocacy groups; tribes
- Clinical: academic centers, community providers, clinical experts, community hospitals, research/evidence; professional societies; students/trainers
- Public policy: legislature, governor, counties - Minnesota Association of County Social Service Administrators (MACCSA), state agencies, advocacy groups
- Employees: human resources, bargaining units
- Administrative: directors, managers/supervisors; governing board, DHS leadership, DHS legal
- Financial: data, publicly funded payers; budget, health plans; philanthropy
- Public Safety: law enforcement; courts; corrections

Each meeting followed the same agenda. The goals and objectives for the meeting were outlined, budget pressures, utilization data, contract bed data and information from the March 2009 "Mental Health Acute Care Needs Report" was presented. Following the dissemination of this information, meeting participants broke into groups to formulate answers to the following three questions:

1. What do you need State Operated Services to do in this region?
2. What do you need State Operated Services *not* to do in this region?
3. How do we create a system of public/private partnerships?

The groups were assembled to report out to the full group and receive questions on their work. Themes were recorded in the meeting minutes and disseminated back to the regions.

IV. FINDINGS & CONCLUSIONS OF STAKEHOLDER INPUT

Twelve themes emerged from these stakeholder meetings. These twelve themes include items that are directly related to SOS redesign and are related to improvements needed within the broader system. These include:

STATE OPERATED SERVICES	BROADER SYSTEM ISSUES
• Improve timely access to SOS Services • Develop multiple levels of care • Maintain the role of the safety net • Provide services for persons with geriatric, medically and/or behaviorally complex needs • Provide services to persons in jails • Improve communications and public awareness • Develop transportation options • Improve the sharing of data and accessibility of medical records • **DO NOT** compete or duplicate existing services	• Develop housing options • Create flexible funding solutions • Improve system-wide recruitment for mental health professionals

Priority issues were identified as presented below. Priority was determined through rankings determined by the stakeholder group.

	High Priority	Medium Priority	Low Priority
Comprehensive assessment service, MA eligible, includes SMRT process.	23	5	0
Transition CBHHs to a medical hospital converted to something else certified on their own.	19	3	0
Address the risks and capacity to providers who have to take high complex, high acuity persons.	12	5	2
Operating subsidy contract for metro hospitals with Medicaid contracts.	12	1	3
Greater collaboration between SOS and community provider (access to psychiatry).	11	6	0
Increase use of certified peer specialists at all levels.	10	8	2
Mobile crisis teams with 24 hour psychiatric access.	10	3	4
Regional solution/collaboration to transportation.	9	8	0
Look at multiple levels within one facility.	8	6	1
Fluid step down levels of care – spectrum of care that allows for immediate movement charge a flexible rate.	7	4	4
24/7 hospital level care system.	6	1	5
Maximize federal match for services – Medicare/Medicaid.	6	5	1
Local control over access to CBHHs.	6	5	1
Incent financially to move people through care.	5	6	4
Can't approve a general hospital stay unless CBHH census is at 90% - regional application.	5	3	10
Special programs for special population. Establish equilibrium: hospital-community-hospital.	4	10	0
Develop a checklist of what information is needed.	4	4	0

Have revenues count toward $17 million deficit. Have revenues go to SOS.	3	10	3
Dictate and standardize a model of care.	1	2	13
One on one talk therapy.	1	5	3
Take the lead in training for service capacity.	1	4	5
Create new models.	0	1	9
Contract with local universities to provide psychiatric coverage.	0	8	5
Reduce dollars not being used for xx to enhance xx.	0	0	8
Adopt a loan repay program for recruitment/retention.	0	7	7

V. APPENDICES

- Minutes of October stakeholder meetings
- Minutes of meetings with the advocates
- Utilization Data
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Minnesota Department of **Human Services**

Chemical and Mental Health Services Administration
Stakeholder Group Meetings

Appendix:

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CMHS STAKEHOLDER GROUP MEETINGS
October 7, 8 and 14, 2009

Structure and Process Considerations

- A common, consistent agenda/format for these meetings was not followed
- Information solicited (questions asked) from the participants varied slightly in wording from meeting to meeting
- Given the short notice of the meetings, attendees represented only a small sample of the stakeholders from each category. As a result, State Operated Services (SOS) needs to exercise caution in generalizing the feedback received
- State staff actively participated in the tabletop discussions. This could have influenced the observations, discussion, feedback and/or recommendations of the table members
- Actual tabletop discussions were not documented in great detail
- These stakeholder meetings, while valuable, do not tell us what the current service/level of care needs of our consumers are – or how these might be distributed statewide
- These meetings allowed DHS/CMHS to engage stakeholders in a proactive and focused information sharing process and dialogue around the evolving direction of SOS as a specialty service provider
- It provided an opportunity for relationship building with some of CMHS' stakeholders

Executive Summary

Participant comments and the information provided during the small group discussion portion of the meetings held on October 7 & 8, 2009, was carefully reviewed and then placed into 11 broad categories reflecting the topic area that participant feedback addressed. These 11 categories, indicating the percentage of overall participant responses that fit into that category, included the following:

1. Philosophy and design of service delivery system – (40.1%)
   Common topics expressed within this category included the need to design a full array of services for individuals with complex needs. Issues of available options, location of services, mobility of services, coordination of care, structural barriers, and removing existing silos were expressed.

2. Fiscal and Payment – (16.7%)
   Common topics expressed within this category included the costs of uncompensated care, integration of funding streams with greater flexibility for use, creating incentives for services and making improvements in payment models.

3. Planning and implementation questions and issues from a regional and local basis – (10.8%)
   Common topics expressed within this category included inclusion of the entire care delivery system through creative partnerships and the development of an electronic infrastructure to support the client.

4. Need to partner and collaborate with others – (10.0%)
   Partnerships with private providers were suggested to improve synergy, access to psychiatric services, and continuity of care.

5. The State's role in establishing standards of care, supplemental resources, facilitation, and professional education – (6.3%)
   The State could assist with core, innovative infrastructure such as telemedicine, quality networks, scheduling networks, training, etc.

6. Legal and commitment process – (4.8%)
   Legal issues around the commitment process, Jarvis orders, EMTALA, and HIPAA need further clarification.

7. Admission process and assessment – (4.5%)
   The admission process needs to be streamlined with a standardized/consistent process to assess and make level of care/treatment determinations and referrals.

8. Need for more housing options – (3.4%)
   A broader array of housing options needs to be developed to support clients with complex needs.

9. Transportation obstacles and challenges – (1.9%)
   Seek other alternatives to ambulance and law enforcement for transportation services.

10. Services available to the criminal justice system – (1.1%)
    Improvements need to be made with jail re-entry.

11. Quality and outcomes – (0.4%)
    Measures need to be developed and put in place so that the effectiveness of the array of services across the continuum of care can be reviewed.

County Representative Stakeholder Group Meeting
Wednesday, October 7, 2009
8:00 a.m. to 12 noon
Carondelet Center, 1890 Randolph Avenue, St. Paul, MN

County Social Service Agencies Represented:

Anoka (2)	Kandiyohi (SW 18)	Stearns
Becker	Mahnomen	Steele, Dodge Waseca
Becker (County Director)	McLeod	Steele (County Director)
Blue Earth	Mille Lacs	Wabasha
Carlton	Ramsey (2)	Wadena
CREST Project Coordinator	Scott	Waseca
Dakota	Sherburne	Washington (2)
Hennepin (3)	SW 18 Counties (Coordinator)	
	Sibley	

Introductions:
Mike Tessneer gave an overview of the purpose of the meeting and what the Department hopes to accomplish with today's meetings. Dr. Sulik gave an overview of the responsibilities of the Chemical and Mental Health Services Administration within the Department of Human Services. He presented a vision for redesigning mental health services provided by SOS. He shared with the group that he held an internal DHS meeting on Tuesday afternoon where this same information was shared.

Open forum -- Comments provided by participants:
- What ideas have you come up with to create a culture shift of your employee's thinking to this new way of thinking – (Response: Dr. Pratt spoke to the implementation of person-centered treatment.)
- The role of the State appears to be changing. Minnesota has a long history of safety net services in a variety of areas (i.e., mental health for both kids and adults); I don't hear that thread in your discussion right now. I personally have seen the shift and counties are not financed or set up as 'healthcare plans' so the ability of counties to institute safety net services is pretty daunting. (Response: Dr. Sulik reframed the definition of safety net as deep end services and noted that the term "provider of last resort" bothers him. Objective is to provide clarity to our mission as to who we are and who we serve. Best define the individuals we serve and best define the services we provide and obtain a common definition of what is meant by "safety net".)
- Where are program/policy people of DHS; the adult mental health, the managed care staff? (Response: Dr. Sulik noted they were in the room yesterday; the purpose of today's meeting is to find out what county representatives are thinking.)
- We know you have a budget problem and sometimes when there is a redesign there are unintended consequences. Counties have budget problems as well and if things like the CADI waiver go under, the counties ability to respond to needs of those clients will not be met.
- We look at the CBHHs as the safety net and if we go into 'specialty care' what happens in our areas of the State. (Response: Dr. Sulik noted that the role of the CBHHs shouldn't change in that this system should provide care for individuals with the most complex care

and acuity. The role of the State should be to provide a specialized role to our patients as well as a specialized role to our community providers in serving individuals with the most complex needs. Question now is how do we restructure this end of the spectrum? We could save money by just shutting down programs but the State is not going to do that. We must save money by achieving efficiencies.)

- Appreciated the MACSSA meeting last week with the metro counties. Want to reiterate the role of the Minnesota Commitment Act and State District Courts in the commitment process. They are powerful stakeholders in this whole agenda and the State needs to bring them along. Also need to acknowledge the role of County Attorneys; if they feel they are not at the table you're going to have some unfortunate flare ups. Some County Attorneys see their role/mission as ensuring access to treatment and will use the Commitment Act to achieve that. (Response: Dr. Sulik noted that one interested marker is that Minnesota is one of the states with the highest number of commitments. How do we reduce commitments? Reiterated that State is not trying to compete with the role of community providers. He noted that, as meetings bring them to areas of the State, he and Mike Tessneer have already started to meet with local community hospitals, county agencies, and mental health centers. He spoke of meetings held, or planned, with law enforcement, professional societies, Health Plans, other State agencies, members of the Legislature, tribes, etc.)
    - Potential Action Step: Meeting with County Attorneys and Court staff.
- What is your definition of integrated care? (Response: Read clarified it is not co-location; spoke to his residency and the necessary cross over of all services necessary to meet the needs of the client. In practice it involves dialogue with primary physician, social worker, school, etc. How do we create the right incentives? Asked that we think about integrating internally and externally.)
- When CMHS is talking about integrating care, how are you going to dialogue with local providers? In rural Minnesota that could include a provider in another state; i.e., North Dakota in the northwest corner of the State.
- In the rural areas, the safety net is basically law enforcement and the local crisis level hospital setting. County staffs have to do a lot of 'fire fighting' with law enforcement officials who, in many cases, are reluctant to be placed in the role of social workers. In rural areas Emergency Rooms are, in most cases, staffed with physician assistants who have telephone contact with a physician who is not on site.
- Health care delivery systems are financed on health codes rather than outcomes – counties have to build a case for the client's deficits rather than then their strengths – and there is no way to finance the services that would help our client utilize their strengths.
- Bill Hudock, SAMHSA consultant, spoke to legislative proposals currently in Congress; specifically two bills that include federally qualified behavior health centers – there was an initiative pushed to move beyond the barriers that exist in communities. This is only a "placeholder" that would be defined by the Secretary of Health and Human Services. Also, noted demo projects for training more primary care professionals in psychiatry. Shared there are other "placeholders," with dollars attached, to work on earlier engagement, prevention, promotion activities but these are two to four years away.
- Steele County created a bundled Medicare rate – this may be an opportunity for something that can be done immediately. A System Care Coordinator position was developed in partnership with a health plan, a local hospital and the Adult Mental Health Initiative. Has been operational since April 2009 and this enhanced communication and coordination result in better integration of care.

- Federally Qualified Health Care organizations (FQHC) hold real potential opportunities. No barrier to adding behavioral health to existing FQHCs. They can purchase medication less expensively than anyone other than the Veteran's Administration and FQHCs can purchase and dispense medications, which results in better compliance.
- Bill Hudock: There is a lot of opportunity with FQHCs, but also integrating primary care into community mental health centers. SAMHSA will soon announce 12 pilot grants; and they received over 400 applications for these 12 grants. The Health Resources and Services Administration (HRSA) doing the opposite – bringing mental health services into primary care clinics. Pilots present a great opportunity to figure out the best way to implement – noted that in Minnesota the DIAMOND Project is a great example of care coordination in the private sector.
- Hope expressed that Dr. Sulik will also hold a stakeholder meeting with parents of children with severe emotional and developmental disabilities.
    - Potential Action Step -- Meeting with parents of children with SED/DD.
- Is PMAP adding value to mental health services; and are the Department's Adult Mental Health and Managed Health Care Divisions working together? There is some value in PMAP but the billing piece is the problem
- Counties are doing a lot of this already because they've had to – they have a charge to provide for their clients. Counties do meet with their stakeholders and they feel they are doing good work. Look at what's working already; don't just create a new wheel.

Presentation of SOS Adult Mental Health by Rod Kornrumpf:
Comments/Questions:

- Concern expressed by a participant that legislation will pop up outlawing law enforcement transport – concern that rural social workers/union represented will not perform transport services.
- Seriously mentally ill individuals with criminal behavior are sitting in jails – should the State be providing consultation services/mobile staff to follow patients?

Presentation of SOS Special Populations by Doug Seiler:
Comments/Questions:

- What is the primary source of clientele in the CABHS program? (Response: Metro area)
- One opportunity is to reduce overhead – alluded to the fact that support systems are buried in a big government system that adds overhead cost to rural programs.
- Shared technology, psychiatry, prescribers, etc. -- the expense of technology is overwhelming and access is a challenge in greater Minnesota. State can be a resource to jails. (Bill Hudock noted that in the State of Vermont, Human Services got the Department of Transportation to pay for IT hardware and infrastructure under the argument that it kept people off the roads.)

Dr. Sulik concluded this portion and noted that the State's role is to enhance the system; not replace it and noted on the spectrum of care there is a new level that is raising havoc in all of our health care systems and that is patients who present as mentally ill and aggressive/violent. He shared his seven goals to achieving excellence and noted that his litmus test would be to apply those goals to any proposals coming forward. He is committed to creating a vision and momentum to ensure that we have the ability to sustain through political turmoil.

Goals:

- Eradicate the stigma
- Right care at the right time and right place
- Achieve quality standards of care
- Integration
- Efficiency
- Continuously committed to the recovery of strength and wellness
- Reduce severe consequences of the illnesses

Break-out notes from County Representative Stakeholder Group Meeting
October 7, 2009 (Morning session)

Question/Exercise:

Group 1

- Things not covered yet
- Timeframe
- Inclusion of entire care delivery system
    - Mayo, Minnesota Psychiatric, Minnesota Medical Association
- County Costs
    - Guardianship, Conservator, Commitments
- Uncompensated care
- Integration of funding streams and service needs
- Review CBHH admission barriers
- Homelessness – Jail diversion
- Maximize prescriber use – regional/public/private
- Funding for psychiatric consults to primary care -- complex
    - Dollars to primary care sites
    - Need for contracts – LMD/Psych
- Ambulance transports too expensive
- School involvement – bring them in?
- Public health
- Medicaid waiver opportunities for care coordination
- Hospital system care social worker plus flexible funds
- Jail re-entry

Group 2

- Services need to be close to home
- Do "intensive specialty" services need to be state run (or could they be "SOS contracted" community run services)?
- What are options under IRT
- Need full array of housing for complex needs clients
- Need more services/options for "neuro-cognitive" clients (i.e., dementia with aggressive behaviors, etc.)
- Need more services for MI/Neuro-cognitive/complex medical
- Long term care for people with cognitive/medical impairment plus severe behavior issues (violence, predatory sexual, wondering)
- Services need to be located near the high volume need
- "Undocumented" clients – inability to obtain funding for the services they use.
- How do we measure effectiveness of the array of services across the continuum of inpatient care through community specialty care and SOS specialty care?
- Institutional entropy – how will you sustain the vision?

Group 3

- Access to right treatment in the right place/right time:
- Who is going to pay for it?

- Local/regional triage
- How can State involve local regions in identifying how current needs are being addressed?
- Payer determines services and where (access)
- State controls PMC contracts/managed care
- Managed care – if they are going to be the "driver" have to know the system
- Integrate the funding in order to integrate care.
- Stable housing – how PC and CADI changes will affect consumers
- Current emergency hold – commitment process interacts with model – liability?
- Regional MHI structure – works for planning and most include community partners

Group 4

- With an emphasis on discharge planning it will be more difficult for social workers (i.e., travel time) to do this if the specialized program is a great distance.
- The risk is putting too many resources in the high end. Reallocate resources to the middle for the best return. Misalignment of resources.
- If you provide the right service at the right time how do you prevent cost shifting? (Infrastructure/clinical/funding)
- Are specialty programs enterprise?
- Are we just finding a way to use beds?
- Are we talking services or buildings?
- Payment should provide incentives for services, not bed days/programs.
- Metro counties concerned about AMRTC wait list. Will the new model decrease or increase the list?

Group 5

- Services attached to a place – bring in "mobile" expertise (ITV?)
- No step-down/transitional
- Keep things local
- Keep formal or informal system involved – resources locally
- Specialized education is the gap
- Localities need ongoing support
- Funding – licensing need to go together
- Transportation – funding
- Expertise training from DHS instead of just rule and procedure training
- Share resources efficiently and effectively
- Funding sources and affordability
- Same rules for all funding sources for same conference

Group 6

- Partnering with private providers
    - Synergy – those who know community
    - Access to psychiatric services
    - Continuity
    - Break regulatory, financing, organizational barriers
- Incentives for retaining psychiatrists being trained here.
- Is continuity of care lost when LOCUS score improves?

- Services move around client
- Should communities run LOCUS 5 services?
    - Use as diversion
    - Retain continuity in community
    - Will this get state “off the hook” especially in rural areas
    - Can regional solution be best mix?
- Is commitment being too directive?
    - County dollars responsible if level of care not meet
    - Does this lead to misuse of resources
    - Is this both bade care and bad policy in the name of safety and lack of appropriate alternatives?
- Violent people
    - What are appropriate alternatives?
    - How does expertise get deployed?

Group 7

- Where is continuum in metro area?
- What are impact areas
    - Deficit vs. recovery focus
    - Medical model focus on deficit
- Need to build community systems
- Infrastructure options at community level are lacking
    - Incentive system – needs to be re-thought
    - Use savings to reinvest in community models
    - $15 million savings – how to best utilize
- Working poor – under-insured
- Gap to provide service and reimbursement (i.e., psychiatric .40 on the dollar)
- Funding in system misused – more efficient models
- Short-term solutions have cost local dollars – shifting costs
- Integrate community health centers
- Create community umbrella between private providers, community clinics, hospitals
- Structural barriers
    - Can’t hire primary care doctors
    - View of mental health center as “home”
- County and regions model working well
    - Supervision of medical residents
- Philosophically aligned – how it hits the streets is what is at issue – gun shy
- All parts of the system use change simultaneously
- So close to the margin fiscally – inhabiting innovation
- Deficit – tool to get innovation
- Community doesn’t benefit from savings within systems

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Community Hospital Administrators and Health Care Group Meeting
Wednesday, October 7, 2009
1:00 – 5 p.m.
Carondelet Center, 1890 Randolph Avenue, St. Paul, MN

Hospitals & Health Care Agencies represented:

Albert Lea Medical Center
Allina
Allina, Center for Healthcare Innovation
Brainerd Lakes Health
CentraCare Health System
Fairview
Hennepin County Medical Center (2)
HealthPartners
HealthEast
Hutchinson Area Health Care
Lake View Memorial Hospital
North Country Health Services – Bemidji
Queen of Peace, New Prague
Sanford Health
St. Cloud Hospital
St. Francis Health Care Campus
St. Luke's Duluth
St. Mary's Duluth Clinic
United Hospital
U of M, Dept. of Psychiatry
Winona Health

Introductions:
Mike gave an overview of the purpose of the meeting and what the Department hopes to accomplish during this series of meetings. Dr. Sulik gave an overview of his administration and outlined his 7 overarching principles/goals.
Goals:

- Eradicate the stigma
- Right care at the right time and right place
- Achieve quality standards of care
- Integration
- Efficiency
- Continuously committed to the recovery of strength and wellness
- Reduce severe consequences of the illnesses

Open forum -- Comments provided by participants:

- GAMC will be eliminated; 20-25% of the individuals served in the rural area are covered by GAMC, worried about losing needed funding [and the effects on the system].
- Recruitment of psychiatry in rural areas
- State sees itself as the "safety net," the provider of last resort but providers in the private arena are serving those same patients. Start by identifying what we have in common. Basics – talk a common language; what does safety net mean and functionally what do we have to build around that concept.
- HCMC – because of loses being experienced in reimbursement through GAMC, as well as the anticipated sunset of GAMC, Hennepin County Medical Center is facing the "perfect storm."
- Need to address duplication of services; every system has a psychiatric service, cardiac service, oncology service, etc. Part of the problem is we put the system together to provide every service. Maybe we need to become experts.
- Dr. Stan Leonard (Pediatric and Young Adult Medicine): Children's Mental Health Initiative reinforces the importance of education. The metro is a large population area and children are not well served because of fragmentation of services. Hopefully Children's Hospital will

soon have a 16-18 bed unit for children under 12. Approximately 20-30% of children have co-morbidity issues that eventually result in mental health issues. Currently doctors are charged 2% of gross income for MinnesotaCare; would like to propose that insurance companies also provide 2% of their gross income to MinnesotaCare.

- We have done a lousy job when it comes to the integration of services for chemical and mental health and integration of primary care with mental health services.
- Along the lines of survival rates of kids with cancer, what do we know in true science of improvement of systems? If things are truly evidence based, you can work toward spreading them on a system level. Treatment of depression is one of those areas. If you're talking about other areas, there is not as much evidence. We need to pilot 'systems of care' and advance those that work.
- How do we measure the cost effectiveness of what we do? How do we give our bosses a number about what the fiscal impact of eliminating one service will have on another service?
- When we look at the systems of improvement, how do we collectively look at our systems of care to fast track a pilot, to engage our resources more effectively? Duplication and competition – have we identified what we compete on or have we identified a list of services that we don't necessarily provide well but that are needed for our success?
- Collaborative nature of our business – DHS could play a broader key role in that collaborative system.
- If you're going to make any headway we have to address the issues of financing. When GAMC goes away, we've shifted the cost of serving individuals with mental illness to other areas. We need a financing system that supports all of us or else it becomes a cost shift game.
- Recognize the fact that mental health illnesses can now be diagnosed before the age of 5; provide appropriate education to day care providers, support early childhood education and help teachers recognize symptoms of mental illness earlier.
- Dr. Sulik's analogy of leukemia to mental illness may not be appropriate. – telemedicine in emergency rooms could lead to earlier identification. ER telemedicine could lead to early identification and intervention. There are over 300 psychiatric illnesses, 200 psychiatric medicines, but 5 out of 10 are psychotropic and not all family physicians are qualified to prescribe.
- Need to emphasize a couple of things regarding brain injury. Approximately 30% of people in Minnesota who are homeless have brain injuries. Estimate is that 90% of people in correctional facilities have had a brain injury. Shaken baby syndrome – impact on educational system. When we fail to treat people correctly, the costs to the human service, correctional and educational systems go up. Have to make it concrete – you can take any illness and follow it throughout all those systems and see the fiscal impact.
- If you are truly talking integration do you really want to separate mental health and chemical dependency?
- Need to think of the family as the focus. Families with an adult with mental illness probably have a child(ren) in need of mental health services and vice versa.
- There are things we can do right now to improve our system; but there are other things that we may only be able to plant the seed. The reality is that the finances are an important piece.
- When we are talking about providing services to individuals with mental illness we need to talk about chronic disease management.

Break-out notes from Community Hospital Representative Stakeholder Group Meeting
October 7, 2009 (Afternoon session)

Questions:
A. What do we want to do? **B. What should the State/SOS do?**

Group 1
Note that the framework of the question already compartmentalizes/creates silos.

What do we want to do?
- Our concern is that we are again organizing around existing silos with proven poor track record rather than organizing around the patient, their need and what the evidence indicates is the best approach to resolving their concerns.
- Leadership voice in reducing stigma through education of standards.
- Current boxes (services) not equally available. Standards help providers know what to do and then allows creativity at local level to develop that function.
- Look to cardiology, radiology for models of electronic infrastructure.
- Consider organizing mental health and chemical dependency as we do cancer – stage it – 1, 2, 3, 4 and treat by stage. Create common framework/language.
- Integrate mental health and chemical dependency.
- Breakdown funding silos (mental health, chemical dependency, medicine)
- Get rid of licensing bureaucracy "goal vs. objective" "objective vs. goal"

What should the State/SOS do?
- Need for State to facilitate development of protocols which describe and standardize care – say this is better.
- Ultimately the State could assist with core, innovative infrastructure such as telemedicine, quality networks, scheduling networks, etc. Step into situations where local team needs assistance to meet a need.

Group 2
- Eliminate barriers to open talk (antitrust, HIPPA). Create "Safe Havens"
- Can we "co-own" the problem/person over time (collectively)? Stop stark hand-offs. Concurrent vs. sequential care.
- Cooperative" model case-by-case

Group 3
What we want to do/our role:
- Serve the people in our service area
- More extended stays with lower acuity/complexity

What the State/SOS should do:
- Create a repository of information, a centralized mental health record that all Emergency Rooms can access.
- Streamline the admission process to obtain the services (doctor privileges)
- High acuity/complex (violent) can go quickly – at a minimum coordinate this.
- Be more of a system, less silos

- Address transportation issues

Group 4

- Enhancing "bed tracking" → automated forms
- Share in cost dollars to hire/attract psychiatrists to Minnesota
- Telehealth → pool of psychiatrists

Group 5

Private Services ← continuum of service →	SOS
Short term intensive (3-5 days	Aggressive, violent, MI/CD
Longer term, committed or not, up to 45 days	
Special unit for aggressive and violent brain injury	
Complex med DX with MI that is short term care	Aggressive violent brain injury with pre-onset treatment – antisocial/criminal
	Complex permanent medical DX with MI

How to make it work:

- Permeable walls
- Clearinghouse across private providers and SOS for patient to get to right place
- Central access point – not admit, but evaluation place post admit
- Quick response time

Models/Partnership:

- Duplicate transitional care service
- Offer joint/continuum of patients with medical complexities
- Figure out if we are SOS's partner or customer even if patient is ultimate customer
- As partners figure out dollars together (is it all funding sources?) (coordinate funding)
- Want to know what SOS wants from the private sector
- Need structure for ongoing discussion – integrated committees/meetings
- Partner on D/C – look for best (?) and compromise for dollars and availability
- Pool resources; MDs, etc. "time share" for hire/coverage
- Will it allow for patient choice, universal access regardless of payer?
- Healthcare delivery system
  - Finance or procedure codes – not outcomes
  - ARMS (rehab) services focused on "correcting deficits" and not building strengths
  - FQHC → FQBHC – can we do this? Can we reimburse mental health like this
  - Demonstration projects to CMS to look at bundling strategies
  - Bundled Medicaid rate? – Steele County Pilot
- System Coordination
  - FQHC
  - Purchase medications cheaper
- Can create ???? pharmacy clinics and dispense

- Bundled rates
- Meeting with ?

Group 6

- Create a clearinghouse with "one-stop shopping" to process assessment data and make treatment determination and referral (county/state/health plan/provider)
- Collaboration on funding determinations (example: Waiting inpatient Friday – Tuesday for county Rule 25 assessment).
- Collaborate on development/implementation of uniform assessment and referral criteria.
- Pilot different models of collaboration in different markets.
- Structure a system of just-in-time feedback from community stakeholders as SOS implements change.
- How do we reconcile our need for a unified strategy for partnership with a "schizophrenic" DHS (policy divisions and SOS)
- Change and transformation needs to be defined by the needs of the patient.

Group 7

- Network of communication to facilitate connections with primary care and specialists (Example: Poison Control)
- Integrate role
- Round-the-clock consultation system
- Health care level: Mental Health Home/Social Services Worker

How to work better together:

- Utilize business models
- Turn CBHHs over to local; provide block grants for access and providers. Manage locally.

Group 8

What do we want to do?

- Move care into medical model (addiction services)
  - Barriers are a factor when we try to bridge the systems (social services)
    - Social Services Model:
      - Poverty/mental illness correlation
      - Housing (supportive)
  - Centers of Excellence
  - Preventive health and medical home for MH and CD
  - Integrates non-medical providers
  - Uses more mid-level providers
  - Chronic disease management (model)/Level 1 (HCMC)
- Stop dividing out addictions
- Collaborate between and within systems (training)
  - Locus of control
  - Regulations
  - Financing
  - Culture

What do we want the State to do?

- Flexible <u>funding stream</u> that covers people when other streams have failed/don't support

- Appropriate levels of care for patients
  - That are available
  - That meet acuity needs of patients

What models and partnerships would we like SOS to work with us on?

- Shortage of psychiatrists
- Change regulatory framework to allow more flexibility in scope of practice/top of license
- Support telemedicine
- Transportation services for mentally ill rather than ambulance/law enforcement (rural issue but affects all)
- Clarify EMTALA issues:
  - Legal
  - Define for mental health
- Address HIPPA issues
- Work on admission process to state facilities – denied transfer/credentialing
- Do a better job of rationalizing structure of services/making them rational
- Define standards for safe and effective care

Allina Input:

- Acute access (historically)
  - Triage/Assessment
  - Decision making about service needs around the boundaries of the safety net (especially children/adolescents)
- Current
  - Integrated care system serving 2 distinct populations
  - Care within Allina ("healthcare home" is inpatient care)
  - Receive care elsewhere but enter Allina system through acute access
    - Requiring partnerships in decision making ("healthcare home" is likely community mental health or nothing)
- Current Dilemma
  - Unclear who needs commitment
  - Scope of SOS services is unclear
  - Need placement when someone no longer needs inpatient (and more timely placement)
  - Consistent or improved assessment of need (and more flexible provision of services to meet need).

St. Francis Healthcare Input:

- Outpatient mental health services in our community
  - Currently unable to meet need due to lack of providers
- (Full service critical access hospital)
- Needs
  Telemedicine consultation to:
  - Emergency Room
  - Inpatient care
- Access to inpatient and/or other beds/services

Community Mental Health Providers and Disability Advocates Meeting
Thursday, October 8, 2009
8:00 a.m. to 12 Noon
Carondelet Center, 1890 Randolph Avenue, St. Paul, MN

Dr. Sulik opened the session by thanking participants for attending and acknowledged the short lead time for the meeting. He gave an overview of the historical role of the State's public mental health care system and reviewed his 7 goals for the Department's Chemical and Mental Health Services Administration (see attached). He emphasized that these goals are his litmus test for any change we will undertake.

Agencies represented:

Annandale IRTS, Wright County Collaborative
Association of Community Mental Health Programs
Catholic Charities – St. Cloud
Children's Mental Health – Grand Rapids
Chisago County Health & Human Services, Director
Consumer/Survivor Network (2)
Elk River
Five County Mental Health Centers
Human Services Inc.
Human Development Center
Medica Behavioral Health
Mental Health Agency in Southwest Minnesota
Mental Health Resources (2)
Minnesota Association of Mental Health Residential Facilities (2)
Minnesota Mental Health Association
NAMI & NAMI's Legislative Chair
Northern Pines Community Mental Health Center – Mobile Unit
Nystrom Associates
People Inc. (3)
Perspectives – Supporting Housing Program
Prairie Community Services, Inc.
Public Policy Consultant – Bill Conley
Range Mental Health Center
Re-Entry House
Regions Hospital Community Outpatient Services
South Metro Human Services (2)
South-Metro Human Services ACT Team (2)
Spectrum Mental Health
Touchstone Mental Health
Wilder Foundation
Zumbro Valley Mental Health Center

Open forum -- Comments provided by participants:

- Talked about developing a system of care rather than hospitals; gets a picture of the State developing a system and then partnering with community instead of sitting down with community providers in a partnership conversation to determine what needs to be developed.
- Concern that the categories 'de-limit' discussion about how to proceed. Divided already by State/non-State services. Another way to proceed would be instead of starting with the "bricks" and how they can be used, start with the people and determine what they need and what tools you have to address their needs.
- Situation where the State's role is to fill gaps that occur due to inadequacies or incompetency or how it is paid. The model fills the "market failure" – understand what those points of failure are. What are

the conditions that lead to the community providers being over-whelmed? Every community provider has their own challenges.

  - Dr. Sulik indicated that the role of the State should be to be involved in enhancing and supporting the provision of services and asked what does that look like? How do we get there?
- Many of us spent a lot of time on the unmet needs reports for adults and children. That should be a basis of this discussion.
- I really like the "enhance and support concept" – where integration collides is with "provide." There are more and more States looking at privatization but still need the State support to make that successful.
- Have you at all considered the demise of GAMC and its impact on the role of the State as the safety net provider?
- Exercise – respond to who are we as the State and provide clarify about the safety net role – what should the State be doing to enhance and support – how do we move to an effective integrated system.
- If we don't take advantage of "person centered" care today from this group it's never going to be person centered. This group knows their people, and this group includes clinicians, direct care providers – it's not where should they go, what "facility" but what services do they need.
- Person centered is what the State has done well. It's great to have State people who have some ability to look beyond the rules and know how and when to bend the rules to serve "this" person. The State has done a great job at that.
- Appreciate the model of complexity and acuity. Helps clarify. Hope we can express what the community providers find as barriers. Understanding where the limitations come in and why community providers can't reach their desired ends.
- When you spoke about the decision to build the first state hospital, the decision makers used concrete to solve the problem – still doing that in some sense; but maybe we need to move to a sense of fluidity and freeing up money will let it flow to where the need is.
- Is there any body here from when the Moose Lake Regional Treatment Center closed? If you look at what happened in that process, the county, providers, politicians all came together – not a perfect solution but it led to closer collaborations and those people are still in the community. This was driven by necessity and we did something pretty good. We've reduced the hospitalizations and re-hospitalizations. It was people willing to sit down and put aside their own wants to determine what was best for the region.
- Throwing more money at it isn't going to solve the problem; but, it shouldn't mean that parents have to travel across the State to get appropriate services for their children either. We need a "The Buck Stops Here" sign – someone has to take the responsibility to serve the client. Gave example of an article in this morning's Star Tribune that showed an example of failure to serve that is completely unacceptable.

Description of Exercises:
First Table Top Exercise: How do we ensure we have an appropriate continuum of care for all people we are trying to serve? Look at the populations you serve, what is the potential continuum of care that they need and what is the appropriate role of private providers;

Second Table Top Exercise: What is the role for SOS; and where are the gaps? Dr. Sulik noted he wanted to pick the participant's brains about the State Operated Services structure currently in place – what should it look like? Could it be restructured and if so, how?

Group 1 - 1st Table Top Exercise:

- Don't get stuck in plans but work at processes
- Relationship
  - We to DHS
  - SOS to DHS
- Provider of last resort = assumption
- Nature of relationship
- State overbuilt – so is this driving the change and budget crisis?
- Basic needs of people need to be met
  - Housing
- Why shouldn't State give up providing?
- County vs. State as safety net
- Who can best service aggressive clients?
- How can medical needs to be met
- Psychiatrist to enhance community safety net – manage aggression – State role
- Need and dollars will allow creative solutions
- State policies create agreement
  - Levels of care
  - Criteria for levels of care
  - Assessment o care
  - Pay for care
- Payment models need to be created
- Providers have ability to create products to meet needs of community and individuals
  - Know market place
  - Understand need
- Not always services
  - Housing
  - Basic needs
- State doesn't need to recreate pieces that already exist
- Partnership would have State support gaps in community services
- Financial and staff supplement to support community providers
- Design model with providers
  - What does community need to keep people in the community
- People/expertise/dollars – make it available in communities
- Figure out solutions together – time limited enhancements are often needed
- Clients are fluid – system needs to be fluid
- Episodic enhancement
- State get integrated into existing system

Group 1 – 2nd Table Top Exercise

- Shift staff coverage to enhance existing services
- Psychiatric consultation
- Access to dental services
- Turn CBHHs over to mental health centers – enhance continuum
- Regional conversations – different for Anoka vs. other regions (others have surplus)
- Unused empty facilities; i.e., Bloomington 16 unit apartment
- Shift to mobile crisis from hospitals/CBHHs

    - Enhance mobile crisis
    - Divert patients
- Shared service agreements with staff – mobility assignment to non-profit
    - State and local community
    - Allow community mental health centers to stop having State Employees
        - ACT
- Fragile/medically compromised/elderly – State model
- Episodic enhancements
- State get out of providing any service
    - allow community to create
    - oversight/accountability
- Build infrastructure to support
- Economies of scare for services – state oversight
- Ohio/Kansas models
- Stage the implementation
    - To enterprise model
    - Coordinated purchasing strategies

Group 2 -- 1st Table Top Exercise:

- Not enough psychiatrists – some areas more than others (children, rural)
- Not enough capacity
- Need more housing and services to assist in housing
- Systems around service: access, financial, meds, etc.
- Alternatives (to discharge)
- Really quick response for appointments, transitional housing
- Trust can be rebuild but takes time
- Primary care is missing
- County/State/Federal funding – all define things differently
- Open CBHH to short term crisis services
- Even if you take money off the table, the client's access to funds is complex. Takes a full day to get emergency/urgent care. Need more urgent care services.
- Licensing/rule making issues are lengthy, take time from providers
- DA (diagnostic assessment): do repeatedly, with not much difference to the client.
- If goal is to care for all, system needs to take into account.
- Transportation is very difficult impediment. Even if there is a public system, what if person is psychotic?
- What is appropriate for those who already have burned bridges? They lack trust in system and everyone else.
- FA (functional assessment) is also done many times, different providers
- Rules sometimes mean we can't see things from client point of view
- Providers are pressured to move client.
- Client may not consistently know direction.
- Limited to medical model – holistic may be more effective, but not evidence-based.
- Mainstreaming skills – but community stigma is huge. People in recovery are okay to hire, attend church, etc.
- Even residential services are subject to stigma. Even people in field may believe things.
- Very few providers truly believe in full recovery.

- "Involuntary" treatment?
- Interdependency is the goal. Minnesota tries to "take care" of people – more independence in Vermont.
- Health care companies.

Group 2 – 2nd Table Top Exercise:

- Collaborative work between state and partners, gradually over time. Use telemedicine technology to help provide statewide 24/7 service, on call. Confidential conference via internet, ala Skype (Vidyo). One-fifth the cost of ITV.
- Open CBHHs to youth services.
- Team members may meet at CBHH; sometimes they do site visits, not always.
- Mobile outreach services would be good.
- DA/FA (diagnostic assessment/functional assessment) information, medications upon admission to IRT.
- Should AMRTC deal with different levels? Aggressive?
- Not sure if person is ready – lack flexibility now. State/provider could partner better.
- Can be like black hole when person is discharged? How can we track better?
- Coordination/collaboration requires funding, but also organization.
- More transitional model: No one is permanently anywhere – the person is always moving toward discharge.
- Journey won't be linear
- Interactive hub that links physical/primary care to mental health
- We haven't talked about cultural competency at all yet.
- Consultant role to allow providers to work outside the box. Some could be addressed through provider group, but not all.
- CMS certification: They haven't visited all 10 CBHHs yet.
- AMRTC is non-accessible to most of metro area.
- Building a facility – if private providers knew what else was being planned it would help.
- The salary disparity between SOS/private is still a barrier
- Can we use State psychiatric resources?

Group 3 – 1st Table Top Exercise:

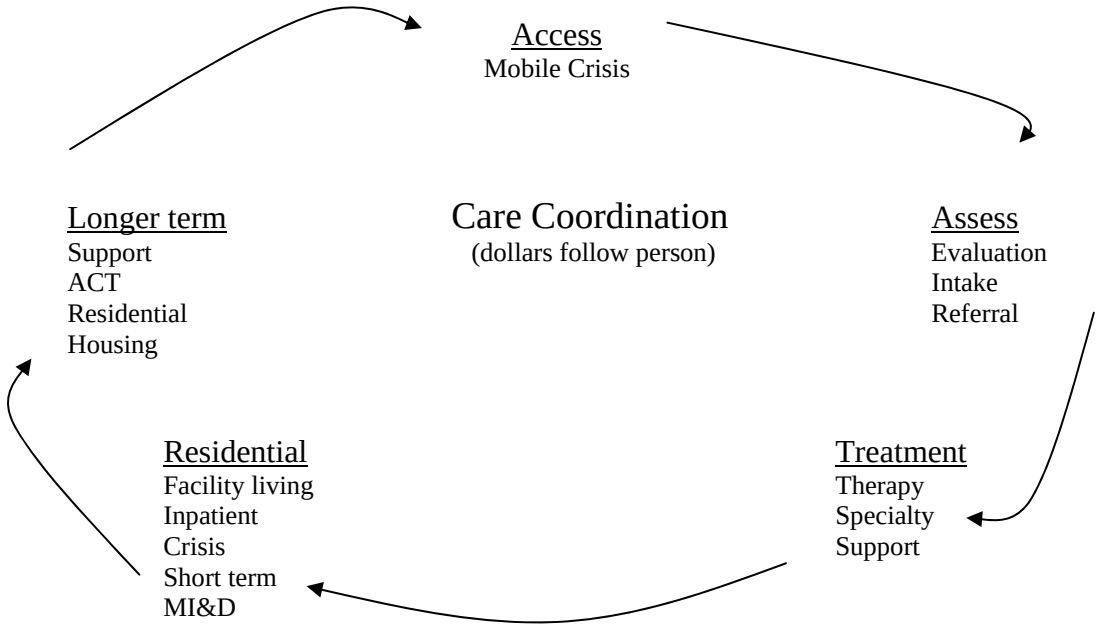
- Access – Parent/consumer
- Health Care Home
    - at the start (like a Social Security number)
    - mental health and physical
    - use technology to provide basis information (telemedicine)
    - provides clearer provider role
- Barriers
    - financial bureaucracy
    - penalizes wellness; system only works when person is ill
    - no fluidity – all siloed, rule…
    - defines rules by needs
- Person owns their health and health needs (eliminates stigma)
- What do you want? Not what do we provide.
- Someone (State?) has to be the streamliner for crisis
- Fluidity follows needs

- Rules penalize recovery
- In treatment – lose housing
- Gap filling is support, not bricks and buildings
- Prevention is key
- Jobs – get job lose insurance; lose medication → quit job – get service.

Group 3 – 2nd Table Top Exercise:

- For those whose insurance can't get them services
- Contracted staff to fill private sector needs
- Metro children's needs (not Willmar)
- CBHH to specialized services (kids, crisis beds)
- Psychiatry triage
    - telemedicine consult
    - medications – 90 days
- Extend MA coverage time
- CBHH as housing – temporary transition
- Different levels of care within each CBHH
- Centralized triage
- Combine primary medical with mental health with dental (it's all primary and preventive)
- Move services more throughout metro

Group 4 – 1st Table Top Exercise:



Group 4 – 2nd Table Top Exercise:

- What are the needs of the region?
- If each CBHH could meet the intensive need for the next step down.
- An un-utilized CBHH spot becomes a crisis bed for evaluation or safety.
- Higher level, longer term.

- Look to SOS for consultation, training utilizing existent technology (ITV access to specialists in metro or out of state
- Need for IRTS "plus"
- Need supervised specialized long-term living
- Provides valuable service
    - Improve access
    - Break-out populations
    - Are residents from out-of-area because there is a lack of resources in greater Minnesota?
- Specialized intensive services
- One care team for complex MI and health care needs
- CBHH expanded services
- Continuity of care
- More resources in metro area → proximity of access

Group 5 – 1st Table Top Exercise:

- Rental assistance – supportive housing
    - Front door
    - Programs with the ability to bring services to the individual
    - Services that follow the individual
    - Choice
    - Assisted living model
- Need to address top of the grid (MI/Aggressive) -- potential ways to address
    - Potential GPS device
    - Increase programming and staffing
- Emergency room – response to be more integrated
- More unrestricted dollars to allow us to be fluid in determining services

Group 5 – 2nd Table Top Exercise:

- Integrated
- Immediate access to psychiatric care
- Psychiatric beds (metro area)
- Specialized residential
    - longer length of stay
    - higher staffing
- Assisted living model – bed capacity/finance issues
- Manage transition into communities
- Staffing – (Advanced Practice)
- Could staffing be adjusted to deal with aggressive?

Group 6 – 1st Table Top Exercise:

- Person centered
- Needs
    - Appropriate level of care – right time, right treatment, right place
    - Rapid access in time of need
    - Quality diagnosis and assessment
    - Follow protocols and evidence base
    - Individual choice of provider

    - Financial/means to pay for service
    - Need a "Buck Stops Here"
- Possible Gaps
    - Lack of health care integration
    - Do health care providers look at complex individuals differently?
    - Lack of one-stop
    - Mental health – triage/assessment – one place
    - Set up discharge/follow up earlier to assure access
    - Discharge plan in "real" world vs. "ideal" world
    - Someone to follow up around medications – 30 day script
- State/community contracts around discharge needs (like psychiatric and medication management)
- Lack of clarity in provider community – who does what
- Care coordination for individuals
- Clearly define or develop health care home
- Make sure plan happens
- Peer advocacy

Group 6 – 2nd Table Top Exercise:

- Mental health services in jails
- Psychiatric consultation from state to:
    - Community mental health
    - Primary care
- State leadership in technology enhancement beyond electronic medical record
- Enhanced IRTS – uniquely SOS or more of a payment issue?
- Use some of the CBHH buildings for housing?
    - Longer term, less acute?
    - Flexible use of beds with menu of services
- Multi-use/multi-purpose beds at AMRTC
- How to move SOS culture to recovery facilitation
- Training and job expectations

Group 7 – 1st Table Top Exercise

- Better hospital discharge planning
- Collaboration between inpatient and outpatient psychiatry
- Service definition limits support (ARMMS)
- Lack of integration between community and inpatient
- End of GAMC
- Lack of housing
- CPT Code 90882 – community intervention

Group 7 – 2nd Table Top Exercise

- Extensions to 45 day hospital beds – person centered!
- Extension to 90 day IRTS
- Expanded supported housing options
- Full array – foster care/CADI/scattered site/assisted living
- Figure out community-based Jarvis
- Tort reform

Wrap Up:
Dr. Sulik shared that he would process and synthesize the comments received from this series of meeting and get them back to all participants. He noted that he has been ruminating about the "number" of providers (i.e., 140 hospitals, 850 mental health providers, 87 counties, 785 primary care providers, 300 chemical dependency treatment providers, unknown number of community correctional facilities, and 15 Minnesota-based payers – noted that these are very do-able numbers for connecting everyone through technology.

He closed by sharing that he is relationship based, collaborative and servant leadership and they should leave with the expectation that he will continue to bring them to the table for these discussions.

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CREST/Safety Net Redesign Meeting
Wednesday, October 14, 2009

Rochester Public Utilities Building
4000 E. River Road, Rochester, MN

Group #1:

Question #1: What needs to be different in our region?
- Access to outpatient psychiatry throughout the region isn't equitable
- Regional access to specialized treatment and residential options which are linked (example: DD model, TBI residential)
- Creative development of customized services which flex to needs and functioning of the person in their community

Question #2: How can State enhance and support efforts in the region?
- Rates frozen (IRTS), ARMHS, FFS)
- Partnering with private provider
- Higher flexibility on what services are offered
- Access new dollars and partners (housing)
- Look at how commitment processes help/hinder re-integration back into the community (Paradox: higher commitment/lower inpatient vacancies

Group #2:

Question #1: What needs to be different in our current system of care?
- More creative way to meet needs of clients with borderline personality disorder. IRTS/hospitals cannot meet needs.
- More creative ways to meet needs of dual diagnosis (DD/TBI/CD) clients
- Integrate MI/CD treatment for CBHHs or RTCs.
- Create health care coverage/reduce cost of medications
- Geographical location of intensive care.
- Improved admission process of voluntary clients – SOS
- Neuroleptic medication administration without commitment
- Regulations inhibit creative care
- Short term hospitalizations – no long term hospitalization options
- More psychiatrists or improved access

Question #2: What can the State do?
- Technology to access specialized services (psychiatry, etc.)
- More affordable housing options for this population
- Specialized consultation on community intervention planning
- Eliminate centralized admissions
- Incorporate CD into all levels of care
- Funding follows client/not vice versa

Group #3:

Question #1: What needs to be different?

- Civil commitments – faster access to SOS decision on/access to placement
- Higher efficiency with medical clearance process
- Better access to technology – virtual presence – civil commitment
- Higher consistency with Central Admissions (rules changeable, response unpredictable)
- What's possible with confinements as we pay attention to individual's rights
- Modify Central Pre-Admission Process – local, regional

Question #2: What can DHS/SOS/CH/MH do?

- Develop/improve ongoing relationships with hospitals, law enforcement, other local
- Involve Health Plans in transformation
- As specialized residential treatment added to continuum, consider patient transition from placement to placement
- Focus on jail discharges – Corrections
- Leadership with standardized measurement of behavioral health services
- Leadership with technology for psychiatric shortages
- Streamline commitment revocation process
- Review licensing requirements for Minnesota – LADC/CD Courts
- Collaboration on discharge plan that overrides/survives utilization review
- Needed training done prior to implementation of transformation
- Need placements for higher aggressive/lower acuity to avoid jail

Group #4:

Question #1: What needs to be different?

- Mandate for medical clearance prior to admit to CBHH. Expedite medical clearance. Use urgent care/community clinics.
- Capacity for psychiatric care -- over site with ITV, other avenues
- Access to funding – waiver, CADI – more quickly
- Limited facilities – handicapped accessible adaptability – licensure/specialized needs
- Mental health in correctional system – medications/treatment while in jail
- Adolescent facilities – no step down – not appropriate for inpatient anymore

Question #2: What can State do to enhance support?

- Behaviors need to follow principles – <u>fund</u> the <u>programs</u> – GAMC, CADI
- State needs to lead integrated health care coverage!!! Support innovative Medicaid waivers – fill the gaps!
- Accept patients in the <u>community</u> hospitals
- Work with communities on outcomes, best practices, <u>comprehensive</u> plan – recovery, strengths, optimal outcomes
- Aging population – requiring nursing home placement with psychiatric history
- Secure inpatient (violent) psychiatric – rapid access to outpatient payer/after care regionally. (DBT, psych appointments, counseling, case management. IT <u>technology</u> needs to be web based.
- Develop appropriate levels of care with immediate <u>access</u> – gaps in service
- Support for <u>housing</u> (vouchers, food), medication monitoring

- Education/training for staff (new hires) at IRTS, adult foster care; i.e., core training protocol avoids staff turnover
- ECF – technological protocol based on diagnoses – treatment protocol pulled out by computer – reduces return to ECF by 50%!!! Could drive minimal standards for psychiatric care with better outcomes!
- Electronic technology in community to correlate with hospital record.
- Work with health plans to pick up MMHAG (Minnesota Mental Health Action Group) recommended benefit set for employer coverage (including IRTS, ARMHS, etc.

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ITV: Minnesota Psychiatric Roundtable
October 19, 2009 (6 – 8 p.m.)
Room 2360, Elmer L. Andersen Building
St. Paul, MN

1. **Single Mental Health Authority and Single Funding Stream**:

   Oversight and accountability of the public mental health system is essential to managing the scarce resources. Funding silos must be taken down for a single funding mechanism to emerge that could address the individual's behavioral health needs. These recommendations would include development of public mental health algorithms and processes to assure data based decision making in utilizing resources.

2. **Collaboration and Integration**:

   Providers of the public mental health system must collaborate and integrate to adequately serve the people using the system. This will ensure the delivery of services in the right place, at the right time and in the right amount. DHS should begin the conversation with expectations of coordination of services.

3. **Specialty Care and Gap Filling**:

   SOS role and responsibilities in the public mental health system is to provide specialized services. It should also identify and fill gaps in the comprehensive, integrated, continuous system of care either through development of needed programs and services or through partnerships with other providers of the public mental health system.

4. **Technical Assistance Center**:

   A need for a DHS sponsored technical assistance center that would advise and support the implementation of the SAMHSA six best practices. The center would provide fidelity and outcome monitoring.

5. **Psychiatric Emergency Services Support**:

   DHS and SOS should provide support to the current emergency services in the public mental health system. Development of psychiatric observation (23' 59") beds, behavioral crisis beds and MI/CD detoxification beds would give emergency services viable triage options. Central Preadmission could coordinate triage and diversion to said beds.

6. **Telemedicine and Consultation/Liaison:**

   DHS should assure a mechanism to provide psychiatric consultation to primary care providers through ITV.
   - Elevate the health care aspect of mental health treatment by enhancing the role of Psychiatry and displace the care giver leadership traditionally provided by social work
   - Make psychiatry available to all levels of care in the public mental health system
   - Connect public psychiatry to the university system to improve status attract practitioner

- Expand the use of technology and find ways to reimburse for its use in consultation
- State role includes those with dangerous behaviors
- Ensure transparency of the cost of the Minnesota mental health system, including SOS
- State should take the lead on establishing the “trauma” levels for inpatient care hospitals
- IRT-like care with psychiatric monitoring is a need

Appendix

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County Representatives Stakeholder Group – E-mail Feedback[i]
John Dinsmore, Director, Otter Tail County Human Services
10/06/09

Dr. Sulik, Dr. Edwall, Sharon, Carol, Mike, Doug and Rod:

Greetings from Otter Tail County Human Services! I am writing in regard to the above referenced meeting and your RSVP invitation forwarded to MACSSA members last Thursday morning, October 1st. I did respond to Shelagh Larkin indicating that I would not be able to attend. I am greatly appreciative of your invitation, however, and of your efforts to seek input "to help [DHS] obtain critical community and stakeholder input." I am encouraged by your efforts to utilize ". . . consultants to help identify potential future business models and partnerships" with the goal of "development of a service delivery concept that could be characterized as an 'integrated regional specialty healthcare system.' "

Fellow directors from our west central Region IV area do plan to attend, and I relayed this information to them as well. Two caveats are in order: first, responsibility for the content of this "feedback" is mine and mine alone – it does not represent our regional counties or MACSSA, and; secondly, I acknowledge that the enumerated items listed below are by no means an exhaustive list of comments or suggestions. I would appreciate it, however, if you would convey this feedback to your consultant team and utilize as you deem appropriate. So . . . here are some topics for your consideration and deliberation:

(1) Regarding the State's Child Adolescent Behavioral Unit @ Willmar: It has been a very valuable service for our kids in need; however, a recent DHS bulletin (http://www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_146428.pdf) cited it's hold order and emergency admission rate at $1650 per day - a high rate indeed! In our Region IV area the only other inpatient psychiatric hospitals available are Prairie St. John's Psychiatric Services in Fargo, N.D. and the Stadtert Center in Grand Forks, N.D. They provide a needed service - but not at the level of skill and expertise that Willmar offers to our highest risk children who have been unable to be successfully stabilized through Prairie or Stadtert. I ask that you be mindful of how to serve these "high risk" children as you consider an integrated system - and realize that the development of "interstate" agreements for residents in many parts of our state are essential to an integrated system.

(2) The recent per diem rate increase for the 10 CBHH's is at a level that is disconcerting - from $889.00 as of 07/01/07 to $1,411.00 as of 07/01/09. This represents a 58.7% increase in two years and is significantly higher than any reasonable standards used to guide and fund our delivery system, e.g., higher than the Consumer Price Index (CPI), any Cost of Living Adjustment (COLA) formulas most of us utilize and recognize, and considerably higher than any measures of industry-wide health care cost increases with which we're familiar. Can an SOS operated system truly "compete" in the market place if the cost of doing business has increased this dramatically? Can these same services be operated any more efficiently or cost-effectively by private and/or not-for-profit organizations?

(3) Our FF-based Community Addiction Recovery Enterprise (CARE) recently downsized - and again, OTC's concern is ongoing utilization and affordability of their inpatient services (in addition, OTC has an additional financial interest in the success of this FF-based program in light of our financing of the building). In order to help CARE-FF stay viable, I would suggest that SOS and our regional counties may need to sit down together, perhaps review a proposal similar to the attached, and determine how we can tie this in with DHS's stated goal: "development of a service delivery concept that could be characterized as an 'integrated regional specialty healthcare system.' " (Attachment A)

(4) The 17 statewide Adult Mental Health Initiatives (AMHI's) have served as a good model for offering an "integrated system". I would urge DHS to be guided by the AMHI's successes as you/we "roll out" or present ideas about integration. Please consider Attachments B & C as examples of how a previous redesign project was a model of collaboration and inter-governmental cooperation.

(5) To suggest/urge that the Children's Mental Health Division "borrow a page" from the Adult Mental Health Division (see item 4 above) - and adopt the latter's style, methodology and philosophy when it comes to collaborating with counties, local providers and stakeholders. Embracing a collaborative, "they are us" philosophy in coordinating with local stakeholders is crucial to a healthy and mutually respectful relationship. Some have suggested that children's mental health be integrated into the existing Initiative structures that have grown and flourished throughout the state. Although it would necessitate expanding partnerships – especially with schools – it might offer a regional model that could build on the excellent work performed by mental health and family services collaboratives.

I agree that evidence-based practices and services that are "driven" by mental health professional developed diagnostic assessments and treatment plans are the foundation of quality services; however, the "meat on the bones" - the intensive, community based services needed to help families and high-risk children make changes and learn new methods of coping - are delivered and provided by practitioners. Policies, procedures and rules of the children's mental health service delivery system need to recognize and support this fact.

For all units of government - DHS and counties included - the "tension" between fulfilling our oversight and regulatory functions, serving as a provider, and leading as a service/system planner is a constant challenge. Please recognize this and understand that this is an "area that needs improvement" in the relationship between "Greater Minnesota" and the business function of DHS's Chemical and MH Services. We are truly "in this together"!

Thank you for your time and consideration. Here's hoping your Wednesday morning meeting is interactive, constructive and productive!

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Attachment A: Region IV CD Pilot Project
Attachment B: Region IV MH Safety Net Redesign Compact
Attachment C: Logic Model-Indicator Responsibility Chart

[1] This document was part of a 10/06/09 e-mail sent to Minnesota Department of Human Services administrators serving in Chemical and Mental Health Services. The above referenced attachments were also included. E-mail recipients included: Dr. L. Read Sulik, Assistant Commissioner, Dr. Glenace Edwall, Children's Mental Health Division Director; Sharon Autio, Mental Health Division Director; Carol Falkowski, Alcohol and Drug Abuse Division Directors, Mike Tessneer, State Operated Services CEO; Doug Seiler, Special Populations Administrator; and Rod Kornrumpf, CBHH Administrator.

Chemical health care home pilot project
Region IV Application

Becker-Clay-Douglas-Grant-Otter Tail-Pope-
Stevens-Traverse-Wilkin-Wadena

Background:

The Chemical Health Care Home Pilot Project, as passed in the 2009 legislative session, requires MACSSA to select one metro and one non-metro county (or group of counties) to participate in the pilot project. Due to resource limitations at the Department of Human Services, Hennepin and Ramsey counties are NOT eligible to apply. Specific expectations and requirements of the pilot projects will be negotiated between participating counties and the Department of Human Services but must adhere to the general expectations specified in law (See "Requirements" section, below).

Individuals interested in being considered for this opportunity must fill out the enclosed application and return to Kate Lerner via email no later than the end of the day on Monday, July 6. A Review Board comprised of MACSSA's elected officers will review all applications and serve in an advisory capacity to MACSSA's President who, according to MACSSA's Bylaws, is responsible for making the appointments. Elected officers who work in a county applying to participate as one of the CD pilot projects will be replaced on the Review Board by another executive committee member in an effort to avoid a conflict of interest.

Description of Requirements:

Below is a description of the specific requirements for participation in the CD pilot project. Please consider these requirements before submitting your application.

Requirements:

1. Counties selected as a participating pilot project must be willing to work in partnership with the Department of Human Services to redesign the current chemical health service delivery system in a way that promotes greater accountability, productivity, and results in the delivery of state chemical dependency services.
2. The pilot projects must look to provide appropriate flexibility in a way that ensures timely access to needed services as well as better aligning systems and services to offer the most appropriate level of chemical health care services to the client. This may include, but is not limited to, looking into new governance agreements, performance agreements, or service level agreements between the Department of Human Services and participating counties.
3. Pilot projects must maintain eligibility requirements of Minnesota Rules, parts 9530.660 to 9530.665 (i.e. Rule 25), and Minnesota Rules, parts 9530.6405 to 9530.6505 (i.e. Rule 31).
4. Pilot projects must not put at risk current and future federal funding toward chemical health-related services in Minnesota.
5. One or more county representatives from each participating pilot must be available to meet with the Department of Human Services in St. Paul on July 14th, 2009, from 8 – 9am to begin initial negotiations and planning for each pilot project.
6. Participating counties must be prepared to implement the pilot project on July 10, 2010.

Chemical health care home pilot project: county application

Contact Information for Primary Representative

Name: John W. Dinsmore – on behalf of all Region IV Partners

County: Otter Tail County
Title: Human Services Director
Phone Number: 218-998-8172 (direct-dial) or 218-205-5476 (cell phone)
Email: jdinsmor@co.otter-tail.mn.us

County or Group of Counties Applying for Participation: Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse, Wilkin, and Wadena

Other Potential Partners: MN Department of Human Services (DHS); Health Plans (PrimeWest, Blue Plus, Medica, UCare and South Country Alliance); White Earth Reservation; primary care providers and treatment providers

1. **Why is your county or group of counties interested in participating in the CD Pilot Project?**

- Our regional data (see attached) suggest that our publicly funded clients in need of chemical dependency treatment services present a profile of significant relapse risk, significant medical and co-occurring disorders, and could benefit from more extensive case management/care coordination services.

- Towards that end, our Region IV Pilot Project would include the following:

  - Creating a model of Chemical Health care coordination/case management that incorporates the ARMHS (Adult Rehabilitative Mental Health Services) model for mental health, ACT (Assertive Community Team) services and IDDT (Integrated Dual Disorder Treatment) principles, e.g.,
    - ARMHS Model
      - Services that enable recipient to develop and enhance chemical health and psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of their illnesses;
      - Services that enable a recipient to retain stability and functioning if they are at risk of losing significant functionality or being admitted to a more restrictive service setting without these services; and
      - Instruct, assist, and support a recipients in areas such as medication education, monitoring, basic living & social skills, symptom management, household management, employment-related, or transitioning to community living.
    - ACT Team Model
      - Multi-disciplinary Team
      - Shared/small caseloads
      - Fixed point of responsibility
      - "In vivo" services & time unlimited services
      - Flexible service delivery
      - 24/7 crisis services
    - IDDT – Six Guiding Principles
      - Employ a recovery perspective
      - Adopt a multi-problem viewpoint
      - Develop a phased approach to treatment
      - Address specific real-life problems early in treatment
      - Plan for the client's cognitive and functional impairments
      - Use Support systems to maintain and extend treatment effectiveness

- Create and implement a "harm reduction" program model that combines behavior management, employment and housing services. Program principles include:
  - Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users "where they're at," addressing conditions of use along with the use itself.
  - Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
  - Establishes quality of individual and community life and well-being--not necessarily cessation of all drug use--as the criteria for successful interventions and policies.
- Regional and program utilization of the Six Dimensions assessment paradigm and LOCUS (Levels of Care Utilization System) as a outcome measurement tool for purposes of standardizing an assessment methodology across all counties/programs
  - Fifty to seventy-five percent of clients present some type of co-occurring mental disorder" (TIP 42-SAMHSA). Use of the LOCUS in conjunction with the Six Dimensions will serve as a standard assessment approach
- Centralizing our contract mgmt functions across all chemical dependency programs within our region that will incorporate the following 13 principles established by the National Institute on Drug Abuse's "Principles of Effective Treatment" as referenced in the Office of Legislative Auditor's 2006 report:
  1. No single treatment is appropriate for all individuals.
  2. Treatment needs to be readily available.
  3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
  4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the persons' changing needs.
  5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
  6. Counseling and other behavioral therapies are critical components of effective treatment for addiction.
  7. Medications are an important element of treatment for man patients, especially when combined with counseling and other behavioral therapies.
  8. Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way.
  9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
  10. Treatment does not need to be voluntary to be effective.
  11. Possible drug use during treatment must be monitored continuously.
  12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients change behaviors that place themselves or others at risk of infection.
  13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.
- Productivity and service level agreements among participating counties to conduct Rule 25 assessments for one another
- Streamlining the health care application process to ensure participants are receiving healthcare coverage

- See attached page seven - "Region IV Chemical Dependency Provider Performance Measures – Client Profile Info 2007" - for a summary overview of our region's services and recipients served

2. What work has been completed in your county or group of counties to date that prepares you for participation in the pilot project?

- We have a long history of working collaboratively in developing a variety of regionally based services: Community and Behavioral Healthcare Hospitals (CBHH); Community Addiction Recovery Enterprise (CARE) program, detoxification services, our adult mental health initiatives, regionally developed employment services via Rural Minnesota CEP and Productive Alternatives, community mental health

center services (LMHC) and crisis services; and joint development of Minnesota Senior Health Options (MSHO) with our health plan partners;

- The southern part of our region (Douglas, Grant, Pope, Stevens, and Traverse counties) are members of PrimeWest Health who have worked closely with PrimeWest in delivering a comprehensive County Based Purchasing Healthcare system.
- The northern part of our region (Becker, Clay, Otter Tail and Wilkin counties) have an established history of working collaboratively with our PMAP healthcare providers.

3. **How does your county or group of counties intend to incorporate each of the expectations listed into the design of your pilot project?**

<u>Expectation #1:</u> Counties selected as a participating pilot project must be willing to work in partnership with the Department of Human Services to redesign the current chemical health service delivery system in a way that promotes greater accountability, productivity, and results in the delivery of state chemical dependency services.

- Accountability:
  - Standardizing provider contracts that create greater consistency in our rate structure and utilization of provider standards as measured by the six dimensions assessment tool
  - Standardized provider contracts as it relates to expectations in the treatment delivery that includes the implementation of research based/evidenced based treatment and coordination with community resources and providers.
  - Establishing partnerships with providers in the assessment and development of a local continuum of care as it relates to chemical dependency? (probably pretty big picture? Is there a benefit as it relates to having a Steering Committee similar to what we have done with BCOW as well as biannual needs assessment? I am thinking that some Counties & providers may have concern with the level of time/commitment needed for this).
- Productivity:
  - Shared responsibility to conduct/complete chemical use "Rule 25" assessments
  - Many have experienced success with our DWI or other specialty drug courts, including a strong team approach. Building on these successes, develop an "ACT like model"- in which billing/funding sources could be CCDTF for the treatment portion, and MH-TCM, VA/DD TCM, or SNBC if eligible.
- Results:
  - Use of evidence-based practices, specifically:
    - Behavior management strategies (for example, teaching clients ways to exercise self-control, change their thinking patterns, or achieve specific goals);
    - The "community reinforcement" approach (for example, creating incentives for clients to reduce their drinking, or working with friends or relatives on ways to support the clients' sobriety);
    - Strategies to help improve clients' personal relationships, such as social skills training and certain types of marital therapy.
    - Create and implement "harm reduction" program models that combine behavior management, employment and housing services
  - Consistent use of the six dimensions/LOCUS assessment philosophy in assessment and measuring outcomes

<u>Expectation #2:</u> The pilot projects must look to provide appropriate flexibility in a way that ensures timely access to needed services as well as better aligning systems and services to offer the most appropriate level of chemical health care services to the client. This may include, but is not limited to, looking into new governance agreements, performance agreements, or service level agreements between the Department of Human Services and participating counties.

- *Similar to the work Region IV and DHS had completed in the development of the agreement known as the "Northwest Minnesota Safety Net Redesign Results Initiative Compact Region IV", we are prepared to create a similar document that will address governance, performance and service level agreements. The Chemical Dependency Pilot Project Region IV Compact will include the following components:*

- Purpose
- Background
- Project Description
- Overall Client Goal
- Expected Client Outcomes and the Measures
- Indicators that will be Utilized to Measure Success at Achieving Client Outcomes
- Terms of the Compact
- Amendments, Revisions or Clarifications
- Roles and Responsibilities of Each Partner
  - Joint Responsibilities
  - Provider Responsibilities
  - County Responsibilities
  - Health Plan Responsibilities
  - Department of Human Services Responsibilities
- Signature page

<u>Expectation #3:</u> Pilot projects must maintain eligibility requirements of Minnesota Rules, parts 9530.6600 to 9530.6655 (i.e. Rule 25), and Minnesota Rules, parts 9530.6405 to 9530.6505 (i.e. Rule 31).

- Minnesota Administrative Rules, Chapter 9530, pertain to Chemical Dependency Programs. Sections include:
  - 9530.6405 to 9530.6505: Chemical Dependency Licensed Treatment Facilities
  - 9530.6510 to 9530.6590: Detoxification Programs
  - 9530.6600 to 9530.6660: Chemical Dependency Care for Public Assistance Recipients
  - 9530.6800 to 9530.7031: Consolidated Chemical Dependency Treatment Fund
- All county partners and members of our provider are familiar with the Minnesota State Rules that pertain to chemical dependency treatment services. We are especially mindful of the placement criteria (9530.6622) and the importance of the risk description and the treatment planning decision criteria across all six dimensions under evaluation.

<u>Expectation #4:</u> Pilot projects must not put at risk current and future federal funding toward chemical health-related services in Minnesota.

- All financial resources allocated for chemical abusing or dependent individuals under Minnesota Statutes, chapters 246, 254B, 256B, and 256D, shall be expended in accordance with parts 9530.6600 to 9530.6655.
- We are conscientious of the fact that in the State's current block grant, approximately $22,000,000 in FFY 2008 was made available to Minnesota from the federal government for alcohol and other drug prevention and treatment. This represents about 20% of the total federal, state and local funds available for prevention, treatment, and support services.
- In SFY 2008, CCDTF expenditures had been projected to total $120.8 million for 32,000 entitled recipients. A portion of the federal block grant, $9 million, is allocated to the CCDTF. Another 15% of the cost is paid by county agencies.
- The department applies the allocation formula in Minnesota Statutes, section 254B.02, subdivision 1 to the annual legislative appropriation of state dollars for chemical dependency services. 2010 Tier I amount for allocation is projected to be $99,851,000 in SFY 2009 and $107,681,000 for SFY 2010
- In our Region, CCDTF cost allocations are as follows:

ounty	Total Allocation		Admin Allowance		Treatment Funds		County MOE	
	$ FY2009	$ FY2010	FY2009	FY2010	$ FY2009	$ FY2010	$ FY2009	$ FY2010
ecker	$ 596,975	$ 684,446	18,844	21,392	$ 578,131	$ 663,055	$ 203,569	$ 233,396
lay	$ 1,008,705	$ 1,124,984	30,836	34,223	$ 977,869	$ 1,090,761	$ 571,936	$ 637,866
ouglas	$ 681,542	$ 728,695	21,307	22,680	$ 660,235	$ 706,015	$ 170,294	$ 182,076
rant	$ 145,245	$ 167,703	5,687	6,341	$ 139,559	$ 161,363	$ 13,147	$ 15,180
tter Tail	$ 1,139,906	$ 1,320,213	34,657	39,909	$ 1,105,248	$ 1,280,304	$ 334,726	$ 387,672
	$	$			$	$	$	$

ope	245,864	261,038	8,617	9,059	237,247	251,979	113,926	120,957
tevens	$ 179,379	$ 193,639	6,681	7,096	$ 172,698	$ 186,543	$ 23,656	$ 25,537
raverse	$ 121,171	$ 106,700	4,986	4,564	$ 116,185	$ 102,135	$ 17,219	$ 15,162
ilkin	$ 173,695	$ 206,353	6,515	7,467	$ 167,179	$ 198,887	$ 46,276	$ 54,977
adena	$ 405,311	$ 420,627	13,261	13,708	$ 392,049	$ 406,919	$ 20,199	$ 20,962
hite Earth	$ 989,999	$ 1,068,544	30,291	32,579	$ 959,708	$ 1,035,966	I A	I A
OTALS					**$ 5,506,108**	**$ 6,083,927**	**$ 1,514,949**	**$ 1,693,785**

<u>Expectation #5:</u> One or more county representatives from each participating pilot must be available to meet with the Department of Human Services on July 14th, in St. Paul, to begin initial negotiations and planning for each pilot project.

- If selected as a participating pilot project, representatives from each county will arrange to be available for an initial July 14, 2009 planning and negotiation meeting

<u>Expectation #6:</u> Participating counties must be prepared to implement the pilot project on July 10, 2010.

- We anticipate that all governance, performance and service agreements will be finalized and ready to implement effective July 10, 2010.

4. **Other information you wish to convey to the Review Board:** (see attached page 7)

Region IV Chemical Dependency Providers[1,2]
Client Profile Information – 2007

	Demographic Profile of Clients by Program							Barriers to Recovery:[3] Six Dimensions Rating of Clients by Program at Discharge					
		end er male)	ace white)	ge over 35)	rima ry Sub stan ce alcoh ol)	nco me job)	C Stat us comp lete)	I ntox/Wi thdrawal Sympto ms	io-me dic al con diti on	ognit ive-Emot ional (Poor Copin g Skills)	esista nce to chan ge	elap se Pote ntial	ecov ery (unsu pporti ve enviro nment)
tatew ide		**7 %**	**6 %**	**6 %**	**4.4 %**	**7.8 %**	**4%**	**5 .7%**	**.9 %**	**0.4 %**	**0.5 %**	**3%**	**2.7 %**
ARE of FF	63	3%	6%	3%	9.9 %	2.6 %	2.2 %	8 .5%	2.8 %	8.3%	3.7%	5.9 %	0.4%
ake Region HH	7	00	9.5	2.1	4.4	2.8	1.4	1 2.3	5.8	5.6	8.6	9.1	2.5
MHC	8	6.3	7.9	4.2	9.2	7.5	2.9	6 .5	0.9	8.3	3.4	3.2	2.8
akes Couns eling	22	4.8	9.5	6.1	1.5	1.6	3,3	5 .8	1.7	2.1	0.4	5.4	2.9
eighbo rhood (Wade na)	5	1.8	1.8	5.9	5.3	3.5	0	6 .5		8.9	4.1	4.2	3.3
								6					

[1] Of the 318 chemical dependency programs licensed as a Rule 31 chemical dependency treatment program in Minnesota, 12 of these providers are geographically based in our Region IV nine-county area. In addition, there are 34 regional providers not listed above due to insufficient data and they include: Anchorage (Moorhead); Drake Counseling Services & Residential Treatment Center (Detroit Lakes); Hope Unit St. Francis (Breckenridge); New Visions Center (Morris); and Recovery Works Minimum Security Program (Detroit Lakes)

[2] Source document: "Chemical Dependency Provider Performance Measures 2007" Chemical Health Division, MN Department of Human Services published on December 12, 2008. It can be found at the following URL site: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_143800.pdf

[3] The figures show the percentage of patients with "serious problems" in each of the six dimensions at time of discharge. "Serious" are persons who have received a "2" (moderate), "3" (severe) or "4" (extreme) rating on a five point scale.

ew Visions Center (outpat)	9	3.4	3.7	1.6	1.8	3.3	6.8	.6	1.8	2.6	9.7	7.6	7.1
ew Visions (residential)	65	8.2	2.1	7.9	9.7	3	9.7	9.1	6.4	0.9	4.8	2.7	1.8
ecovery Works – BC	1	1	3.3	8.1	8.1	4.3	2.4	0	.5	3.3	1.4	5.7	1
ed River Valley	41	9.3	5.1	3.6	8.5	7.7	5.2	5.1	.3	3.8	8.9	6.1	0.2
ewind	5	00	0	3.3	0	0	6.7	0	.7	3.3	6.7	6.7	6.7
hare House – NYM	0		7.5	5	5	.5%	2.5	5	7.5	7.5	0	5	5
hare House Wellness – Mhd	4	5.9	6.8	1.8	9	6.8	0	0	.8	7	4.1	5.3	5.6
hite Earth CD-Outpatient	4	0.2	.2	0.9	1.1	2.3	5.3	1 0.6	2	4.5	7.2	6.7	8

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NORTHWEST MINNESOTA SAFETY NET REDESIGN

RESULTS INITIATIVE COMPACT

REGION IV

Purpose

The purpose of this compact is to facilitate an agreement between the Department of Human Services and the counties of Region IV (Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse & Wilkin) to redesign and implement an outcomes-oriented approach to the services provided to individuals with serious mental illness and serious and persistent mental illness. This special partnership and commitment will provide a demonstration of principles and practice that may serve as a model for statewide changes in the way mental health services are delivered.

Background

The Minnesota Results Initiative is an effort to improve results for human services clients. It brings together partners in the delivery of those services to clarify outcomes in order to increase accountability first to clients, then to each other, and ultimately to the people of Minnesota.

Project Description

- The Department of Human Services and the counties of Region IV share a common goal in serving individuals with mental illness in the most clinically appropriate, person-centered, and cost-effective way possible. This project will redesign the community mental health and State Operated Services network to expand treatment options for people with mental illness, through new partnerships between DHS, counties, and local health and mental health providers. This partnership is comprised of Region IV counties and the Minnesota Department of Human Services. The focus is on improved outcomes for individuals as a result of increased collaboration between community treatment and State Operated Services programs.

Overall Client Goal

- Individuals experiencing serious mental illness and /or serious and persistent mental illness will receive the right amount of services at the right time and in the most appropriate setting, as close to home as possible balancing personal choice and responsibility.

Expected Client Outcomes and Their Measures

1. Patients are discharged from the hospital when recommended by consensus of the treatment team.
- 75% of patients will be discharged within five days of recommendation.

2. Individuals on 72-hour hold orders will be appropriately discharged from in-patient hospitalization to community services.
- The regional percentage of individuals discharged to the community from 72-hour holds will increase 5% by 12-31-03.
3. More patients will be able to successfully stabilize in community-based inpatient settings.
- Increase the number of regionally based 45 day contract inpatient beds developed to serve clients in need. Goal: Increase from 0 beds to 5 beds by 12-31-03.

4. Consumers will be satisfied with the mental health services they receive.
- 80% of respondents receiving mental health services who complete the satisfaction survey will be satisfied with the services they utilize by 6-30-03.

5. Individuals will access community-based services in lieu of being placed on a hold order.
- There will be a 5% regional reduction in the number of individuals put on a hold order by 12-30-03. Of those individuals referred to pre-petition screening, 10% more will be served through community-based alternative services rather than through inpatient commitment.

6. Individuals receiving services will maintain or improve their individual level of functioning based on individual goals.
- 100% of individuals receiving services will maintain or improve their individual level of functioning based on individual goals.

7. Individuals will not be readmitted to a Regional Treatment Center within 30 days of an inpatient discharge.
- There will be a 50% reduction in the number of individuals readmitted to a Regional Treatment Center within 30 days of an inpatient discharge.

Indicators that will be utilized to measure success at achieving client outcomes

A variety of strategies will be utilized to meet the seven client outcomes identified for this initiative. Attachment A identifies the client outcomes and the indicators that will be employed to measure success towards meeting the identified targets and dates.

Terms of the Compact

This compact will be effective on the date the final signature is obtained from the authorized county representative pursuant to initial authorization by the Commissioner (or designee) of the Minnesota Department of Human Services. The conditions and commitments of each party to this compact will apply until such a time that one or more parties wishes to withdraw from this compact, and provides 90 day written notice to the remaining parties. At such a time, the parties agree to meet to review the conditions and commitments of this compact and to consider revisions as may be agreed upon by the parties.

Amendments, Revisions or Clarifications

The Compact shall be reviewed annually by the parties, and may be amended to reflect mutually agreed upon changes. Amendments are to be agreed upon in writing by the designated representatives of each party.

Roles and Responsibilities of Each Partner

Counties from Region IV and the Department of Human Services both have a number of responsibilities with respect to meeting the client outcomes as identified in the project description above. The following are the key responsibilities of each partner.

Joint Responsibilities

- Region IV Safety Net Redesign Council – This council shall consist of the nine county Social Service Directors of Region IV, and designated representatives of the Minnesota Department of Human Services. The Department of Human Services representatives will be from State Operated Services and the Division of Mental Health.

- The Council is established to ensure Compact implementation, monitoring and compliance. The Council shall review and approve any Compact amendments.

- The Council shall communicate activities surrounding the Compact to DHS, Region IV Counties, SOS Governing Board, Region IV Adult Mental Health Initiatives and Local Advisory Council's.

- The State Operated Services Program will engage in collaborative decision making with community partners to determine when in-patient psychiatric care at FFRTC shall be utilized to meet client needs.

- The Department of Human Services and the county partners agree to meet at least quarterly to review their progress in implementing services and activities and to support each other in the attainment of outcome targets.

County Responsibilities

- The counties of the Region IV Northwest Minnesota Safety Net Redesign agree to implement services and activities that correspond with the seven client outcomes identified in this agreement and detailed in the Attachment A.

- The counties agree to collect and report data (indicators) as necessary to determine the success of meeting the outcome targets outlined in Attachment A

- The counties agree to work with the Department to develop, implement and administer a consumer satisfaction survey as identified in Attachment A.

- The counties agree to work with the Department in identifying and implementing a standardized assessment tool to determine success in meeting the outcome target for Client Outcome #6 regarding levels of functioning based on individualized client goals as identified in Attachment A.

Department of Human Services Responsibilities

- The Department agrees to meet with the counties as needed, but at least quarterly, to provide technical assistance and support to the initiative.

- The Department agrees to consider waiving state administrative rules and regulations that interfere with the implementation of this compact as identified and determined by the Region IV Safety Net Redesign Council

- The Department agrees to develop non-IMD community based multiple site in-patient psychiatric and integrated community based mental health services supported by SOS staff and/or via 45 day contract bed services. These services will be located in the Region IV catchment area. Regionally based inpatient and community based psychiatric services for

the seriously mentally ill and seriously and persistent mentally ill will be sufficiently funded using state appropriated resources to adequately meet the needs of Region IV clients served by this system.

- The Department agrees to provide a minimum of 50 inpatient beds for chemical dependency services based in the Fergus Falls, MN area.

- The Department agrees to redirect staff resources to the Region IV Northwest Minnesota Safety Net Redesign if the partners mutually agree that the patient census justifies reassignment/redirection of State Operated Services Resources.

- The Department, through its representatives at the FFRTC, SOS and the Mental Health Division, agrees to provide data (indicators) as necessary, to determine the success of meeting the outcome targets outlined in Attachment A.

- The Department will assist the counties in identifying a consumer satisfaction survey consistent with Client Outcome # 4 as identified in Attachment A.

- The Department agrees to work with the counties in identifying and implementing a standardized assessment tool to determine success in meeting Client Outcome #6 regarding level of functioning based on individualized client goals.

THE PARTIES ACCEPT THE UNDERSTANDINGS AND COMMITMENTS CONTAINED IN THIS COMPACT.

_____

Commissioner, Minnesota Department of Human Services Date

_____

Authorized Representative, Becker County Social Services Date

_____

Authorized Representative, Clay County Social Services Date

_____

Authorized Representative, Douglas County Social Services Date

_____

Authorized Representative, Grant County Social Services Date

_____

Authorized Representative, Otter Tail County Social Services Date

_____

Authorized Representative, Pope County Social Services Date

_____

Authorized Representative, Stevens County Social Services Date

_____

Authorized Representative, Traverse County Social Services Date

_____

Authorized Representative, Wilkin County Social Services Date

Attachment

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Attachment C
Northwest Minnesota Safety Net Redesign – Region IV
Indicator Accountability Chart

Client Outcome	**Indicator**	**Outcome Target**	**Decisions/ Action Steps**	Target Date
#1 Patients are discharged from the hospital when recommended by consensus of the treatment team.	Number of days past the date the patient is recommended for discharge by consensus of the treatment team.	75% of patients will be discharged within five days of recommendation.	SOS and DHS's Mental Health Division will collate and distribute data on a monthly basis	12-31-02
#2 Individuals on 72 hour hold orders will be appropriately discharged to community services.	Number of individuals on 72-hour holds appropriately discharged to community services.	The regional percentage of individuals discharged to the community from 72-hour holds will increase by 5% by 12-31-03.	SOS and DHS's Mental Health Division will collate and distribute data on a monthly basis	12-31-03
#3 More patients will be able to successfully stabilize in community-based inpatient settings.	Number of persons in Region IV transferred from a community-based inpatient setting to a RTC.	Increase from 0 to 5 the number of regionally based 45 day contract inpatient beds developed to serve clients in need.	Region IV Safety Net Redesign council will meet with Region IV inpatient providers to encourage 45 day contract inpatient bed development.	12-31-03
#4 Consumers will be satisfied with the mental health services they receive.	Consumer satisfaction surveys will indicate satisfaction with the mental	80% of respondent's receiving Mental Health services who	The Safety Net Redesign will choose and implement a method of determining	6-30-03

Attachment C
Northwest Minnesota Safety Net Redesign – Region IV
Indicator Accountability Chart

Client Outcome	Indicator	Outcome Target	Decisions/ Action Steps	Target Date
	health services they receive.	complete the satisfaction survey will be satisfied with the services they utilize.	consumer satisfaction by 12/31/02.	
#5 Individuals will access community-based services in lieu of being placed on a hold order.	Number of individuals placed on a hold order. Number of individuals referred to pre-petition screening that are served through community alternatives rather then more restrictive services	**There will be A 5% regional reduction in the number of individuals put on a hold order. .** 10% more of those individuals referred to pre-petition screening will be served through community alternatives rather then through inpatient commitment.	Counties will establish baseline data. Counties will report the # of CY2001 and 02 and 2003 pre-petition and petitions initiated and deferred.	12-31-02 12-31-03
#6 Individuals receiving services will maintain or improve their individual level of functioning based on individual goals.	Number of individuals receiving services level of functioning based on individual goals	**100% of individuals receiving services will maintain or improve their individual level of functioning based on individual goals.**	A uniform assessment tool will be developed and implemented Data will be reviewed.	6-30-03 12-31-03

Attachment C
Northwest Minnesota Safety Net Redesign – Region IV
Indicator Accountability Chart

Client Outcome	**Indicator**	**Outcome Target**	**Decisions/ Action Steps**	Target Date
#7 Individuals will not be readmitted to a RTC within 30 days of an inpatient discharge.	Number of individuals readmitted to an RTC within 30 days of and inpatient discharge.	Number of individuals readmitted to an RTC within 30 days of an inpatient discharge will be reduced 50%	Baseline = For data collected from January 1, 2001 to June 30, 2002 for Region IV is 50 Target = 25	12-31-03

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Seven Goals for Achieving Excellence

1. We must **eradicate the stigma**, misunderstandings and misperceptions of mental illness and addictions.

2. We must **improve access to the right care at the right time** for all Minnesotans suffering from a mental illness and/or addictions.

3. We must **establish best practices and quality standards of care** and practice across all providers.

4. We must **break down the silo walls** and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment.

5. We must **reduce the overall cost of care for mental illness and addictions** as well as work to reduce the full cost of untreated mental illness and addictions. I believe we can accomplish this if we have successfully strived to eradicate stigma, improve access to the right care at the right time, improved quality standards of care. And integrate care effectively across services.

6. We must promote and expand those activities that improve wellness and ultimately can **prevent mental illness and addictions**.

7. We must **reduce the severe wide-ranging consequences** of mental illness and addictions.

November 19, 2009
4 PM to 5:30 PM
Room 2223, Andersen Building

Present:
Mike Tessneer, Shirley Jacobson, Charlie Cook, Sharon Autio, Bill Wyss, Gene Anderson, Larry Burzinski, Alan Radke, Bill Conley, Pat Siebert, Sue Abderholden, Ron Brand, Ed Eide, Mary Regan, Maureen Marrin

Convened at 4:06 PM.

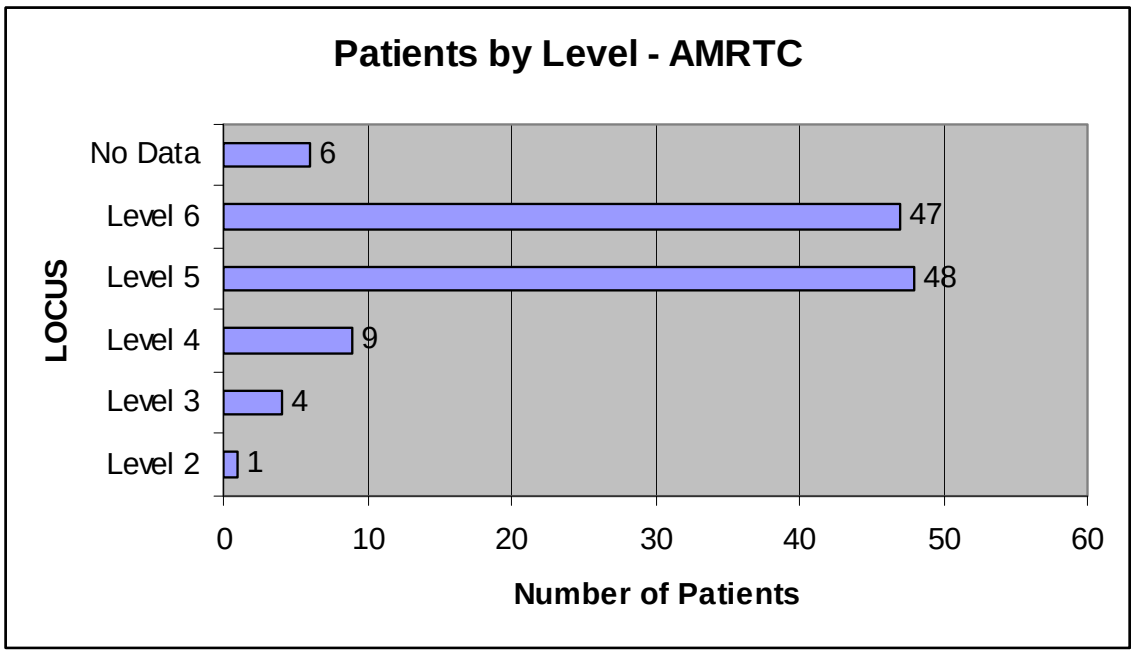
1. Agenda (Charlie Cook) – Purpose of the meeting is to continue discussions on the SOS redesign.
2. Utilization Data for SOS Adult Mental Health (Alan Radke) –

   Diagnosis Summary for SOS Adult Mental Health Programs

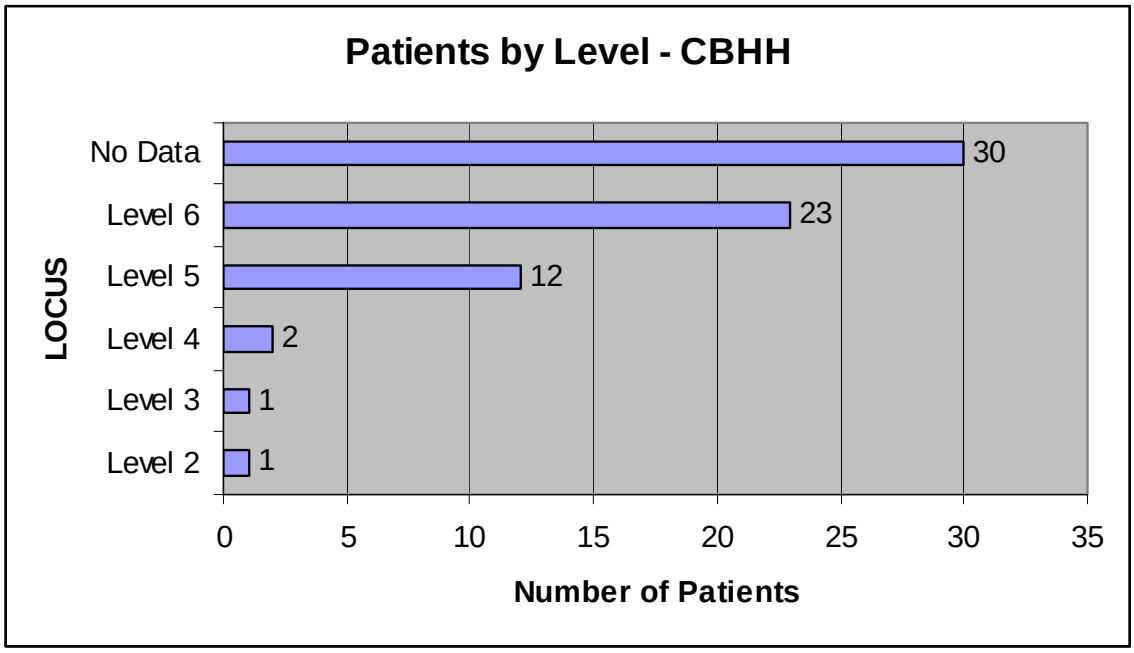
   - Psychotic Disorder – 63 to 75% (70%)
   - Bipolar Disorder – 16 to 33% (25%)
   - Major Depressive Disorder – 14 to 21% (18%)
   - Substance Use Disorder – 40 to 75% (60%)
   - Personality Disorder – 19 to 37% (30%)

   30 individuals within State Operated Services Adult Mental Health Programs no longer meet the criteria for a continued stay in a hospital setting.

   The chart below represents a data run on 11/11/2009 and represents the LOCUS score of the population receiving services at AMRTC on that day.



The following chart represents data run on 11/13/2009 and represents the LOCUS Score of the population receiving services at CBHHs on that day.



Alan also presented information on the current AMRTC wait list. Alan reviews the wait list twice a day. Alan is most concerned about individuals who have been on the wait list over 6 weeks. Presently, there is only 1 person is in this category right now.

3. Denials and Diversions (Alan Radke) – Less than 3% of individuals are denied admission. Most of the denial is due to detox and crisis services needs. Fifteen percent are diversions. Diversions also occur do to physical health care needs that cannot be met within the CBHH. Average of 2,500 calls per month to the Centralized Pre-admission.

    - Those with extremely aggressive behaviors are not accepted into the CBHHs. Some individuals are in a jail at a time of referral. These individuals receive consultation within the jail by SOS staff or are served at Anoka.
    - Question: Of the current case load, how many are in the four categories? Are you currently serving that population or are they underserved now? When you look at people with SMI and violence, those individuals are few, but very high profile and are difficult to serve. Community hospitals are used to stabilize persons with SMI and co-occurring medical problems including and cognitive disorders before the person comes to State Operated Services. SOS collaborates with community providers to locate the best services for persons with TBI but no psychiatric disorders.

4. Budget Pressures (Shirley Jacobson) – Shirley walked through the budget pressures for SOS. (See Attachment A)

- Federal Stabilization money – assigned to SOS by the Legislature. Due to barriers, money could not be used for certain expenses and therefore the funding was spread across a number of programs.
- Mike Tessneer presented the worst case & best case scenario based on the budget pressures faced by State Operated Services. The amount of budget pressures faced by SOS would result in the loss of 250 to 170 FTE's based on the timing of the restructuring.

5. Mental Health Acute Care Needs Report – 2009 Legislative Report (Sharon Autio) – Sharon distributed copies of the report and suggested that the elements of the report be considered in the SOS redesign. (See Attachment B).
6. Mental Health Grant applications (Dave Schultz) – Dave presented information on unmet mental health needs data gathered from each region of the state from the mental health grant applications. (See attachment c)
7. AMHI Meeting Schedule (Dave Schultz) – Dave presented a calendar for December, January, and February meetings.
8. Open Forum (Charlie Cook) –
    - Is discussion limited to adults versus children? Yes, children and adolescents will be addressed separately.
    - Consultant group could lead meetings with the regions and remove the state from the process.
    - Maureen is working with SOS to gather consumer input. The plan is hold 10 meetings in east and west metro with 5 to 8 consumers in December and the rest of Minnesota throughout January and February.
    - The group felt that discussions would benefit from having individuals who are not affiliated with the state leading the discussions on the new design.
    - Are we talking about a listening process or a design process?
    - Out of regional meetings, partnership discussions will begin.
    - Should we focus on using the unmet need report as a starting point?
    - What does the local region think SOS should change its resources (CBHH) to?
    - Questions have to be specific.
    - Audience agendas – What is DHS doing with policy or funding? What is SOS doing with regard to the redesign?
    - What are the needs of the individuals served by SOS?
    - There is a trust issue between SOS and the community.
    - What ever short term fixes we do now have to meet the future.
    - What can we do together to improve the lives of the persons served.
    - How is the question framed?
    - Common elements:
        i. Funding issues for SOS
        ii. Larger policy issues around funding streams
        iii. Trust
        iv. What do you want to change to?
        v. How would you direct the redesign to the system?
        vi. Help us design the best thing possible as funding to the system gets cut?

- Notify regional planning groups of the importance of the issue at hand and that the reason this is occurring is due to the budget pressures. The purpose is to address the budget deficit and therefore a quick turn around is needed.

9. What would the advocacy group see as a helpful end product to these regional planning meetings? Send these to Sharon.
10. Adjorned at: 5:45 PM

Forward notes out for review. Fashion a question or two that could go out as well as an information packet including data. Facilitated discussions should not be lead by individuals who represent the state. Need to be honest with the participants.

DHS – CMHS - State Operated Services
Legislative Impacts and Projected Pressures

	FY10	FY11	FY10/11	Notes
2009 Legislative Reductions				
AMRTC Restructure	$ -	$ 700,000	$ 700,000	Right-sizing units on campus
General Administrative Reduction	$ 700,000	$ 700,000	$ 1,400,000	Replaces $3.2 million per year original value
General Administrative Reduction Buy-Back	$ (322,700)	$ -	$ (322,700)	IT & Telepresence proposed reductions
SOS Operating Reduction	$ 770,000	$ 770,000	$ 1,540,000	On-Call/Technology reduction
Total Funding Reductions	$ 1,147,300	$ 2,170,000	$ 3,317,300	
Unallottment Adjustment	$ 422,000	$ 4,588,000	$ 5,010,000	Phase II of Adult Mental Health Redesign
Total Reduction - State Bottom Line	$ 1,569,300	$ 6,758,000	$ 8,327,300	
Known Pressures on SOS				
Salary Adjustments - FY2009 COLA	$ 1,300,000	$ 1,300,000	$ 2,600,000	Tails incurred from 2009 salary increases
Salary Adjustments - FY2011 Steps	$ -	$ 1,356,000	$ 1,356,000	Non-funded step increases
Dental Loss	$ 723,000	$ 1,500,000	$ 2,223,000	Unfunded amount of request
Loss of Critical Access Dental Payments	$ -	$ 420,000	$ 420,000	Projected loss from both PMAP and Medicaid
Total Known Pressures	**$ 2,023,000**	**$ 4,576,000**	**$ 6,599,000**	
Impact to SOS Appropriated Services	**$ 3,592,300**	**$ 11,334,000**	**$ 14,926,300**	
Cost Reductions Achieved:				
Restructured Human Resources	$ 227,300	$ 227,300	$ 454,600	Completed
On-call modifications	$ 164,000	$ 164,000	$ 328,000	Medical Specialists
Non-salary cost reductions	$ -	$ -	$ -	Results not known at this time.
Known Cost Reductions Achieved	$ 391,300	$ 391,300	$ 782,600	
Net Impact to SOS Appropriated Services	**$ 3,201,000**	**$ 10,942,700**	**$ 14,143,700**	

NOTE:

Cost projections are as information becomes available. Reductions impact all appropriated programs which include:

Mental Health Services:

- Community Behavioral Health Hospitals (CBHH)
- Campus-Based Adult Mental Health Program (Anoka)
- Community Mental Health Program
- Child & Adolescent Behavioral Health Services (CABHS – Inpatient Services)

Forensic Services:

- Minnesota Security Hospital (MSH)
- Forensics Nursing Home

Minnesota Extended Treatment Options (METO)

Centralized Support Services and Administration

Patients who do not meet criteria for continued stay as of January 7, 2010		
CBHH	**# of Patients**	**Non-Acute Bed Days**
Alexandria	1	45
Annandale	2	24
Baxter	0	0
Bemidji	1	21
Cold Spring	NA	NA
Fergus Falls	0	0
Rochester	1	35
St. Peter	2	30
Wadena	0	0
Willmar	2	24
Total	**9**	**179**

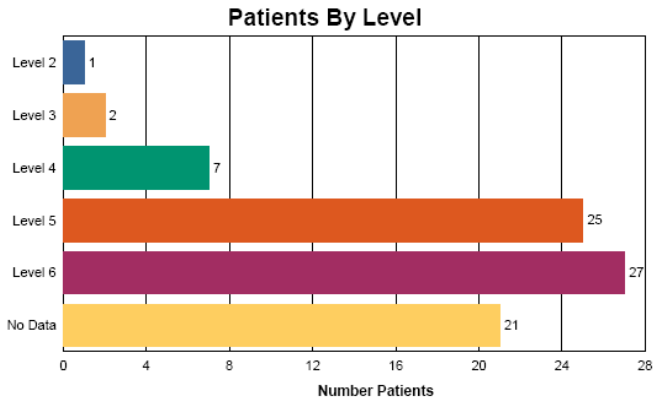
Non-acute bed days for Mental Health Programs January 1, 2009 to December 31, 2009	
Alexandria	401
Annandale	758
Baxter	238
Bemidji	130
Cold Spring	120
Fergus Falls	195
Rochester	385
St. Peter	309
Wadena	126
Willmar	923
CBHH Total	**3585**
Anoka RTC	18546
Mental Health Total	**22131**

AMRTC Patient Profiles Based on Patients served 01/01/08- 11/30/08 AMRTC (all units) Age Distribution 25-54---- 75%		
Axis 1	**Psychotic disorder**	**68%**
	Bipolar disorder	**20%**
	Major Depressive disorder	**16%**
	Cognitive disorder	**10%**
	Substance Use disorder	**54%**
Axis 2	**Developmental disorders**	**3%**
	Personality disorders	**28%**
	Borderline	**8%**
Axis 3	**Metabolic Syndrome**	**39%**
	Cardiovascular diseases	**20%**
	Respiratory diseases	**16%**

LOCUS_CurrentStatus_CBHH
1/22/09 by jd

Current LOCUS Status - CBHHs

Summary of All Programs



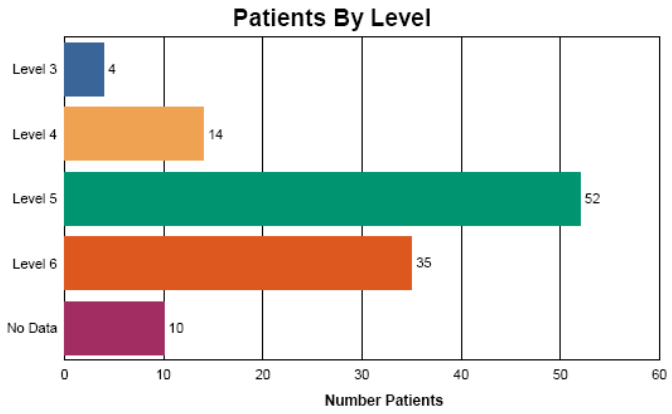
Patients By Program and Level

	Level 2	Level 3	Level 4	Level 5	Level 6	No Data	Total
10BA01-CBHH-ALEXANDRIA	0	0	1	5	3	2	**11**
10BA02-CBHH-ST.PETER	0	1	0	0	2	7	**10**
10BA03-CBHH-WADENA	0	0	1	3	4	0	**8**
10BA04-CBHH-ROCHESTER	0	0	1	4	2	1	**8**
10BA05-CBHH-ANNANDALE	1	1	2	3	2	1	**10**
10BA06-CBHH-FERGUS FALLS	0	0	0	3	4	2	**9**
10BA07-CBHH-BAXTER	0	0	0	4	2	3	**9**
10BA09-CBHH-BEMIDJI	0	0	1	1	4	2	**8**
10BA10-CBHH-WILLMAR	0	0	1	2	4	3	**10**
Total	**1**	**2**	**7**	**25**	**27**	**21**	**83**

LOCUS_CurrentStatus_AMRTC
1/22/09 by jd

Current LOCUS Status - AMRTC

Summary of All Programs



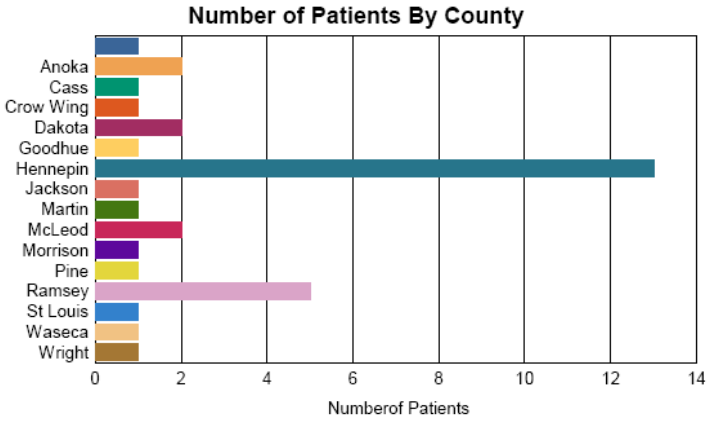
Patients By Program and Level

	Level 3	Level 4	Level 5	Level 6	No Data	Total
1-BA04-UNIT B-A	2	2	5	9	1	19
1-BA05-UNIT C-A	0	1	8	10	1	20
1-BA07-UNIT D-A	0	0	12	5	3	20
1-BA08-UNIT E-A	1	1	9	9	1	21
1-BA09-UNIT G-A	1	3	11	1	3	19
1-BA11-MILLER NO-A	0	7	7	1	1	16
Total	**4**	**14**	**52**	**35**	**10**	**115**

ContinuedStay_NotMet
3/2/09 by jd

Anoka Continued Stay Criteria Not Met

Total Number = 35



SOS Redesign Stakeholder Meeting
Region 4 South – Hoffman, Minnesota
January 12, 2009

Participants: 90

Introductions were made and the facilitator outlined the agenda for the meeting. Charlie Cook, Chief Administrative Officer for the Chemical and Mental Health Services (CMHS) Administration of the Department of Human Services, introduced himself, and noted that staff from the Department were scattered throughout the audience to "listen" to input. He gave an overview of CMHS for the audience. He noted that today's meeting is about quality, efficiency and partnership. He outlined the format for today's discussion, identified the budget pressure facing SOS during the current biennium, and clarified that no decisions or choices have been identified. He reiterated that it was at meetings such as this that CMHS and SOS are seeking input from consumers. He noted that today's discussion is not meant to solve unidentified future budget challenges.

Charlie introduced Mike Tessneer, Chief Executive Officer of State Operated Services. Mike presented utilization data from SOS, reviewed the $15M budget shortfall facing SOS in the current biennium, and addressed the need to identify efficiencies throughout SOS. Mike provided background on the utilization of the community behavioral health hospitals including average length of stay, and noted that although we are serving 50% more patients than served in the old regional treatment center model, SOS continues to face under utilization of the available inpatient bed capacity within the system. Mike informed the audience that this scenario presents an opportunity to change the way we provide services, or to change the services we provide, to better meet the needs of our clients. He addressed the LOCUS (Level of Care Utilization System) scale used and noted that approximately half the individuals currently served in our acute care hospitals do not need hospital level care, but instead need other levels of services that may or may not be available currently in the community.

Sharon Autio, Director of the Adult Mental Health Division within CMHS, was asked to address a question from the audience regarding private community hospital psychiatric unit census and an inquiry if DHS has a comparison of the census of private community hospitals' versus CBHHs. The audience member noted that in Region V (the neighboring region), private hospitals with psychiatric units are running full and yet there is a CBHH within the region that is experiencing under-utilization. Sharon addressed the question by sharing information regarding the Mental Health Division's utilization of statewide contract beds with community hospitals and explained that hospitals under contract with the Department receive an enhanced per diem for providing mental health services.

Sharon also thanked the group for allowing DHS to attend today's meeting; noting that historically this region of the State has a very high level of consumer involvement and a list of achievements that are not evident in other areas. Sharon called attention to the handouts and acknowledge the input provided by Region 4 South in the development of the Acute Care Needs Report as well as the Unmet Needs Report. She noted that one of the handouts identified a summary of the unmet needs from the 2010-2011 Adult Mental Health Initiative (AMHI)

applications submitted in October of 2009. Sharon provided background on the development of the Acute Care Needs Report for the State and shared that the need for additional acute care beds was not identified as a need but rather a way to move individuals through the system quicker. She also addressed the challenges facing greater Minnesota and highlighted work force issues as an identified barrier. Sharon then briefly address the 5 identified "unmet needs" for the region, including access to the right type and intensity of acute/intensive care, key areas to reduce unnecessary bed days in acute care, safe and affordable housing, information sharing and crisis stabilization bed availability within the county.

Charlie Cook gave instructions for the breakout sessions in which participants at today's meeting would be asked to address three questions (identified below) for the Department's State Operated Services. He strongly encouraged innovation and creativity from the participants and thanked them for their input. After responding to the questions, the groups were asked to identify their priorities and "report out" by table. The theme responses identified in the "report out" are identified in **bold type**:

Question #1: What do you believe State Operated Services (SOS) needs to do in this region?

- **Revamp or close Central Pre-Admissions. Continues to be a huge barrier to access!**
- Need long tem care
- 24-hour statutory crisis line
- **Provider evaluations done by neutral agency/group**
- Access for transportation
- Restore dollars to county grants
- Increase access to crisis and respite (specialize for parents with children)
- Certified peer specialist utilized in CBHHs – could also do the evaluations
- Outpatient psychiatric follow-up upon discharge from CBHH
- Lay-off staff when their program closes
- **More education for consumers when in the CBHH (i.e., medications, diagnosis, resources and referrals)**
- Standardize forms across providers (electronic data on key cards, care plans, medical history)
- Better and more timely access to care
- Local care (face-to-face) not through interactive TV
- **After hours care mostly evenings, holidays, weekends (*Peer Specialists*)**
- Education of community hospital medical personnel
- Does SOS manage peer specialist program? If so, can more people be trained for this? Better training for peer specialist. Where is there a peer support specialist?
- Better access to patient records so there isn't repetition in giving information
- **Seriously recruit more professionals *(psychiatrists, psychologists, etc.)***
- **Maintain role of safety net** – but redefine role (need to continue acute care in the region)
- **Better access to the CBHH system (easier, faster) (*Should require transport by law enforcement)***

- **Design system where State psychiatrists can partner/consult/train local physicians and the other private mental health professionals in the region. (*Don't compete for mental health professionals.)***
- **(*Make rules that allow for necessary flexibility.)* Make rules (Licensing) adjustable to meet Region 4 South's needs; for example, get rid of 5th bed variance for AFC, get rid of 90-day limit in IRTS**
- **Make medical records more accessible to medical and psychiatric facilities (i.e., intake should not take 2-hours and patient in crisis should not be expected to provide critical medical information; CBHH should have access to that information already). *Less paperwork, better access to records.***
- **Train CBHH employees to interact better with patients; to approach patients who look upset or who are isolating a lot.**
- **Cut admission process in half.**
- Continue CIT process
- Provide after hours services
- More crisis beds
- Funding to assist with security in hospital to free up local law enforcement
- Reduce liability
- Facility designed for faster release; law enforcement back to work (instead of hospital)
- **Re-evaluate criteria for length of stay and need for hospitalization**
- **More treatment oriented at CBHH**
- **Long term residential facility (*Residential services needed in this region)***
- **Something "in between" crisis and IRTS**
- Partial hospitalizations
- **More input from social workers and family members before discharge**
- Cold Spring: Specialized Care Facility step down, hard to serve
- Maintain existing hospitals – with step down and long term care
- Re-evaluate admission criteria for co-existing conditions such as CD, physical disabilities
- Access to psychiatric treatment – **provide consultation to clinics and community providers.**
- More community resources
- **Services for people needing detox, elderly, higher behavioral issues, DD/MI aggressive, chronic users of the mental health system. (or medication resistant)**
- Safety net! Fergus Falls RTC would take all of the above populations before – need a service system to replace this.
- Use one of the sites as a detox center for people who have mental illness
- Develop sites for people with bizarre or aggressive behavior for a short-term, maybe long term placement
- Provide nursing services after hospital stay
- Longer hospital stays – listen to people who know them.
- **More local services; respite beds, more group homes, more psychiatrists**
- **Restructure CBHH into *(separate)* individual units to better utilize services; split between high level care to address people who are a threat to themselves or others/*longer term* transitional care to address people who are a threat to themselves or others.**

- **We need other options *(ICF and group homes)* besides CBHH for *(individual with)* high behavioral long term needs**
- **Keep a full-time psychiatrist at the CBHH who would do outside appointments.**
- Law enforcement – when we get patient to ER we cannot get into CBHH or next level of care.
- Beds have been available closer, but we are sent to a CBHH further away.
- Is there a way to do assessment in a timely fashion – safe – inpatient or residential – then determine disposition
- State might ok is the first step.
- **Once a determination is made (by law enforcement) they cannot be at home, we (law enforcement) should be done as far as making decisions.**
- We can see the need for medical clearance but when clear, process needs to move timely.
- Level of care is not a law enforcement decision – our role is transport to a safe, supervised place.
- More efficient staff at CBHHs, more interaction between staff, clients – less repeat documentation.
- Update information given to clients at CBHH – same information is reused, regardless of client's repeat history of being hospitalized.
- Less staff could be effective, if less paperwork was required. **Night staff has mostly "down time"** and receives huge salaries; one does documentation, one cleans briefly then has leisure time for rest of shift, remaining are highly paid "stand-by body guards!!"

Question #2:
What do you believe SOS should not do in this region?

- Central Pre-Admissions!!
- Build local community resources then bail out when dollars get tight
- Cost-shift to counties
- **Quit automatically reallocating State staff when programs/services close. *(Cold Spring)***
- Should not dismiss person's knowledge of their illness.
- Stop providing MSOCS care (this would free up funding for private AFC) ***(Don't complete with community providers.)***
- Don't compete for psychiatrists or mental health professionals but work together to meet the region's needs.
- **Do not lay-off the most experienced workers.**
- Local control for placement
- Impose DHS decisions
- Program takeover – lose identify and local knowledge/experience
- People are not getting their needs met while at the hospital – we don't want them to be shoved out the door.
- Protect State employees – lay off rather than save jobs
- Don't put up barriers to what the community says they need. ***(Give power to counties/consumers)***

- Evidence Based Practices (EBP) have not been established in rural areas – don't always work because limited resources (people) – MHW – mental health professionals, psychiatrists, psychologists
- Partners in medical stability assessment not always listened to. State should develop own medical stability assessment capability.
- **Don't cut finances for local services**
- ACT/Milestones/Private sectors takes care of the stable people – works well as it is.
- Close SOS' ICF homes/waivered homes to use the dollars for individuals with higher behavioral needs
- **Law enforcement – we should not be hearing the agencies saying "no."**
- **Should not override the ER doctor – they are with the consumer! (Takes time)**
- **Should not make us wait 2-3 hours!**
- Don't change financial compensation for case management and ARMHS – support staff is a MUST for ongoing recovery. ***(Don't cost shift to counties.)***

Question #3:
How do we create a system of public/private partnerships that best serves individuals and their families?

- **Consider differences between rural and metro – allow <u>local</u> control, development – give us the dollars**
- Listen to consumers!
- See consultation statement regarding psychiatrists in #1 (Design system where State psychiatrists can partner/consult/train local physicians and the other private mental health professionals in the region.) ***(Increase access to psychiatric services.)***
- Utilize some of the CBHH beds as either IRTS or longer term stay
- **If Region 4 South crisis beds are full, let us have access to an open CBHH bed.**
- Tiered system of care – acute, super IRTS, IRTS ILS, independent.
- Train local crisis intervention people (warm-line type) that would be available 24/7. Many times hospitalization and emergency room visits could be avoided if there was just someone to talk to during off-service hours.
- **Continued communication with consumers**; examples: LAC, Conversations
- **Listen to consumers on formal/informal usage of services**
- More local education to help develop partnerships
- Brainstorm on gaps in service coverage (disparity in coverage, services due to low income)
- Continue to work on effective communication.
- Consider RFP process rather than State provision
- Contracting for staff to purchase what you need
- Public/private partnerships – explore how we can do this.
- Develop a system of **better communication between CBHH, CM, community providers**
- Partner with community services to keep people in community after hospitalization or before (nursing)
- **Takes good communications;** create more contracts for CBHH (beds), more mental health support groups, **more communication between consumers and professionals. *(consumer education/support groups)***
- Coordinate/partner with Veterans Administration – funds/needs

- **Law Enforcement – Doctor to doctor consultation with ERs.**
- Increased access to outpatient – may decrease emergency calls.
- **Transportation assistance would be valuable.**

Addendum:
Received via e-mail after the meeting from an unidentified social worker in Douglas County:
Question #1 –
What do you believe State Operated Services (SOS) needs to do in this region?

- *(Services for) Aggressive/violent/"nearly MI&D" patients who cannot be served in small foster care settings and are repeatedly hospitalized or are in jail.*
- *Good quality residential programs that can address co-occurring mental health and chemical dependency treatment – long term.*
- *Access to psychiatric treatment/APRNs*

Question #3:
How do we create a system of public/private partnerships that best serves individuals and their families?

- *Douglas County has had some success in developing specialized foster care for persons who have complex health care needs and have serious and persistent mental illness. These are funded by CADI and sometimes TBI waivers; elderly waiver caps are a barrier to serving an MI patient in this kind of setting.*

Parking Lot:

- What is the step-by-step process for admitting?
- Utilize Cold Spring – i.e., specialized hospital for step down services, treatment of aggressive behaviors, long term care
- Re-evaluate admission criteria for individuals with co-occurring illnesses
- Develop partnerships with private providers – change restrictions to meet the needs rather than the provider having to meet the restrictions.

SOS Redesign Stakeholder Meeting
Region 7E – Cambridge, Minnesota
January 25, 2010

Participants: 13

- **Adult Mental Health Initiative (AMHI) Governing Board**
- **Members of the Local Advisory Councils**

Chuck Hurd, Kanabec County, requested introductions be made and then turned the agenda item over to Charlie Cook, Chief Administrative Officer for Chemical and Mental Health Services (CMHS). Charlie gave background regarding the purpose of being at today's AMHI Governing Board Meeting and referenced the handouts that were being distributed around the table. Charlie shared that, contrary to any rumors that may be going around, no decisions have been made by SOS or the Department regarding the redesign of SOS. Staff from the Department were at today's meeting to get input regarding that redesign and indicated that the Department staff scattered around the table were here to "listen" to input. He then briefed the audience on the mandate of the 2009 Legislative Session to look at the redesign of the Anoka-Metro Regional Treatment Center, the current budget deficit facing SOS as well as the uncertainly of any future budget pressures that may need to be faced.

Charlie then asked Mike Tessneer, CEO of SOS, to address the group. Mike reiterated that no decisions have been made and shared that SOS is seeking input from meetings such as this across the State. He too referenced the handouts that were distributed earlier in the meeting and spoke to the utilization data that shows that many of the individuals coming to SOS' doors are not necessarily in need of acute inpatient care, but rather would benefit from more fully developed specialized support services in the community that would prevent or shorten inpatient hospitalization stays.

Mike then addressed the $15M budget shortfall facing SOS in the current biennium and spoke to the initiatives currently underway to help address this shortfall. These initiatives include changes in staffing as well as other non-salary administrative cuts. He noted that SOS continuously looks at ways to operate more efficiently and effectively to save money. Mike spoke to the utilization of the CBHH beds throughout the State, including unused capacity, and noted that SOS is looking at what other potential services are needed throughout the regions and how current SOS unused bed capacity may be utilized to alternatively serve the needs of the individuals referred to SOS for service. Mike addressed LOCUS levels and noted that, on any given day, a percentage of individuals within our hospitals are not in need of "acute" hospital level care according to their LOCUS score. This data shows us that we need to adjust the level of care we are providing and by doing that we may have the ability to save or redirect our resources to better meet the needs of the individuals.

Sharon Autio, Director of the Adult Mental Health Division, then distributed copies of the Executive Summary of the Mental Health Acute Care Needs Report to the Legislature dated March 2009 and spoke to the findings of that survey. She indicated that she would focus her comments on adult mental health services and referenced Adult Subcommittee Report key highlights which addressed such issues as access to the right type and intensity of acute and/or

intensive care as well as key areas to reduce unnecessary bed days in acute care including expanding intermediate and more intensive community based services; uniform protocols and procedures, and establishing a chronic care model of treatment and support for individuals who present with complex care needs; either dually diagnosed or severe medical issues that present complex issues serving their mental health issues. She also addressed the key recommendations of the subcommittee; including the need to address chronic care issues, specialized acute care with medical problems, or dual diagnosis, and improved access after hours or on weekends and holidays. She also briefly addressed the need for development of a matrix to measure how long people are waiting in ERs before they are being referred to appropriate services.

Sharon also addressed the utilization of contract beds; specifically in Region 7E, including the contract beds at the Cambridge Medical Center. The data for 2008 shows there were 18 admissions to the Cambridge Medical Center and 2009 data (January – September) shows 14. She noted that part of the challenge in this region is utilization by the metro area which reduces the availability of beds at Cambridge. Utilization of crisis services in this region has resulted, in many cases, in fewer hospitalizations or shorter hospital stays due to the availability of support services.

Sharon also distributed the unmet needs information received from Region 7E and noted that housing and housing with supports continues to be an identified need. The unmet needs summary indicates that transportation is available in most areas of the region and although expansion is planned, has been postponed due to budgets.

Before breaking into small groups to address the 3 questions identified on the agenda for today's meeting, Charlie reiterated that today's discussion should focus on adult mental health and spoke to the larger Chemical and Mental Health Services (CMHS) Administration summit meetings that will be held later than summer. He informed the participants that the information gathered at today's meeting will be shared back with them and will be utilized in developing the mandated Report to the Legislature scheduled to be submitted at the end of February.

After responding to the questions in the break-out session, the groups were asked to identify their priorities and "report out" by group. The theme responses identified in the "report out" are identified in **bold type.**

Group 1: Print outs

Question #1: What do you need SOS to do in this region?

- Create a sub-acute, long term care service for the complex (medical, behavioral) clients.
- Change in CBHH access for medically fragile mental health clients **(CPA will only take someone in perfect health. Need SOS not to refuse our clients – old RTC system could get someone in the door. Not true anymore.) (Not unusual to get a call from CBHH to "come get them," they are ready to go.)**
- Available housing with services (coordinate with regional housing services)
- Create a SOS "last resort" facility that can't refuse eligibility/admission. **(Have to prevent yo-yoing affect. Need consultation. SOS should be the last resort.)**

Questions #2: What do you need SOS not to do in this region?

- (SOS is) **Not a big presence here!**
- No ACT in region
- No IRT
- No CBHH
- In one year – no state staff.

Questions #3: How do we create a system of public/private partnerships?

- State provides "safety net" service, then private may be more willing to take risk on these clients. **(Private providers may be willing to take risk on some clients "if" they knew SOS provided the "safety net.")**

Group 2: Print outs

Question #1: What do you need SOS to do in this region?

- Partnership with housing providers (affordable housing). (**Develop housing partnerships and bring supports into the housing.) (ACT or team approach model to address housing, vocational.)**
- Identify housing programs: (i.e., MHFA, CMHP, HRA, Rise, EDA) with supports, coordinate supports.
- Wrap around – ICRS
- Regional vs. county access **(Counties should all provide the same services.)**
- Statewide crisis and public/private partnership. **(Statewide crisis number to help people find what is available in their community.)**

Question #2: What do you need SOS not to do in this region?

- Don't stereotype –don't want to be treated like we are incompetent (children, uneducated, etc.) **(Don't brand, categorize or stigmatize us.)**
- Preconceived ideas about individuals
- Not a label – "Living with mental illness" vs. struggling to, or challenged, or other "branding."

Question #3: How do we create a system of public/private partnerships?

- Communications
- Accountability
- Establishing wraparound supportive housing **(Transition services back into the community)**
- One-stop shop – coordination of services
- Information sharing. **(One-stop shopping.)**

In wrapping up the meeting it was noted by some participants that affordable housing is being lost in this region and that, although there is a lot of new construction, those units won't accept Section 8 or subsidized rent programs. The region uses the "fair market value" used in the Twin Cities and it is not just the population with mental illness affected by this but the economy has affected affordable housing throughout the region.

Chuck Hurd concluded the discussion by noting that Region 7# needs to focus on services for individuals with serious and persistent mental illness first and that “corporate foster homes” are not the answer in this region. He noted his appreciation to the staff of the Department for coming to today’s meeting and listening to their concerns.

SOS Redesign Stakeholder Meeting
Scott/Carver Counties
January 27, 2010

Participants: 22

Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, opened the meeting by introducing his role within CMHS and identifying the divisions within CMHS; i.e., Alcohol and Drug Abuse, Adult Mental Health, Children's Mental Health, and State Operated Services. Charlie informed the attendees at today's meeting that, when Dr. Read Sulik, Assistant Commissioner for the CMHS Administration, came to the Department in the fall of 2008, he established his "7 Goals for Achieving Excellence" for the staff of the CMHS Administration. These goals are:

- Eradicate the stigma, misunderstanding and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and addictions.

Charlie noted that the Department's role in today's meeting is to talk about the redesign of State Operated Services (SOS) and shared that the rumors that decisions have been already been made and that the meetings with the regions are "window dressing" is not true. The Department has scheduled 14 meetings with the Adult Mental Health Initiatives (AMHIs) throughout the State, inviting a number of different stakeholders, including law enforcement, consumers, family members, and providers to seek input on the needs of their regions. He reiterated that staff from the Department are here to listen only, and they will not participate in the discussions or interject their ideas into the conversations. Charlie then addressed the budget shortfalls faced by the Department of Human Services and SOS in particular. He shared that SOS is working to resolve those budget pressures through efficiencies and partnerships with public/private entities while maintaining quality services for the individuals we serve.

Charlie also informed the participants of today's meeting that the CMHS Administration will be holding "visioning summits" later this summer to gain input from stakeholders regarding the services of the entire CMHS Administration, but again clarified that today's meeting will focus on State Operated Services. He shared that information gained in meetings such as this around the State will be used to create the mandated report to the 2010 Legislature which will be

submitted at the end of February. Charlie then distributed copies of the handouts that will be referenced in today's meeting and introduced Mike Tessneer, CEO of State Operated Services.

Mike Tessneer shared that SOS is formulating how to do business in a specialized health care system through the Community Behavioral Health Hospitals (CBHHs) and the Anoka-Metro Regional Treatment Center (AMRTC). He noted that available data shows that many individuals currently receiving services through SOS' acute care hospital system are not in need of acute inpatient care; but instead need a level of service and/or services that are currently not available through SOS, and in some cases, are not yet available in the community.

Mike provided background regarding the creation of the CBHH system and spoke to the regional meetings that were held throughout the State to meet with stakeholders and gain input about the needs of their region. At that time, it was anticipated that SOS would need about 140 acute care beds to meet the needs of the regions. He noted that, in reality, SOS bed capacity has been running about 50% of that or an average daily census of 80 patients; but also noted that availability of clinical services (psychiatrist, advanced practice psychiatric nurses) and the acuity of patients at any given hospital may impact acute bed availability in that region. He shared that the average length of stay has been dramatically reduced from that of the old RTC system – which means SOS is serving more individuals per year and for shorter periods of time. In addition, he stressed that the development of additional community based support services (i.e., crisis services, ACTs, IRTs, ARMHs), has resulted in an array of available services to help meet the needs of individuals and in many incidents helped avert the need for in-patient hospitalization. Or, once hospitalized, have allowed individuals to leave the hospital sooner and return to the community with appropriate support services. Mike noted that the transition of SOS continues and that the current utilization of AMRTC and the CBHHs shows us that approximately half of the people in our hospitals do not need "inpatient" acute care. With that in mind, the intent is to continue the redesign of SOS services to be more responsive to the needs of the individuals coming through our doors. Based on the characteristics of the individuals being served, the data shows us that more specialty services, such as outpatient clinics, specialized residential services with supports, etc., are needed.

Mike informed the participants that SOS' purpose at today's meeting is to seek input on what SOS should be doing in this region, what they should not be doing in this region, and what kind of partnerships should be pursued to help meet the specific needs of the population in this region.

In response to a question from the audience regarding how people were informed of this meeting, Charlie Cook noted that in December, DHS requested a meeting with the metropolitan counties to inform them of our desire to seek input from stakeholders in the metro area. At that December 21, 2009, meeting metro county representatives were asked to extend an invitation to their stakeholders and to invite CMHS representatives to meet with those stakeholders. Mike Tessneer added that if anyone in the audience felt there were stakeholders not represented, they should feel free to contact Charlie Cook and let him know. DHS would be happy to arrange to meet with them.

There was also a comment from a participant regarding the episodic nature of mental illness and a question regarding the State's role in addressing those changing needs (i.e., the LOCUS level

of an individual with mental illness will ebb and flow with their illness). It was acknowledged that the system needs to be beefed up to address those changes and to develop strong community and inpatient services to address those needs.

Mike then spoke to the budgetary issues facing SOS, and noted that like any other health care system, SOS is obligated to address those issues. He briefly spoke to some of the contributing factors (i.e., administrative cuts, unfunded COLA, unallotment, and unanticipated costs associated with maintaining the Brainerd campus). He spoke to some of the actions currently underway to address the budget shortfall, including a number of administrative steps such as instituting flex staffing, non-salary administrative cuts, instituting a change in the on-call system of SOS practitioners, as well as other budgetary exercises being undertaken to help identify ways to more efficiently use available resources. He noted that SOS has also initiated a strategy to seek feedback from consumers about their experience while in our care. Ideally that feedback will help SOS identify what works and what doesn't work and what SOS should do differently to meet the needs of our consumers. He noted that SOS has initiated conversations with the Minnesota Consumer/Survivor Network and will be working with them to ensure consumer participation.

In response to a comment regarding the "marketing" of the CBHHs, and a question that if the CBHHs are under utilized, why does AMRTC continue to have a waiting list -- why aren't those individuals being served in the CBHH system -- Mike responded that when necessary, some patients are diverted to the CBHH system; however, one of the goals of the current system when it was established was to serve individuals within their regional communities and as close to their natural support system as possible. Moving a patient across the state to an available bed in a CBHH just complicates the discharge planning and natural transition back to the home community.

Mike then introduced Sharon Autio, Director of the Adult Mental Health Division. Sharon called the participants' attention to the copy of the summary of the March 2009 "Mental Health Acute Care Needs Report" to the Legislature that was distributed earlier in the meeting. She also distributed a copy of the unmet needs information (dated 10/15/09) received from Scott and Carver Counties. Sharon also take this opportunity to give specific kudos to the crisis team in this region for the excellent job they have done in helping to prevent unnecessary hospitalizations.

Sharon briefly spoke to the identified needs from the Mental Health Acute Care Needs Report; including improved communication between and coordination among the various levels of care; work force shortages, most notably for psychiatrists and advanced practice nurses, and noted that the average time to successfully recruit these professionals was a minimum of one year. Sharon spoke to front door/back door issues, as well as the lack of services after 4:30 p.m., weekends and holidays. She briefly addressed the recommendations of the report, including the need to design a chronic care model of treatment for people with multiple and challenging diagnoses and complex co-morbidities including medical care and cognitive deficits. She addressed the need for simplification of the process, a standard intake form, direct access to ACT teams and IRTs; rapid access to psychiatry and/or medication follow-up and monitoring; and briefly spoke to the utilization of contract beds with hospitals in the metro area that have psychiatric units. She

shared that hospitals that utilize these contract beds for Medicaid eligible patients are very successful in maintaining the client in their local community. Sharon turned the meeting back to Charlie Cook who requested that the audience break into 2 smaller workgroups to respond to the three questions identified on the today's agenda.

After responding to the questions in the break-out session, the groups were asked to identify their priorities and "report out" by group. The theme responses identified in the "report out" are identified in **bold type.**

Group 1:
Question #1 -- What do you need State Operated Services (SOS) to do in this region?

- **Specialized housing with services for (dually diagnosed) SPMI/CD** (but not with DD trained staff)
- **Intermediate level of care** (i.e., apartments with community room, medical monitoring, supportive living, permanent housing, staff available) – 8 unit housing units
- **Develop local housing stock (instead of more costly corporate foster care/CADI placements)**
- Crisis beds (Nancy Pace like) – **prevent need for long term hospital admissions**
- **Specialty need – medical/behavioral unit at CBHHs**
- **Transitional beds –similar to an IRT**
- **Small volume ACT model**
- Use CBHH for wait list at AMRTC – consistent policy
- **Timely communication for discharge**
- **Include county staff in discharge process**

Question #2 -- What do you need SOS not to do in this region?
There were no responses to this question.

Question #3 -- How do we create a system of public/private partnerships?

- Look at other states.
- **SOS part of meeting with local developers.**

Group 2:
Question #1 -- What do you need State Operated Services (SOS) to do in this region?

- Local short term care
- CBHH accepting people on stays of commitment
    - Increase access in general
    - Streamline or make it easier to access the CBHH system
- Increase options for those who have dual diagnosis **(Increase options for dual diagnosis)**
- St. Peter as alternative to Anoka for Scott/Carver Counties
- Change catchment area
- **Quicker access to psych/neuro-psych services**

- **Supportive living environments**
- **Local beds, with more flexibility**
- **Shift funds to bolster psychiatry services,** ACT teams

Question #2 -- What do you need SOS <u>not</u> to do in this region?

- Don't take dollars from local resources and services
- **Don't duplicate local services (i.e., forensic testing, outpatient mental health, case management**

Question #3 -- How do we create a system of public/private partnerships?

- Redistribute staff to meet local need; example: nurse for Antabuse program; training for motivational interviewing; catalyst to develop new services.
- State psychiatrist work in Community Mental Health Center (**SOS psychiatrists work within existing clinics),**
- "Circuit Rider" system
- **Share information about innovative new ideas and services; LAC Conference is a great resource for sharing what is happening in other counties.**

In wrapping up the meeting, Charlie Cook thanked the participants for their input in today's meeting and noted that staff of the Department is available for further discussion. He again reminded the participants that the CMHS Administration will be holding visioning summit meetings later this summer and shared that he looked forward to their input in that process.

SOS Redesign Stakeholder Meeting
Region 3 – Duluth, Minnesota
January 28, 2010

Participants: 38 (Including one by telephone conference)

Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, opened the meeting and requested introductions be made. He shared with the group that contrary to rumors, no decisions have been made and the purpose of holding these regional meetings is to seek input from AMHIs and stakeholders from throughout the State. Charlie shared that meetings are being held region-by-region as it is recognized that the needs of the regions of the State do differ. Charlie spoke to the Minnesota Council for Quality survey currently underway throughout CMHS as well as shared that a number of "achieving excellence" work groups are being held within the CMHS Administration to address Dr. Read Sulik's "7 Goals for Achieving Excellence" that he established for the CMHS Administration when he came to the Department in the fall of 2008. These goals are:

- Eradicate the stigma, misunderstanding and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and addictions.

Charlie also informed the audience that Dr Sulik will be holding a "visioning summit" later this summer for the CMHS Administration and again, input from stakeholders and consumers will be sought. He noted that the focus of today's meeting, however, will be adult mental health and distributed the handouts that will be referenced during today's meeting. Charlie also clarified that the DHS staff at today's meeting are here to "listen" only and will not be participating in the small group discussions that the audience will break into later in the meeting to address the 3 questions identified on today's agenda.

Charlie then introduced Doug Seiler, SOS Administrator for Special Populations, who shared that he was standing in for Mike Tessneer, CEO of State Operated Services, who was not able to be at today's meeting. Doug acknowledged that in the earlier work around the redesign of the regional treatment center campuses, he was the representative to this region, so he is familiar

with some of the participants at today's meeting as well as some of the issues facing this particular region of the state. Doug briefly addressed the $15M shortfall facing SOS' in the current biennial budget; as well as some of the contributing factors, including administrative reductions within the Department, unallotment, unfunded COLA mandates, underfunded dental services and ongoing maintenance costs of the Brainerd campus.

He noted that in its goal of identifying efficiencies, SOS is also looking at the redesign of the programs and services provided at the Anoka-Metro RTC (AMRTC) campus and the Minnesota Extended Treatment Options (METO) Program in Cambridge. A review of all programs is underway to determine what potential savings may be found by redesigning the services provided.

Doug then referenced the handouts distributed at today's meeting and called attention to the handout which addressed LOCUS data. He spoke to the characteristics of individuals at the various LOCUS levels (i.e., LOCUS level 6 and some level 5 are individuals in need of active inpatient hospitalization; other LOCUS level 5 individuals may not need hospitalization if available community support services are available to support them in the community.) Doug pointed out that approximately 60% of the individuals in AMRTC are not in need of "inpatient acute hospitalization services." Doug also shared that the current C BHH system is serving more individuals annually than we did within the RTC system of care – approximately 3 times as many individuals – and noted this can be contributed to a shorter length of stay and the development of enhanced community support services. Doug referenced the admission data, reviewing the specifics for CBHH-Alexandria, and pointed out that the current length of stay (LOS) in the CBHH system is about one-third of that of campus based services.

Doug then introduced Dr. Robert B. Jones, Medical Director for the northern region of the State and shared that he is the Central Pre-Admission (CPA) "on-call" psychiatrist for this region. Dr. Jones spoke to his role within the region, including his role as Medical Director for the Minnesota Neurorehab Services program in Brainerd. Dr. Jones shared that, during the last quarter, the revenue reimbursement for the patients in the CBHH system (if they had meet hospital level of care criteria) would have been $1.3 million; however, because they remained in an acute care bed but no longer need inpatient acute hospital care, SOS was not able to collect that revenue. And, if you included AMRTC, that potential revenue would increase to approximately $20M. He briefly addressed the types of issues keeping patients within the hospital after they no longer require active inpatient hospitalization (i.e., lack of appropriate community services such as stable/appropriate housing options, access to community psychiatry, medication monitoring, etc.) He noted that based on the average daily census, while SOS has flexed up to 95% capacity briefly, we have never hit 100% of the "available" 120 staffed bed capacity.

Doug Seiler then introduced Sharon Autio, Director, of the Adult Mental Health Division, who noted that it has been 18 years since the Department, in partnership with this region, closed the Moose Lake Regional Treatment Center. Sharon noted that many of the individuals in this room were involved in the planning for the community development to meet the needs of the individuals formerly served in the RTC and acknowledged that this region really set the tone for the future of community service development around the State.

Sharon then called attention to the document in the handouts entitled "Mental Health Acute Care Needs Report" and shared that this March 2009 report to the Legislature was in response to a directive of the 2008 Legislature to the Department of Human Services to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. She addressed the process that was instituted to look at the issue of acute care psychiatric bed capacity, ACT teams, IRTS, supported housing and crisis services within the State. Sharon informed the participants that a steering committee of 17 individuals representing key stakeholder organizations provided oversight and direction to three subcommittees (child/adolescent, adult and workforce) who met monthly over a four month period and prepared individual reports with recommendations for review by the Steering Committee. Membership of the subcommittees included members of the Steering Committee and other individuals who were interested in participating.

Sharon briefly addressed the work of the work force subcommittee and noted that a survey was commissioned of hospital and community-based providers of mental health services from across the State to obtain information from the field about position-specific shortages, service impacts due to any shortages and recommended strategies to address the issue. Work force shortages were identified by many of the survey respondents, most notably for psychiatrists, psychiatric nurse practitioners and clinical nurse specialists and it was noted that it takes an average of one year to recruit these professionals. Sharon also noted that, not surprisingly, it was determined that licensed social work capacity was mostly in the Twin Cities.

Sharon also shared that the findings of this survey determined that although there were enough inpatient acute care beds in the State, lack of a well developed community support service system can have a serious impact on accessing the appropriate level of care at the right time. She shared that the findings also noted that the "system" is more reactive then proactive, that there is an increase in the number of individuals who present with dual diagnosis and/or fragile medical conditions in addition to their mental health needs, and that development of specialized services was not feasible in areas of the State with a more dense population.

Sharon informed the participants that with the establishment of crisis services and ACT teams, we are seeing a significant decrease in hospitalizations. One of the most significant issues with the current system is on the front door end with the lack of access to service "after hours, weekends and holidays." On the back door end, once individuals are no longer in need of hospitalization, we are finding the lack of available appropriate community services; especially for the individuals with challenging behaviors and or histories. Sharon briefly reviewed the findings of the legislative report including the need to design a "chronic care" model of treatment and support services for the growing number of individuals with multiple and challenging diagnoses and complex co-morbidities. She informed the participants that the full report is available on the Department's website listed at the back of the summary and shared that this report is receiving a lot of attention from the Legislature.

Sharon then turned the meeting back to Charlie Cook who again addressed the economic issues facing SOS, reiterating that we are here today seeking their input into the process of redesigning State Operated Services to better meet the adult mental health needs of the individuals served.

He asked the audience to break into 4 small groups to response to the three questions identified on the agenda for today's meeting.

After responding to the questions in the break-out session, the groups were asked to report back one or two salient responses to the questions to the whole group. Charlie noted that all their responses would be shared with them in a report of today's meeting and that report will be incorporated into a larger report to be submitted to the Legislature at the end of the month. He also encouraged anyone with additional ideas after today's meeting to feel free to communicate them.

The theme responses identified in the "report out" are identified in **bold type** below**.**

Before concluding the meeting there was a brief discussion in response to a question if the redesign of SOS would be going forward even if there was not a $15M shortfall. Charlie indicated that the answer was "yes" because the time has come to look at efficiencies within our system and how to more effectively provide services and look at what services need to be changed or developed to meet the specific needs of the regions. He reiterated that DHS and SOS need to understand the needs of the region before we can make smart decisions.

Group 1:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- To **provide service when funding runs out** (between hospital and community care) -- Client needs the bed and provider needs time to get the staff or training. (State's job to provide services when local money isn't available.)
- **Hire Peer Specialists** -- to take up lack of professional mental health providers
- Transportation to social events to promote better mental health.
- **CIT (for all law enforcement in region)**
- CSS for people with mental illness – beef up Synergy
- **Something to replace Personal Care Assistants (PCAs) for people with mental illness**
- **Need dental care for people with mental illness** – (provide training to community providers)

Question #2 – What do you need SOS <u>not</u> to do in this region?

No response to this question.

Question #3 – How do we create a system of public/private partnerships?

- **Include funding for psychiatry at Bridge House – (**enhance capacity)
- Need to fund drive time so people can have someone come in to assist with medications/eye drops/BSC, etc.
- **Dental Clinics – also provide training on how to manage behavioral issues**
- Training for medical professionals and law enforcement **– (provide peer specialists)**
- **Combine Community Health Center and Community Mental Health Center; example: primary care and mental health care** – more collaboration
- Urgent care bed to prevent hospitalization (Carlton County has one, but funding can be a concern for some people)

Group 2:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **How do we plan to address the needs of the American Indian people?** Involve culture diversity and Native American spiritual healing
- **Consultation with Psych PharmDs – face to face or telemedicine**
- More case management/care coordination
- **Keep Bridge House**
- **More services like Bridge House**
- Supportive, affordable, housing – for Native Americans as well
- Keep the crisis team
- Keep courtesy screening team by crisis team across the region
- Teams should represent diversity as well
- Something to get services in Region
- **Is there a moratorium on ACT teams? Could use more in outlying Region 3.**
- ICRS – need to know more – something like ACT.
- Access to APRNs or psychiatry!
- Transportation major issue
- **MI/CD** dual diagnosis **major issue – not many options**
- **CIT Training for law enforcement**
- **Continuity of service model – so many eligibility silos – seems backward –** (too many silos and complex/different eligibility criteria)
- Seem to have a level of care between acute and community!!
- Better care coordination between acute provider and community level of care.
- **Further away, harder to connect – results in service migration (**The further away a client receives services the harder it is to connect them back with their home community.)
- Short term crisis close to where they live – like DD
- Fund crisis beds separately
- Remember unique needs of children
- **Remember spiritual and cultural aspect before diagnosis**
- Advocacy for the population at the street level
- Services should be culturally equitable

Question #2 – What do you need SOS <u>not</u> to do in this region?

- **Do not touch Bridge House**
- **Do not mess with ACT teams and Crisis**
- **Do not mess with Eveleth**
- Do not forget about Native American population.

Question #3 – How do we create a system of public/private partnerships?

- **More collaboration with Bands and Tribes**
- More collaboration with advocacy organizations
- Establish, maintain and nurture relationships
- **Collaborate with primary care facilities**
- Fold State into relationships

Group 3:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **Need flexibility of state funding for rural areas**
- **Permanent commitment to State services in region**
- **Happy and blessed with the number/range of state operated services in this region—Extensive level of services available (hospitals, Bridge house, foster homes)** *C*urrent resources
    - 1 Rule 36 – Eveleth
    - 3 Mental Health hospitals
    - 3 ACT teams and Carlton – **blended teams form all agencies**
    - 3 IRTs
    - Crisis response team
    - Imbedded state staff
    - Partnered teams
    - Bridge House – Crisis
    - 3 mental health agencies (HDC/RMHC/Northland)
- Multi-leveled services
    - Hospitals, IRTS/ACT/CRT/Foster Care beds
- **Selectively lift adult foster care corporate moratorium to promote access --** Looking at data about AMRTC shows need for corporate foster care – moratorium now on corporate foster care is going to hurt

Question #2 – What do you need SOS <u>not</u> to do in this region?

No response to this question.

Question #3 – How do we create a system of public/private partnerships?

- Extensive partnerships (exist) in region – ACT/CRT/CADI

Addendum to meeting received from Jeff Hardwig, M.D. via e-mail:

- Services need to support what we have locally – need support for stable housing, board and care, foster and crisis beds.
- 16 bed (CBHH) units are beds of last resort so we did not have an established regular contact with the staff there.
- (CBHHs) did not allow for complex medical and psychiatric cases so many real life patients were not eligible.
- Makes more sense to place psychiatric supports in community hospitals so that complex patients can be cared for in the community and get integrated rather than segregated care.
- Crisis beds in ERs would probably prevent psychiatric hospitalizations every year in every location and take strain off other community resources such as ambulance, law enforcement, etc.

SOS Redesign Stakeholder Meeting
Region 2 -- Bemidji, Minnesota
February 1, 2010

Participants: 53

Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, called the meeting to order. Charlie identified the divisions (Alcohol and Drug Abuse, Adult Mental Health, Children's Mental Health, and State Operated Services) within the CMHS Administration and shared that, with this meeting, and others like it being held around the State, CMHS is seeking input on quality, efficiencies and partnerships. He informed the audience that he wanted to dispel any rumors that the State has already made decisions around the redesign of SOS and that meetings such as this are window dressing – he stressed that DHS is attending 14 meetings statewide and will be actively seeking input from each of the 16 Adult Mental Health Initiatives. He shared that a report of this meeting will be made available to the AMHI for distribution to the participants at today's meeting and the information gathered from this meeting, and others like it, will be compiled into a report to the Legislature that is due at the end of the month.

Charles informed the audience that Dr. Sulik has established "7 Goals for Achieving Excellence" for the CMHS Administration; which are:

- Eradicate the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and additions.

Dr. Sulik's overarching goal is to apply these 7 goals to reduce disparities in access and outcomes for minorities and to engage staff and stakeholders in the process. Charlie also informed the group that later this year, late spring or early summer, the CMHS Administration will embark on a larger "visioning process" that will look at all the services provided by the divisions within the administration and similar stakeholder meetings will be held to gather input on the visioning process.

Charlie also clarified that DHS staff at today's meeting are here to listen only and will not be participating in the small group breakouts. They will be available to respond to questions but will not contribute to the discussion.

Charlie then briefly addressed the budgetary issues facing the State, the Department and SOS and shared that during the current biennium, which ends on June 30, 2011; SOS has a $15 M budget shortfall that needs to be resolved. It is SOS' goal to solve that without sacrificing the quality of the services provided or the effectiveness of those services. He then introduced Mike Tessneer, CEO of State Operated Services.

Mike reiterated, as Charlie had said earlier, that DHS staff are here today to listen to how the region's system operates and to learn what SOS needs or doesn't need to do in this region to bolster the current system of care. He referred to the handouts that were made available for today's meeting and noted that these handouts reflect the data SOS has gathered about the clients we serve. He called attention to the handout referencing patients who do not meet criteria for continued hospital level stay and noted that during calendar year 2009, there were over 3500 patient days where a patient was not in need of acute inpatient hospital level care but was in a SOS hospital bed because they needed a level of care that was not readily available to them. He acknowledged that these are resources and dollars that could be utilized elsewhere in the continuum of care for mental health services.

He then referenced the handout that reflects LOCUS data and noted that this data gives us a sense of the acuity level of the patient upon their admission to the CBHH. He noted that a LOCUS 6 level indicates the need for acute inpatient hospitalization. The data shows us that, that on any given day, roughly 50% of the people in our hospitals need hospital level of care; and the rest could benefit from a different level of care. This could include an array of community support services (i.e., crisis beds, ACT, IRTS, outpatient clinics, etc.) He called specific attention to the data for the CBHH-Bemidji and pointed out that the average length of stay is 10 days and the CBHH-Bemidji is running about 50% of capacity. He clarified that although the CBHH capacity is 16 beds, they are staffed to handle 14 patients. So the question becomes, what is it that people really need when they come to our door? In looking at utilization for this region, there appears to be potential gaps in service that may be more appropriately addressed by specialty health care services such as specialized residential services, additional crisis bed capacity, acute care observation beds, or maybe outpatient clinic with quicker access to psychiatry; or psychiatric consultation to community providers.

In response to a question from the audience seeking clarification of the difference between specialized residential, IRTS and a Rule 36, Mike noted that specialized residential services could be for individuals in a CBHH bed who are no longer in need of acute inpatient hospitalization, but in order to transition to the community successfully, may need ready access to a psychiatrist, medication adjustments, medication monitoring, etc. It is a level of community based support services to maintain the individual in the community and prevent the need for hospitalization.

A question was raised why the length of stay at the CBHH-Bemidji is less than other CBHHs and does the shorter length of stay account for the higher level of admission? And, what about the forensic patient; and how should they be managed to address the episodic nature of their illness? Mike responded that these are exactly the type of questions we are looking for input on in the table top exercises – is there a role for the State in addressing these issues and are their

additional consultative services that can be developed in the region to meet the needs of the population.

Mike emphasized that SOS has been monitoring our data since the closure of the regional treatment centers and the current budget issue is NOT driving this change. He noted that, like any other health care system, SOS needs to make better use of our resources to enhance the quality and right level of care; efficiency will translate to more resources and efficiency and partnerships could lead to better quality of care.

Mike then introduced Sharon Autio, Director of the Adult Mental Health Division. Sharon called attention to the summary of the March 2009 "Mental Health Acute Care Needs Report" to the Legislature that was included in today's handouts. She gave background regarding the 2008 legislative mandate to the Department to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities, to develop recommendations on how to best meet the acute mental health needs of children, adolescents, and adults; and an examination of current and future workforce issues. She noted that a 17 member steering committee representing key stakeholder organizations provided oversight and direction to three subcommittees, comprised of steering committee members and other stakeholder representatives, who in turn looked at those issues and made recommendations to the full steering committee. Sharon shared that the work force subgroup surveyed psychiatrists across the state and, not surprisingly found that it takes about a year to recruit psychiatrists and advanced practice psychiatric nurses. Sharon also noted that the survey found that although there are enough inpatient beds within the state; a number of front door/back door issues were identified – that is, people who were no longer in need of acute inpatient services but were still in the hospital due to a lack of, or the right level of, available support services in the community. She shared that Minnesota appears to have developed an 8 a.m. to 4:30 p.m. Monday-Friday system of care and noted that unfortunately individuals in mental health crisis don't always fit into that system of care. She did acknowledge that with the movement to a more enhanced system of community based care; including crisis services, ACT teams, and IRTS, this is starting to be addressed. She also addressed the category of individuals who are in need of a different level of services due to their complex medical conditions and/or aggressive behavior and noted the need for an integrated mental health/substance abuse treatment program for dually diagnosed individuals.

Sharon briefly addressed the key recommendations of the report's Adult Subcommittee which included recommendations to design a chronic care model of treatment and support, to address the need for the development of a common set of protocols, standard intake forms, and to improve access to the full array of mental health services, especially during non-business hours, weekends, and holidays.

Before turning the meeting back to Charlie Cook, Sharon called attention to the handout that was distributed which identified the unmet needs submitted by Region 2.

Charlie Cook then instructed the participants to break into groups of 8-10 to address the 3 questions on the agenda for today's meeting. He asked that participants think strategically, be innovative and creative. He also cautioned that any budget pressures facing us today are from

last year's budget shortfall and cautioned that we are not yet addressing anything that may come out of the coming budget forecast or the 2010 Legislative Session.
After responding to the questions in the break-out sessions, the groups were asked to "report out" by group. The theme responses identified in the "report out" are identified in **bold type.**

Group 1:
Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **More public awareness of services available** and how to access them
- Psychiatric services; especially outpatient, "after care," partnering with local providers – i.e., Mental Health Courts similar to DWI Courts
- APRN's – partnering with local providers; especially public non-profits
- Partnering with local providers – integrate
- **Simplify centralized admission process** – regional decision making
- SOS meets with Indian Health Services, tribal MH providers, and community providers
- Refer directly to CBHH; if medical needs, then refer to Emergency Departments -- **access common medical needs at CBHH level**
- Expand CBHHs to house juveniles; **coordinate staff – share staff across adult/adolescent systems -- costly to transport juveniles**

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Not direct community service – **too institutionally focused**
- Don't go away!
- Don't use utilization data as survey/decision making – **should not drive the decisions**

Question #3 – How do we create a system of public/private partnerships?

- **Work with local providers,** others to establish triage at jail – pre-release program; establish plan for needs prior to discharge/release
- Assure timely and consistent communication with community providers/county agencies – **Extended care planning**
- Redefine safety net on a regional basis to be sensitive to changing needs/service design – safety net is not State.
- Better understanding of local/regional partnerships – keep communication open.

Group 2:
Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Forensic piece – very violent acting out behavior – **don't forget the forensic piece**
- **CBHH is valued in Bemidji** – remain here!
- Referral patterns got established by CPA early referral actions **– patterns established early, not changed**
- **Services close to home** – not North Dakota
- Why cannot CBHH do outpatient clinic at the CBHH – independently or in collaboration with other health providers? **CBHH provide inpatient & outpatient services**
- Can you staff it to serve adolescents/kids?
- Transportation is an issue for all counties!
- Transportation – who is truly "legally responsible" (and manage the risk)

- Could SOS augment or staff transportation?
- Could we incent others to be in the transportation business? (Besides law enforcement)
- There are private units that service adults and adolescents – why not SOS

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Do not close CBHH!
- Do not pull adult mental health dollars
- Need flexibility in "rules"
- Focus rules on outcomes – not "process" **More flexibility**

Question #3 – How do we create a system of public/private partnerships?

- Staff collaboration/agency collaboration on staffing/recruitment issues!
- Collaborative high end professionals. **Develop collaboration among professionals – public and private**
- What can we do different?
- Collaborative tele-health in assorted area
- How can we collaborate on transitional housing?
- Statewide system of various residential openings across the state – like bed tracker! **Collaboration on transitional housing.**
- Collaboration around dual diagnosis – hard to coordinate right now between private and public.
- Move to **certification of Bemidji CBHH – dollars back to state!**

Group 3

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **Look at efficiency of each CBHH – what is working? What isn't?**
- **Balance out the funding formula** to take into account demographics – there will always be a bias otherwise
- Create an option to assist in evaluating, assessing, holding adolescents
- **Rededicate beds to adolescents – Look at what's best for our kids.**
- Look at statistics in a different way – what does it really tell us?
- Help "**beef up" outpatient access to psychiatric/psychological services – currently take 3-4 months once back in the community.**
- Establish case management when person is discharged from the CBHH. **(chronic cases)**
- Put time/energy into understanding greater Minnesota issues
- Help with access to inpatient services
- Transportation system support (and financial support)
- Co-morbidity issues
- Chronic alcoholic housing
- Transportation access
- Access 3rd party payment support
- Have after care and case management as part of the process
- Give referral source feedback – clarify under HIPAA rules. **HIPAA sometimes a barrier to transition to local services**

- **Help in recruiting psychiatrists**; **mental health professionals; build telemedicine resources** – Bemidji has a physician access problem

Question #2 – What do you need SOS not to do in this region?

- Back off on red tape for ARMHs = barrier
- **ER physicals --** Evaluate need for **"another"** EKG, check of aspirin/Tylenol levels on individual basis – discuss with the physician before mandating it. **Patient may have been in ER 2 weeks ago.**
- Don't define local needs – listen

Question #3 – How do we create a system of public/private partnerships?

- Have forum where CBHH meets with stakeholders/providers to discuss system – evaluate – make changes. **Shared care model – utilize local primary care**
- Utilize model that includes government, primary care, mental health providers
- Fund more early prevention
- Create more opportunities for people in the community to talk about these issues -- **listen to stakeholders/communities**

Group 4

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Children's facility – presently Duluth, Fargo, Grand Forks – services appropriate to level of care – **Need adolescent facility**
- Discharge plans – uniform/consistent! **Patient returns home with very little information**
- Simplify admission process to CBHH – easier to use private now!
- Use empty CBHH beds for kids
    - TBI services
    - FAS/FAE
- Prescribe meds that IHS supports to prevent readmission – **meds that fit the HIS formulary**
- Give private sector room to invent/create needed services
- Provide incentives for new mental health professionals

Question #2 – What do you need SOS not to do in this region?

- Don't close Bemidji CBHH!

Question #3 – How do we create a system of public/private partnerships?

- Partnerships with IHS and tribes
- Use telemedicine more
- Private entities; **work more with private providers**
- TBI providers
- **Talk to consumers and peers**

Group 5

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Communication between SOS services, local providers re: providers/services in area; **increase communication between SOS and providers**
- Streamline admissions to the CBHH
- Develop effective, timely hand-off to next provider (or old one); also include old providers during inpatient phase
- **Include (collaborate with) client's community provider while client is in inpatient**; include community provider in patient discharge meetings
- Sub-divide levels of care to acute/non-acute
- Increase range and timeliness of evaluations – (neuro-psych, CD, behavioral)
- (Have options to) extend crisis length of stay (LOS) as needed to increase stabilization; Establish chronic/acute adolescent crisis beds (short-term) to maximize transportation arrangements
- Evaluate potential for readmission, provide information regarding rapid readmit as needed **-- identify barriers early on; streamline readmission process.**
- CBHH **tele-psychiatry** with community providers regarding shared clients
- Solution for adult/adolescent transport needs

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't discharge patient without consult and follow-up with community provider
    - Provide immediate discharge summary
    - Detailed aftercare plans

Question #3 – How do we create a system of public/private partnerships?

- Increase long-term supports (and training) for client supports (family, follow-along) – **make it easier to access flex funding.**
- Make financial/jurisdictional boundaries more flexible regarding mental health treatment

In concluding the meeting Charlie thanked the audience for their participation and again shared that a copy of the report from this meeting will be forwarded to the AMHI coordinator. The information gathered in today's meeting will be incorporated into the overall report to the 2010 Legislature and will also be made available to participants in these regional meetings. He stressed that the CMHS Administration wants to establish on-going communication – so if there is a meeting that someone from the State should participate in, he asked that that information be brought to his attention.

SOS Redesign Stakeholder Meeting
Region 5+ -- Brainerd, Minnesota
February 2, 2010

Participants: 50

Emily Steinert, Todd County Social Services, introduced Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration. Charlie thanked the participants for allowing staff of the Department to be at their meeting today and for their participation in today's discussion. He requested a show of hands for each county in the region and noted he was pleased with the turnout and was looking forward to a good discussion. Charlie then introduced Dr. Read Sulik, Assistant Commissioner for CMHS, and briefly spoke to a survey commissioned by Dr. Sulik to be conducted by the Minnesota Council for Quality throughout CMHS. Charlie shared that staff from CMHS are attending meetings such as this one across the State with the expressed purpose of obtaining input into the continuing redesign of the services provided by State Operated Services (SOS), services that address efficiency, quality and partnership.

Charlie then referenced the packet of handouts for today's meeting and called attention to the last page which addresses Dr. Sulik's "7 Goals for Achieving Excellence" for the CMHS Administration. These goals are:

- Eradicate the stigma, misunderstanding and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and addictions.

Charlie noted that although today's meeting will be focused on SOS, the CMHS Administration will host a larger "visioning process" to be held later this spring, early summer, to look at all the services provided by the four divisions of the Administration (Alcohol and Drug Abuse, Adult Mental Health, Children's Mental Health, and State Operated Services) and noted that information about that process will be shared later this year.

Charlie informed the participants that later in the meeting they would be asked to break into smaller workgroups to address the 3 questions on today's agenda. He briefly spoke to the $15M shortfall in SOS's funding for the current biennium but clarified that that shortfall is not driving today's discussion – he acknowledged it needs to be addressed -- but is not the focus of today's

discussions. Charlie also informed the group that the rumors that decisions have already been made and meetings such as this one are just "window dressing" are not true. He reiterated that CMHS is holding 14 meetings across the State to actively seek input into this process. Charlie informed the audience that the State employees in the room today are here to listen only – they are available to answer questions but are not to interject themselves into the discussion. He then introduced Mike Tessneer, CEO of State Operated Services.

Mike too thanked the participants for their attendance at today's meeting and directed them to the packet of handouts that were distributed for discussion during the meeting. He directed their attention to the sheet which reflected patient criteria data and called specific attention to the number of patients who were in an SOS inpatient acute care hospital bed (either a CBHH or AMRTC) who did not meet criteria for continued hospital level stay. He acknowledged that, although these individuals may still be in need of services, they no longer met criteria for inpatient hospital level of care. He shared that these are resources and dollars that could be utilized elsewhere in the continuum of care to more appropriately address the mental health needs of our clients.

Mike then referenced the fiscal year to date utilization data of the CBHHs and the LOCUS status of the patients within our inpatient hospital beds. In response to a question from the audience regarding the data, Mike noted that the data has remained consistent over the past 2 years; and spoke to the array of potential services that could be developed to support clients in the community to help prevent admission to the hospital and/or support them once they have returned to the community. He again reiterated that no decisions have been made, but shared that SOS leadership has given thought to potential services and partnerships that could be developed to support these services. Mike then briefly addressed contributing factors to the $15M budget shortfall for the current biennium; (i.e., administrative budget cuts, unallotment, unfunded COLA, unreimbursed dental services, maintenance of the Brainerd campus, etc.) and stressed that our intent is not to change the quality of services provided, but to achieve savings through efficiencies across our system to better meet the needs of our clients. Mike then introduced Sharon Autio, Director of the Adult Mental Health Division.

Sharon acknowledged that the turn out for today's meeting was one of the highest attended meetings to date and thanked the audience for their willingness to offer their input into this process. She called attention to the March 2009 legislative report handout entitled "Mental Health Acute Care Needs Report" and gave background regarding the 2008 legislative mandate to the Department to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities, to develop recommendations on how to best meet the acute mental health needs of children, adolescents, and adults; and an examination of current and future workforce issues. She spoke to the formation of a 17 member steering committee representing key stakeholder organizations, which in turn provided oversight and direction to three subcommittees. The three subcommittees, comprised of steering committee members and other stakeholder representatives, looked at the identified issues above and made recommendations to the full steering committee.

Sharon briefly addressed the findings of the three subcommittees, including the one addressing work force issues and noted that the workforce subcommittee found that it took about a year to

recruit psychiatrists, advanced practice registered nurses and licensed social workers skilled in the area of mental health. She noted that more recent data she has seen also suggests a shortage of licensed social workers throughout the State.

Sharon then called attention to the last two pages of the report summary, the Adult Subcommittee Report Key Highlights. The report found that although there was not a shortage of inpatient care beds, there were pressures on the system in the area of front/back door issues. Contributing to back door pressures is the shortage of services for individuals with complex health care needs, people with impulse control or challenging behaviors who are consistently identified as having a lack of services. She addressed the need for a long-term care chronic care model and noted that Minnesota has developed a mental health system that operates an 8 a.m. to 4:30 p.m. Monday through Friday system of care that, unfortunately directs people to access their ER after 4:30 p.m. on Fridays. Sharon gave the example of tracking available inpatient mental health beds for a 3-month period and noted that beds are usually available in the system from Tuesday through Friday morning but then sharply decreased through the afternoon and weekend and noted that by Monday morning there is not a bed available in the system. She also noted that another critical piece identified in the recommendations was the lack of consistent treatment plans, coordinated discharge planning, and engagement of family members and consumers in the discharge process. Sharon then distributed a handout which summarized the "unmet needs" from Region 5's 2010-2011 AMHI Applications and noted that this was one of the regions that not only identified unmet needs, but addressed how the region is trying to address those needs.

Sharon then turned the meeting back to Charlie Cook who asked the participants to break into 5-6 small workgroups and to respond to the 3 questions that were on today's meeting agenda. He asked that participants think strategically, be innovative and creative and cautioned that any budget pressures facing us today are from last year's budget shortfall and noted that we are not yet addressing anything that may come out of the coming budget forecast or actions of the 2010 Legislature.

After responding to the questions in the break-out session, Charlie called the meeting back to order and asked Tom Ruter, CMHS Stakeholder Liaison, to coordinate the group report out.

Group #1
Question #1 -- What do you need SOS to do this in this region?

- Continue what you are currently doing (i.e., CBHH)
- Need "sub-acute" and acute resource for aggressive, medically fragile, incarcerated (higher care than IRTs, but step down from hospital)
- Space when crisis beds full – don't need hospital, but more support than staying home – short term foster care? Respite care?
- Better discharge planning
    - Understanding discharge process
    - Coordinating resources
    - Seems to happen immediately
- Better advertising about what services are available
    - Public services announcements

- Support services for parents coping with children with mental health issues
- Don't close hospitals – use half as sub-acute care
- Re-examine admission process – so many not admitted; where do they go?
- Address full spectrum of needs
- Define what is acute vs. Subacute
- Make sure meds are where they need to be before coming home
- Better collaboration post hospitalization
- Keep admission process local but with access to statewide resources.

Question #2 -- What do you need SOS not to do in this region?

- Don't have one statewide crisis line
- Don't duplicate what we can do in the community.

Question #3 -- How do we create a system of public/private partnerships?

There were no responses to this question.

Group 2

Question #1 -- What do you need SOS to do in this region?

- Continuity of care between providers, hospital (CBHH)
- Better communication with all stakeholders involved in person's care
- More secure residential program to deal with elopement, etc.
- Communication between CBHH psychiatrist and community psychiatrist -- **medical changes not communicated well**

Question #2 -- What do you need SOS not to do in this region?

- Do not need more group homes that are State run in this region. Need to utilize what we have.

Question #3 -- How do we create a system of public/private partnerships?

- Invite private sector to meetings to find out what they have to offer.
- Building relationships with private sector.
- Private sector to invite State to see what they have to offer
- Trainings and in-services

Group 3

Question #1 -- What do you need SOS to do in this region?

- Rapid access to psychiatry and nursing within 72-hours
- Television/Internet connection for services – coordinate
- Better access to crisis/respite
- Assist with transitional services
    - Residence – step down option
- Communication between inpatient and outpatient providers
- Transportation
- Keeper of information of resources, expertise

Question #2 -- What do you need SOS not to do in this region?

- No longer duplicate services
- No discharge/services contact with community provider
- Remove disincentive for communication

Question #3 -- How do we create a system of public/private partnerships?

- How do keep them out of SOS
- Incentive to communicate
- Follow-up/prevention 2+ years – tracking what contributes to independent living and relapse

Group 4

Question #1 -- What do you need SOS to do in this region?

- Safety net services
    - Expand for consultation to assist county to find appropriate placement/service options when CBHH admission is denied.
    - Provide more options for complex needs across the State
    - Partner with private hospitals for specialty care issues (i.e., high medical needs and MI)
    - Streamline intake process and be flexible to allow local CBHH to direct admits
- Sub-acute care resource
- Local acute care resource to keep local agency connections for discharge
- Communicate with State court system for commitment issues
- Resolve patient transportation issues within the mental health system, not law enforcement role

Question #2 -- What do you need SOS not to do in this region?

- Not reduce service options in rural/out-state Minnesota

Question #3 -- How do we create a system of public/private partnerships?

- Partner with private hospitals for specialty care issues
- Include private industry services in the expanded central intake role to assist in placement needs for holds and commitments
- Community education
- Develop better partnerships at DHS between divisions (mental health, chemical dependency, developmental disabilities, corrections, courts).

Group 5

Question #1 -- What do you need SOS to do in this region?

- Provide a safety net.
    - Not based solely on diagnosis
    - What to do with people that fall between the cracks
        - aggressive, predatory behaviors (who has the capability to take them?),
        - long term needs

- State workers that inform counties/communication
- Quicker admission procedures
    - Long wait in ER
    - Screening tool for hard to take people
- Serve as a conduit for "best practices"
- Rethink regions as hospitals change
- Need integrated facilities for MI/CD dual diagnosis
    - Dual diagnosis treatment facility
    - Reimbursement issues (MI/CD, physical issues, aging
- Figure out how to get out of the way
    - Admission taking 4-6 hours – be more local
    - Too many people to go through

Question #2 -- What do you need SOS not to do in this region?

- Don't increase paperwork
- Don't directly compete or duplicate what the private sector provides
- No exclusionary admission policies

Question #3 -- How do we create a system of public/private partnerships?

- See previous.

Group 6

Question #1 -- What do you need SOS to do in this region?

- Remain the "safety net"
- Get CBHH-Baxter certified
- Develop a Subacute care unit
- Serve "local" needs (Region V+)
- Options developed for geriatric behavior dis-control (dementia as well as SPMI)
- Ongoing discussion of "safety net" – what does it look like over time?
    - i.e., geriatric, predators, medically fragile, TBI, MI and aggressive
- Staffing pool to support staff in SNF or other settings rather than moving patient/client
- Continue to partner so that community-based services will further develop
- Utilize and promote peer support (i.e., discharge plans, wrap, etc.)
- Abandon CPA, customizing for each region, including transportation, appropriateness screening, etc.

Question #2 -- What do you need SOS not to do in this region?

- Design services in way that perpetuate failed model/safety net
- Develop long term Rule 36s
- Provide services that are now available through non-state providers (don't compete)
- Wait so long before asking for our opinions
- Abandon children and adolescents with mental illness, behavioral problems, etc.
- Enterprise operations that self-perpetuate
- Build services only to capture Medicaid revenue stream

Question #3 -- How do we create a system of public/private partnerships?

No responses to this question.

Tom Ruter concluded the meeting by again thanking everyone for their participation in today's meeting. He reiterated that the information gathered in today's meeting will be compiled into a report that will be forwarded to the AMHI coordinator. That information, along with information gathered from meetings like this across the State, will be incorporated into the legislative report to be submitted to the 2010 Legislature at the end of the month.

SOS Redesign Stakeholder Meeting
Region -- Mankato, Minnesota
February 4, 2010

Participants: 75

Charlie Cook, Chief Administrative Officer for the Department's Chemical and Mental Health Services Administration, welcomed the participants to today's meeting and thanked them for taking time to respond to our request for input into the redesign of the Administration's State Operated Services.

Charlie referenced the packet of handouts for today's meeting and called attention to the last page which addresses Dr. Read Sulik's "7 Goals for Achieving Excellence" for the CMHS Administration. These goals are:

- Eradicate the stigma, misunderstanding and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and addictions.

Charlie shared with the participants that workgroups of CMHS Administration employees have been formed around these 7 goals and noted that members of those workgroups may also be seeking input from our stakeholders as they explore implementation of strategies to address these goals. He briefly addressed Dr. Sulik's goal of a system of quality, efficiencies and partnerships to better meet the needs of the individuals we serve; and, with this goal in mind, Charlie shared that Dr. Sulik recently commissioned the Minnesota Council for Quality, an organization that uses the Malcolm Baldridge measures of organizational leadership and quality, to engage in a survey of the CMHS Administration.

Charlie opened the business part of today's meeting by briefly addressed the $15M shortfall in the current biennium for State Operated Services and noted that, although that is not the focus of today's meeting, it does lend itself as a catalyst to find efficiencies within our system. He then introduced Mike Tessneer, CEO of State Operated Services.

Mike too thanked the participants for their attendance at today's meeting and shared that the drive to redesign SOS is similar to any other health care organization that looks at the provision of their services to determine if they are meeting their needs and what if anything needs to be

changed to better meet those needs. Mike referenced the data shared in the handouts for today's meeting regarding utilization of the Community Behavioral Health Hospitals (CBHHs) and noted that average length of stay within the CBHH system has dramatically shortened the inpatient phase of treatment; i.e., 18-20 days on average, which translates to more individuals receiving services in the acute inpatient hospital level of care then formerly served in the State's regional treatment centers. He noted that the enhanced array of community based support services (i.e., crisis services, ACT Teams, IRTS, etc.) that have developed have also greatly contributed to the shorter stays in inpatient hospital care. He referenced the handout that shows criteria for continued inpatient hospital stay which gives a one-day "snap shot" of the individuals in the hospital on any given day and their need for acute inpatient hospital level of care. He noted that SOS data shows that roughly 50% of the individuals in our hospitals no longer meet continued stay criteria; however remain in a hospital bed because they need a level of care that is not readily available to them in the community. He noted that this translates into resources and dollars that could be utilized elsewhere in the continuum of care for mental health services.

Mike also spoke to and explained the current LOCUS status for the CBHHs and addressed FY 08-09 data that gives information about admissions, discharges, average length of stays, and current census for each of the CBHHs within the SOS system. He stressed again that the redesign is not about saving money, but about continuing to create a system of care that best meets the needs of the individuals we serve. He noted that SOS will move to a more efficient system of care; and through those efficiencies will save money, but stressed that becoming more efficient and allowing for the development of the right level of care at the right time is far more critical to meeting the needs of our patients.

Mike then introduced Tom Ruter, CMHS Stakeholder Liaison, and shared that, in the absence of Sharon Autio, Director of the Adult Mental Health Division, Tom would be presenting Sharon's agenda item. Tom referred the audience to the handout entitled "Mental Health Acute Care Needs Report" and provided a brief background of the mandate of the 2008 Legislature gave to the Department to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities, to develop recommendations on how to best meet the acute mental health needs of children, adolescents, and adults; and an examination of current and future workforce issues. He spoke to the formation of a 17 member steering committee representing key stakeholder organizations, which in turn provided oversight and direction to three subcommittees. The three subcommittees, comprised of steering committee members and other stakeholder representatives, looked at the identified issues above and made recommendations to the full steering committee. Tom briefly addressed the findings of the three subcommittees, including the one addressing work force issues and noted that the workforce subcommittee found that it took about a year to recruit psychiatrists, advanced practice registered nurses and licensed social workers skilled in the area of mental health. He called attention to the last two pages of the report summary which spoke to the need for a long-term care chronic care model and noted that Sharon likes to note that Minnesota has developed a mental health system that operates an 8 a.m. to 4:30 p.m. Monday through Friday system of care that, unfortunately directs people to access their ER after 4:30 p.m. on Fridays. He referenced an example that Sharon gives in which she notes that a 3-month review of the inpatient bed tracking system showed that beds are usually available in the system from Tuesday through Friday morning but then sharply decrease through the afternoon and weekend and by Monday morning

there is not a bed available in the system. Tom shared that another critical piece identified in the recommendations was the lack of consistent treatment plans, coordinated discharge planning, and engagement of family members and consumers in the discharge process. Tom then distributed a handout from Region 15's 2010-2011 AMHI Applications which identified unmet needs as well as identified existing services and plans to address those unmet needs.

Tom then turned the meeting back to Charlie Cook, who instructed the participants to break into 6-7 smaller groups and, for the next 40-45 minutes, address the 3 questions listed on the agenda for today's meeting (i.e., What do you need SOS to do in this region? What do you need SOS not to do in this region? And, how do we create a system of public/private partnerships?). In responding to the questions, he asked that the participants think strategically, be innovative and creative and noted that before concluding the meeting, there would be a brief "report out" from the work groups.

After responding to the questions in the break-out session, the groups were asked to report back to the whole group. Specific comments from "report out" are identified in **bold type** below**.** Charlie noted that all their responses would be shared with them in a report of today's meeting and that report would be incorporated into a larger report to be submitted to the Legislature at the end of the month. He also encouraged anyone with additional ideas after today's meeting to feel free to contact him.

Group 1:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **Define: Where is/who does safety net into the future?**
- **Define: What labor force is needed given this shift?**
- Need to: Integrate inpatient and community-based care (admission, treatment planning and discharge)
- Better hand-offs – transitional care – **discharge planning, better role definition and more client centered**
- Need more discussion on efficacy of crisis center
- Revenue max – billing
- Gaps analysis document – specialized populations – **a lot of work went into this document.**
- Dialog about utility/quality of life with club houses

Question #2 – What do you need SOS not to do in this region?

- Don't abandon role of safety net **– without clarity**
- Don't dismantle infrastructure – AMHI
- Don't let quality suffer – **economy may affect quality; local level is struggling as well**
- Don't assume community-based system will continue "as is." **-- economy may have affect on that due to budget pressures**
- No Band-Aid – consider ripple effects

Question #3 – How do we create a system of public/private partnerships?

- Could SOS help with training in key areas of need (MH training for General Practitioners or Family Practice Doctors) **– facilitation through the state to expand doc time beyond psychiatric**
- Cross-training; shared staffing models; private/public
- Consider real cost vs. business cost (to clients) for policy and procedure issues.

Group 2:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Address issues of persons with mental illness who are incarcerated **– develop models of care for clients in jails**
- Issues around homelessness and lack of appropriate and affordable housing – **significant MI and CD issues contribute to homelessness**
- Flexibility of inpatient stays for people who do not respond to medications – i.e., longer stay until stable **– LOCUS shouldn't be only measure; case manager should be allowed to do good discharge planning.**
- Lack of psychiatrists and prescribers **– training for family physicians; majority of prescribing is through family medicine.**
- Development and adequate funding/resources for partial hospitalization and day treatment **– partial hospitalization may address readmissions**
- Private acute hospitalist need CBHH to take individuals after initial commitment hearing **– address long stays (ISJ) of individuals awaiting second hearing in commitment process**
- All funding for sex offenders should be responsibility of corrections – we compete for limited dollars.
- More long term residential housing care for individuals who need that care; i.e., LOCUS IV and V
- Consider other criteria than LOCUS to make decisions about CBHH continuing care – discharge planning doesn't happen or is not timely/adequate to meet quality of care for patient
- Provide training for staff to develop <u>individualized</u> treatment
- Assist in recruitment to fully staff CBHH so we can utilize 16-beds instead of 8
- Ability to serve level 4 and 5 in CBHH – amend/change licensing rules
- Make the admission process for CBHH easier – i.e., allow local decision making

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Reduce our State staffing funds
- Reduce our initiative grant
- <u>Only</u> use the LOCUS as determination for hospital care

Question #3 – How do we create a system of public/private partnerships?

- <u>Funding</u> allows the planning and development of integrated services as we have a well developed Initiative with many partners coming to the table **– adequate funding makes change happen**
- More meetings; i.e., focus groups to discuss and understand issues to develop solutions
- NAMI Chapter is looking at working with pastors; education on MI

- DHS and SOS to be willing to listen to and see differences in outstate needs versus metro area
- Hold educational forums/focus groups to learn more about services to help match needs with agency that can provide it
- Discussion between crisis center and ISJ to reduce dependence on hospital care
- More integrated services – with law enforcement, mental health providers
- Better communication and effective service delivery with DHS and PMAP plans

Group 3:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- (Admission resistance) – Adjust admission criteria to meet needs **– too many hoops**
- Sub-acute interventions
- Preventative/proactive measures
- Resource (staff) availability in acute crisis (hospitals, CBHH)
- Expedited response
- Law enforcement training in mental health
- 24/7 crisis response team
- Transportation
- Realistic discharge criteria from CBHH
- Long term and transitional housing
- Funding for Board & Lodge licenses
- Discharge planning
    - Earlier in process
    - Inclusivity
- Hospital/CBHH vacancies **--acute and sub-acute unit in same facility**
    - Acute vs. sub-acute

Question #2 – What do you need SOS <u>not</u> to do in this region?

- No duplication of services

Question #3 – How do we create a system of public/private partnerships?

- Creative transitional housing **– options with minimum staffing**
- Board & Lodge housing funding
- More streamlined services
- Stakeholder unification

Group 4:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Take patients from acute hospitals prior to the preliminary hearing when long-term care is needed
- Need care close to home for continuity of care (6 CBHHs in the north; 2 in the south)
- SOS centralized admission system is too cumbersome
- Consider CBHH and community hospitals as the same level of care; nurse-to-nurse reports – **originally nurse to nurse reports not wanted; now it is; community hospitals also providing acute care treatment.**

- Communication is lacking
- LOCUS – doesn't always identify patients readiness for discharge; doesn't account for stressors for patient at home (patients are being billed if LOCUS says discharge)
- All CBHHs need to be Joint Commission accredited
- Need greater stabilization at CBHH prior to discharge to community
- Increased need for long-term care (residential/treatment) medical/physical/mental health needs (housing with services) **– long term care for aging individuals with mental health issues (not 60+ but 45-50 years of age).**
- Need for transitional unit for hard-to-place individuals

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't' increase paperwork
- Don't give **<u>unfunded</u>** mandates
- Don't ignore feedback from case manager, families, providers, etc. when decisions are being made
- Don't cut community clubhouses or crisis center
- Don't pass costs onto others (county, patients, local hospitals)

Question #3 – How do we create a system of public/private partnerships?

- Incentives to those (counties) who provide evidence of community collaboration
- Keep patients close to home so partnerships can work **– can't do good discharge planning for clients from the metro**
- Networking improves collaborations **– and access to provide appropriate services --** NPs, CNS work at multiple sites can help provide needed services
- Constellation of needed services: employment, social support, providers, housing, places to volunteer, clubhouse, additional in-home services, transportation

Group 5:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Track number of people released from CBHH who end up in correctional system (Access jail data and MA)
- Speed up process/those who "wait" in local hospital etc, to get into a CBHH
- Consistent delivery of service within region and/or State
- Timeliness – challenges
- Look at transportation issues in best interest of patient, cost and timeliness
- Tiered level of care at CBHH – "reverse triage"; elderly care
- Eliminate centralized intake – let us talk with specific CBHH, etc.
- Improve discharge planning – communication **-- data practices is an issue**
- **(Provide)** Training to nursing homes and senior living
- Developmental delay, MI, sex offenders – what works? **There is a lack of available resources in the area of sex offenders**
- Supplant – if you utilize another profession to help out (transport) help fund replacement
- Improve billing function for CBHH, crisis center. Maximize billing opportunities – training

- Provide/set-up "bridging services" for continued psychiatric care **– state to provide financial incentives**

Question #2 – What do you need SOS not to do in this region?

- STOP saying NO. Help find solutions!
- Don't forget outstate Minnesota; don't rely on "one size fits all" metro model
- Don't duplicate services. Rely on existing services. Don't throw out what is already working
- Do not automatically send transients back to the county of commitment
- Don't talk about the Baldridge system without explaining it

Question #3 – How do we create a system of public/private partnerships?

- Some level of cross training
- Consistent legal advice
- Start conversation before the crisis arrives – pre-plan.
- Equal responsibility in desired outcome. Do not compete.
- Ongoing contractual relationship for consistent delivery of services. Stay within the area. Common/shared goals.
- State to provide financial incentive to engage private sector. Costs vs. profit; tax, loans, educational opportunities.

Group 6:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Maximize third party billing; all reimbursement
- Leadership of recruitment of brining in psychiatric work force; create incentives to maintain and increase work force **– not just psychiatrists**
- Partnership around integrating care (to break down silos)
- SOS maintain expertise in serving hard to serve clients. Help us fill the gap between the outlier individuals; i.e., step down program and long term arrangements
- A change or review re: medical clearance – at this time fragmented and inefficient

Question #2 – What do you need SOS not to do in this region?

- Don't dismantle the community services we have developed!
- Don't create more barriers/red tape. Extra administrative layers
- Don't loose sight of the initiative successes

Question #3 – How do we create a system of public/private partnerships?

- Model and build upon what we are going in the initiative **– we are providing good service**
- Honor the partnerships you have with the region.
- Technical assistance – meaningful and detailed data **– better communication -- i.e., discharge, where are they going? We can better respond if we know what leads to readmissions**.
- Training, education, communication with law enforcement, ERs, courts
- Encourage creative solutions **– don't stifle us.**

Group 7:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Need for intermediate **and long term** level of care
- LOCUS method/accuracy/use range? Use team involvement **– may be good tool but the way it is being used may not be in client's best interest; involve case manager**
- Need to continue supporting services already in place
- Look at regional plans; not statewide
- Address needs of "special populations" (LOCUS 6) MI/CD diagnoses, convert some CBHHs to "long-term" care similar to RTCs
- Need for integrated medical care
- Need to continue funding for crisis center services

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Keep programming in place (community based); i.e., flex funds, clubhouse, medication management, housing support **– don't take what's working away.**
- Look at individual regions – not "clumped" together **– emphasize creative planning and don't push something that's not appropriate to our region on us**
- Stop comparing methods to metro areas
- Do not want "mobile crisis" mandated – do not put mandates on things we may not need.

Question #3 – How do we create a system of public/private partnerships?

- Continue to support efforts with working with private/public agencies – we have good working relationships with public agencies and service providers.
- Central admission causes barriers between public/private sectors **– relationship hard to maintain because they don't know our clients**.

Tom Ruter concluded the meeting by again thanking everyone for their participation in today's meeting. He reiterated that the information gathered in today's meeting will be compiled into a report that will be forwarded to the AMHI coordinator. That information, along with information gathered from meetings like this across the State, will be incorporated into the report to be submitted to the 2010 Legislature at the end of the month.

In response to the expressed confusion regarding the "Baldridge process" during the report out session, Charlie Cook provided a brief explanation of the Baldridge Quality Award process before wrapping up the meeting. He encouraged interested participants to look at the Minnesota Council for Quality Website for additional information regarding this detailed process. He also shared that the leadership of the CMHS Administration will meet in a two-day session on February 22-23 to review all the input received during the meetings held across the state regarding the redesign of SOS services and briefly spoke to the "visioning session" that the CMHS Administration will be undertaking later this spring or early summer. He noted that many of the individuals participating in this meeting will be encouraged to participate in that process as well.

SOS Redesign Stakeholder Meeting
Region 4 (BCOW) – Fergus Falls, Minnesota
February 5, 2010

Participants: 48

Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, called the meeting to order. Charlie identified the divisions within the CMHS Administration (Alcohol and Drug Abuse, Adult Mental Health, Children's Mental Health, and State Operated Services) and shared that, with this meeting, and others like it being held around the State, CMHS is seeking input on quality, efficiencies and partnerships. He informed the audience that he wanted to dispel any rumors that the State has already made decisions and that meetings such as this are window dressing – he stressed that DHS is attending 14 meetings statewide and will be actively seeking input from each of the 16 Adult Mental Health Initiatives. He shared that a report of this meeting will be made available to the AMHI for distribution to the participants at today's meeting and the information gathered from this meeting, and others like it, will be compiled into a report to the Legislature that is due at the end of the month.

Charles informed the audience that Dr. Sulik has established "7 Goals for Achieving Excellence" for his administration. These goals are:

- Eradicate the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and additions.

Dr. Sulik's overarching goal is to apply these 7 goals to reduce disparities in access and outcomes for minorities and to engage staff and stakeholders in the process. Charlie informed the group that later this year, late spring or early summer, the CMHS Administration will embark on a larger "visioning process" that will look at all the services provided by the divisions within the administration and similar stakeholder meetings will be held to gather input on that visioning process. Charlie also informed the participants that, in line with his goal of a system of quality, efficiencies and partnership to better meet the needs of the individuals we serve, Dr. Sulik recently commissioned a survey of the CMHS Administration by the Minnesota Council for Quality. MCFQ surveyors recently completed individual interviews of approximately 250

employees of CMHS and will be preparing a report to be shared with leadership of the Administration.

Charlie informed the participants that later in today's meeting he will ask them to break into small groups to address the three questions on the agenda. He called for a show of hands of DHS staff at today's meeting and clarified that staff of the Department are here to listen only and will not be participating in the small group breakouts. They will be available to respond to questions but will not contribute to the discussion. He also addressed the fact that he is well aware that there are rumors that decisions have already been made but he wanted to assure the participants that is not true. We have some ideas regarding efficiencies that can be addressed, we know there are some things we cannot do; and we have some direction from the Legislature regarding the scope of things we can address, but the fact is we cannot do any of those things without input from the stakeholders in today's meeting.

Charlie then briefly addressed the budgetary issues facing the State, the Department and SOS. He noted that although it is not the driving force behind the redesign of SOS, SOS is facing a $15M budget shortfall during the current biennium, which ends on June 30, 2011. This needs to be addressed but it is SOS' goal to solve that without sacrificing the quality of the services provided or the effectiveness of those services. He then introduced Mike Tessneer, CEO of State Operated Services.

Mike welcomed the participants and called their attention to the packet of handouts that was shared with participants for today's discussion. He noted that he would be addressing the utilization data of the CBHHs, the budget challenges facing SOS, and reiterated it is his intent to seek creativity and innovation to develop services to better meet the individuals served by SOS through its statewide health care system.

Mike then briefly addressed the data that reflects the utilization of the CBHHs, and noted that during calendar year 2009 there were approximately 3,500 non acute care inpatient bed days in the CBHH system – which suggests that there is room for efficiencies within the system and the potential for additional resources for the development of different or more appropriate levels of service for individuals no longer in need of "acute" inpatient hospitalization.

Mike called attention to the LOCUS (Level of Care Utilization Scale) status data which measures the acuity level of a patient's mental illness and noted that a LOCUS score is assigned upon admission and administered every 6 days while the patient is in the hospital. He referenced the data that addresses total admissions, discharges, average length of stay, current census, average daily census, etc., and noted that our data tells us we are seeing approximately 3 times as many people as who were served in the old RTC system. The average length of stay is also much shorter and with improved accessibility of the CBHH hospitals, and shorter lengths of stay, clients are less likely to lose their community supports, housing, job, etc. He shared that the average daily census in the CBHH system has been running about 80 clients per day for the last year and acknowledged that capacity at any one of the CBHHs may be affected by acuity of the patients currently in the system and the availability of psychiatric coverage.

Mike shared that SOS has given some thought to the range and type of potential services that could be developed or enhanced to address the needs of the patients currently seen in the inpatient CBHH system. These potential services include an array of services such as outpatient clinics to follow the client once they leave the CBHH until they can see their community psychiatrists and reestablish that relationship, specialized residential services for those patients who have challenging behavioral issues and have "burned their bridges" in the community, and crisis stabilization to prevent re-hospitalization.

Mike then addressed the current $15M biennium budget shortfall facing SOS and noted there are a number of contributing factors to that shortfall; i.e., administrative cuts to the Department's operating budget, unallotment, unfunded dental clinic costs, unfunded cost of living increases for employees and continued maintenance of the SOS Brainerd campus. Mike concluded by saying that, like any other health care system, these need to be addressed and he is confident SOS will address them by the end of the biennium.

Mike then introduced Tom Ruter, CMHS Stakeholder Liaison, and shared that, in the absence of Sharon Autio, Director of the Adult Mental Health Division, Tom would be presenting Sharon's agenda item. Tom referred the audience to the handout entitled "Mental Health Acute Care Needs Report" and provided a brief background of the mandate the 2008 Legislature gave to the Department to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities, to develop recommendations on how to best meet the acute mental health needs of children, adolescents, and adults; and an examination of current and future workforce issues. He spoke to the formation of a 17 member steering committee representing key stakeholder organizations, which in turn provided oversight and direction to three subcommittees. The three subcommittees, comprised of steering committee members and other stakeholder representatives, looked at the identified issues above and made recommendations to the full steering committee. Tom briefly addressed the findings of the three subcommittees, including the one addressing work force issues and noted that the workforce subcommittee found that it takes about a year to recruit psychiatrists, advanced practice registered nurses and licensed social workers skilled in the area of mental health. He called attention to the last two pages of the report summary which spoke to the need for a long-term care chronic care model and noted that Sharon likes to note that Minnesota has developed a mental health system that operates an 8 a.m. to 4:30 p.m. Monday through Friday system of care that, unfortunately directs people to access their ER after 4:30 p.m. on Fridays. He referenced an example that Sharon gives in which she notes that a 3 month review of the inpatient bed tracking system shows that beds are usually available in the system from Tuesday through Friday morning but then sharply decrease through the afternoon and weekend and by Monday morning there is not a bed available in the system. Tom also shared that another critical piece identified in the recommendations was the lack of consistent treatment plans, coordinated discharge planning, and engagement of family members and consumers in the discharge process. Tom then distributed a handout which summarized Region 4's 2010-2011 AMHI Application which identified unmet needs and changes from the previous report.

Tom then turned the meeting back to Charlie Cook, who instructed the participants to break into 4-5 smaller groups and, for the next 40-45 minutes, address the 3 questions listed on the agenda for today's meeting (i.e., What do you need SOS to do in this region? What do you need SOS

not to do in this region? And, how do we create a system of public/private partnerships?). In responding to the questions, he asked that the participants think strategically, be innovative and creative and noted that before concluding the meeting, there would be a brief "report out" from the work groups.

After responding to the questions in the break-out session, the groups were asked to give a brief report back to the whole group. Specific comments from "report out" are identified in **bold type** below**.** Charlie noted that all their responses would be shared with them in a report of today's meeting and that report would be incorporated into a larger report to be submitted to the Legislature at the end of the month. He also encouraged anyone with additional ideas after today's meeting to feel free to contact him.

Group 1

Question #1: What do you need State Operated Services (SOS) to do in this region?

- **SOS staff in Initiative work (State staff to continue to play a roll in initiatives)**
- Need for MI&D – dangerously aggressive
- Need to be the safety net where no one else is.
- **Be the collaborative policy maker**
- **Centralized data base for a consumer's health record**
- **Electronic record linked to other mental health providers**
- **Crisis response to other residential providers – gap here**
- Knowledge of services available
- **Sharing in outpatient services – but don't duplicate**
- Call hospital directly for bed as opposed to Centralized Pre-Admission – could it be regional?
- Easier, quicker access
- Could we have mixed services in a CBHH?
- Can SOS facilities have step-down/step-up in one facility?
- **Step-up services for individuals with MI who are:**
    - **aggressive or**
    - **medically fragile**
    - **sex offenders/predators**
    - aging population
- Appropriately mix population, maybe collaborative
- Transportation/participate/incent other/collaborate

Question #2: What do you need SOS <u>not</u> to do in this region?

- **Do not compete with outpatient market**
- If state were to pilot a program – when well oiled, turn it over to local/regional – **provide seed money**
- Maybe step-down service belongs in non-profit
- Not be controlling
- No centralized pre-admission
- Put state money into region
- Facilitate into regional system

- **Do not replicate existing services**

Question #3: How do we create a system of public/private partnerships?

- **Collaborative "holistic" approach to care between providers. Example: MI/diabetes, medically fragile**
- **Collaborative recruitment**
- **Collaborative solution for MI, predatory, aging populations**
- Promote, lead, model in collaboration
- Promote communication of service/resources available to consumers and health care providers

Group #2:

Question #1: What do you need State Operated Services (SOS) to do in this region?

- **Continue to have SOS be "safety net" with easier access**
  - **Aggressive patients**
  - **Geriatric**
  - Adolescent services
- **People incarcerated should have accessible mental health needs met** – at least up to 3 month wait
- **Easier access to CBHHs**
  - **Too many players in the admission process**
  - **Centralized Pre-Admissions is a failed process**
- **Need more IRTs beds**
- Need more Subacute beds
- Need more crisis beds

Question #2: What do you need SOS <u>not</u> to do in this region?

- **Don't compete** – identify who is doing what *(Competing and duplicating services kills services)*

Question #3: How do we create a system of public/private partnerships?

- **Pilot project in this region to bypass Central Pre-Admission process (talk doctor to doctor)**
- **Shared care – collaborative partnerships**
- **Bridge/develop a partnership with state, county to develop plan to identify what actions state can take – *identify key players that could step up and collaborate and make decisions with us.***
- **Increase CSP and aftercare services (utilize vacant beds)**

Group 3

Question #1: What do you need State Operated Services (SOS) to do in this region?

- Keep in touch with other community services. **(Formal partnerships with community mental health centers, local hospitals, nursing facilities, etc.)**
- **Provide step-down services to the CBHH; i.e., transition housing, assisted living housing, outpatient psychiatric services**

- **Having CBHH staff involved more with the discharge planning.**
- More communication between mental health and chemical dependency services.
- **Each CBHH have their own qualified Rule 25 Assessor.**
- **Integrate dual diagnosis services at CBHH**
- Need to evaluate and offer transportation resources – very critical issue in many ways!!!!
- Need to train CBHH staff in acute care needs for the geriatric population
- Re-evaluate admission criteria for crisis situations, or with violent persons.
- Upon discharge from CBHH, provide adequate supply of medication until first psychiatric appointment (outpatient)

Question #2: What do you need SOS not to do in this region?

- **To not have CBHH staff put additional pressure on county case managers who are working to find a placement for their patient**
- Do not create barriers for admissions; i.e., voluntary admits

Question #3: How do we create a system of public/private partnerships?

- **Access of records between public and private providers for continuum of care (*Electronic Record)***
- **Foster existing partnerships**

Group 4

Question #1: What do you need State Operated Services (SOS) to do in this region?

- **Accept patients**
- Provide inpatient in a manner that addresses rural need; CBHH doesn't take people with some co-occurring medical issues.
- Address needs of people who have sexual acting out issues (broaden access, partner with community providers).
- Work with border states to make services accessible; i.e., North Dakota/Minnesota
- **Partner with private hospital to provide all services**
- Clarifying and agreeing on admission criteria
- Revisit criteria for health care clearance
- Improve communication/relationships with law enforcement
- **Don't assume that people who come in on a hold and soon go voluntary don't need higher level care**
- Don't assume numbers of people at LOCUS 5 are ready to go (wasteful use) – look beyond the numbers
- Lower high re-admission rate
- **Make it clear that voluntary admissions are okay – holds not required.**
- Family is important and part of care – keep people local

Question #2: What do you need SOS not to do in this region?

- Don't compete with outpatient services (partnering is okay)
- **Don't limit SOS expertise**
- **Don't specialize to the point that services for certain groups are available only at AMRTC**

- Don't try to force North Dakota facilities to provide care for people who should be in a CBHH
- **Don't ask if we have called another hospitals – the CBHH is the local hospital**

Question #3: How do we create a system of public/private partnerships?

- **Partner formally with local mental health centers on recruitment/sharing of staff**
- **Expand beyond mental health services; look at hospital, clinics, nursing homes, jails**
- Look at shared care partnership (MCARTT) **– (Sharing resources, including staff, to ensure continuity of care)**
- **Focus on whole person (employment, etc.**
- **Have floating staff**
- **Work hard to develop trust** with local law enforcement, private providers, etc. **(come to the table together)**
- **Involve private providers/others in treatment and discharge planning**
- **Educate local medical community about mental health**
- Have specialty consultation teams
- Improve reimbursement standards to value community/outpatient
- Include diagnosis of CD

Group 5

Question #1: What do you need State Operated Services (SOS) to do in this region?

- **Certified Rule 25 assessor at each CBHH (Integrate MI/CD services; C.A.R.E. facilities need more mental health staff training)**
- **Residential site to take clients not psych-acute but well enough to be independent but can't go to IRTs.**
- **CD services to be more integrated to mental health and vice versa**
- **County perspective: CBHH to help with discharge planning. Take more active role – want their recommendations, especially for clients unknown to county.**
- **Train CBHH staff to provide acute care for geriatric population**
- **Easier admission process (maintain importance of placement as close to home as possible)**
- Maintain/increase importance on home/geographic location for ease of family visits
- **Strive for resources (psychiatrist) so CBHH-Fergus Falls can be at full capacity**.
- LOCUS 4/5 range – need for residential setting – those especially with dual diagnosis and/or challenging behaviors.
- What aftercare is possible; especially for single parents?

Question #2: What do you need SOS <u>not</u> to do in this region?

- **Don't use all dollars for crisis – use for prevention with existing community resources**
- **Don't do outpatient – partner with existing resources. Communicate!**

Question #3: How do we create a system of public/private partnerships?

- Have some of it already with our initiative – foster existing partnerships. **(AMHI is good example)**

- Meeting such as this help "lift the veil." **(Share information about what's happening in the area.)**
- **Include consumers and families represented in focus/study groups** (*were these people represented on the steering committee for the March 2009 report?)*

Tom Ruter concluded the meeting by again sharing that the notes from this meeting will be shared with the AMHI and it, along with similar reports from around the State, will be incorporated into the report that will be submitted to the 2010 Legislature at the of the month.

Charlie Cook again thanked the participants for their input into this meeting and reminded them that it is Dr. Sulik's intent to hold "visioning summits," similar to these meetings, later this spring or early summer to address where the Chemical and Mental Health Services Administration will be in 2015; and, as many of the stakeholders at today's meeting will be invited to participate, he looked forward to see them again.

SOS Redesign Stakeholder Meeting
Region 4 South – Hoffman, Minnesota
January 12, 2009

Participants: 90

Introductions were made and the facilitator outlined the agenda for the meeting. Charlie Cook, Chief Administrative Officer for the Chemical and Mental Health Services (CMHS) Administration of the Department of Human Services, introduced himself, and noted that staff from the Department were scattered throughout the audience to "listen" to input. He gave an overview of CMHS for the audience. He noted that today's meeting is about quality, efficiency and partnership. He outlined the format for today's discussion, identified the budget pressure facing SOS during the current biennium, and clarified that no decisions or choices have been identified. He reiterated that it was at meetings such as this that CMHS and SOS are seeking input from consumers. He noted that today's discussion is not meant to solve unidentified future budget challenges.

Charlie introduced Mike Tessneer, Chief Executive Officer of State Operated Services. Mike presented utilization data from SOS, reviewed the $15M budget shortfall facing SOS in the current biennium, and addressed the need to identify efficiencies throughout SOS. Mike provided background on the utilization of the community behavioral health hospitals including average length of stay, and noted that although we are serving 50% more patients than served in the old regional treatment center model, SOS continues to face under utilization of the available inpatient bed capacity within the system. Mike informed the audience that this scenario presents an opportunity to change the way we provide services, or to change the services we provide, to better meet the needs of our clients. He addressed the LOCUS (Level of Care Utilization System) scale used and noted that approximately half the individuals currently served in our acute care hospitals do not need hospital level care, but instead need other levels of services that may or may not be available currently in the community.

Sharon Autio, Director of the Adult Mental Health Division within CMHS, was asked to address a question from the audience regarding private community hospital psychiatric unit census and an inquiry if DHS has a comparison of the census of private community hospitals' versus CBHHs. The audience member noted that in Region V (the neighboring region), private hospitals with psychiatric units are running full and yet there is a CBHH within the region that is experiencing under-utilization. Sharon addressed the question by sharing information regarding the Mental Health Division's utilization of statewide contract beds with community hospitals and explained that hospitals under contract with the Department receive an enhanced per diem for providing mental health services.

Sharon also thanked the group for allowing DHS to attend today's meeting; noting that historically this region of the State has a very high level of consumer involvement and a list of achievements that are not evident in other areas. Sharon called attention to the handouts and acknowledge the input provided by Region 4 South in the development of the Acute Care Needs Report as well as the Unmet Needs Report. She noted that one of the handouts identified a summary of the unmet needs from the 2010-2011 Adult Mental Health Initiative (AMHI)

applications submitted in October of 2009. Sharon provided background on the development of the Acute Care Needs Report for the State and shared that the need for additional acute care beds was not identified as a need but rather a way to move individuals through the system quicker. She also addressed the challenges facing greater Minnesota and highlighted work force issues as an identified barrier. Sharon then briefly address the 5 identified "unmet needs" for the region, including access to the right type and intensity of acute/intensive care, key areas to reduce unnecessary bed days in acute care, safe and affordable housing, information sharing and crisis stabilization bed availability within the county.

Charlie Cook gave instructions for the breakout sessions in which participants at today's meeting would be asked to address three questions (identified below) for the Department's State Operated Services. He strongly encouraged innovation and creativity from the participants and thanked them for their input. After responding to the questions, the groups were asked to identify their priorities and "report out" by table. The theme responses identified in the "report out" are identified in **bold type**:

Question #1: What do you believe State Operated Services (SOS) needs to do in this region?

- **Revamp or close Central Pre-Admissions. Continues to be a huge barrier to access!**
- Need long tem care
- 24-hour statutory crisis line
- **Provider evaluations done by neutral agency/group**
- Access for transportation
- Restore dollars to county grants
- Increase access to crisis and respite (specialize for parents with children)
- Certified peer specialist utilized in CBHHs – could also do the evaluations
- Outpatient psychiatric follow-up upon discharge from CBHH
- Lay-off staff when their program closes
- **More education for consumers when in the CBHH (i.e., medications, diagnosis, resources and referrals)**
- Standardize forms across providers (electronic data on key cards, care plans, medical history)
- Better and more timely access to care
- Local care (face-to-face) not through interactive TV
- **After hours care mostly evenings, holidays, weekends (*Peer Specialists*)**
- Education of community hospital medical personnel
- Does SOS manage peer specialist program? If so, can more people be trained for this? Better training for peer specialist. Where is there a peer support specialist?
- Better access to patient records so there isn't repetition in giving information
- **Seriously recruit more professionals *(psychiatrists, psychologists, etc.)***
- **Maintain role of safety net** – but redefine role (need to continue acute care in the region)
- **Better access to the CBHH system (easier, faster) (*Should require transport by law enforcement)***

- **Design system where State psychiatrists can partner/consult/train local physicians and the other private mental health professionals in the region. (*Don't compete for mental health professionals.)***
- **(*Make rules that allow for necessary flexibility.)* Make rules (Licensing) adjustable to meet Region 4 South's needs; for example, get rid of 5th bed variance for AFC, get rid of 90-day limit in IRTS**
- **Make medical records more accessible to medical and psychiatric facilities (i.e., intake should not take 2-hours and patient in crisis should not be expected to provide critical medical information; CBHH should have access to that information already). *Less paperwork, better access to records.***
- **Train CBHH employees to interact better with patients; to approach patients who look upset or who are isolating a lot.**
- **Cut admission process in half.**
- Continue CIT process
- Provide after hours services
- More crisis beds
- Funding to assist with security in hospital to free up local law enforcement
- Reduce liability
- Facility designed for faster release; law enforcement back to work (instead of hospital)
- **Re-evaluate criteria for length of stay and need for hospitalization**
- **More treatment oriented at CBHH**
- **Long term residential facility (*Residential services needed in this region)***
- **Something "in between" crisis and IRTS**
- Partial hospitalizations
- **More input from social workers and family members before discharge**
- Cold Spring: Specialized Care Facility step down, hard to serve
- Maintain existing hospitals – with step down and long term care
- Re-evaluate admission criteria for co-existing conditions such as CD, physical disabilities
- Access to psychiatric treatment – **provide consultation to clinics and community providers.**
- More community resources
- **Services for people needing detox, elderly, higher behavioral issues, DD/MI aggressive, chronic users of the mental health system. (or medication resistant)**
- Safety net! Fergus Falls RTC would take all of the above populations before – need a service system to replace this.
- Use one of the sites as a detox center for people who have mental illness
- Develop sites for people with bizarre or aggressive behavior for a short-term, maybe long term placement
- Provide nursing services after hospital stay
- Longer hospital stays – listen to people who know them.
- **More local services; respite beds, more group homes, more psychiatrists**
- **Restructure CBHH into *(separate)* individual units to better utilize services; split between high level care to address people who are a threat to themselves or others/*longer term* transitional care to address people who are a threat to themselves or others.**

- **We need other options *(ICF and group homes)* besides CBHH for *(individual with)* high behavioral long term needs**
- **Keep a full-time psychiatrist at the CBHH who would do outside appointments.**
- Law enforcement – when we get patient to ER we cannot get into CBHH or next level of care.
- Beds have been available closer, but we are sent to a CBHH further away.
- Is there a way to do assessment in a timely fashion – safe – inpatient or residential – then determine disposition
- State might ok is the first step.
- **Once a determination is made (by law enforcement) they cannot be at home, we (law enforcement) should be done as far as making decisions.**
- We can see the need for medical clearance but when clear, process needs to move timely.
- Level of care is not a law enforcement decision – our role is transport to a safe, supervised place.
- More efficient staff at CBHHs, more interaction between staff, clients – less repeat documentation.
- Update information given to clients at CBHH – same information is reused, regardless of client's repeat history of being hospitalized.
- Less staff could be effective, if less paperwork was required. **Night staff has mostly "down time"** and receives huge salaries; one does documentation, one cleans briefly then has leisure time for rest of shift, remaining are highly paid "stand-by body guards!!"

Question #2:
What do you believe SOS should not do in this region?

- Central Pre-Admissions!!
- Build local community resources then bail out when dollars get tight
- Cost-shift to counties
- **Quit automatically reallocating State staff when programs/services close. *(Cold Spring)***
- Should not dismiss person's knowledge of their illness.
- Stop providing MSOCS care (this would free up funding for private AFC) ***(Don't complete with community providers.)***
- Don't compete for psychiatrists or mental health professionals but work together to meet the region's needs.
- **Do not lay-off the most experienced workers.**
- Local control for placement
- Impose DHS decisions
- Program takeover – lose identify and local knowledge/experience
- People are not getting their needs met while at the hospital – we don't want them to be shoved out the door.
- Protect State employees – lay off rather than save jobs
- Don't put up barriers to what the community says they need. ***(Give power to counties/consumers)***

- Evidence Based Practices (EBP) have not been established in rural areas – don't always work because limited resources (people) – MHW – mental health professionals, psychiatrists, psychologists
- Partners in medical stability assessment not always listened to. State should develop own medical stability assessment capability.
- **Don't cut finances for local services**
- ACT/Milestones/Private sectors takes care of the stable people – works well as it is.
- Close SOS' ICF homes/waivered homes to use the dollars for individuals with higher behavioral needs
- **Law enforcement – we should not be hearing the agencies saying "no."**
- **Should not override the ER doctor – they are with the consumer! (Takes time)**
- **Should not make us wait 2-3 hours!**
- Don't change financial compensation for case management and ARMHS – support staff is a MUST for ongoing recovery. ***(Don't cost shift to counties.)***

Question #3:
How do we create a system of public/private partnerships that best serves individuals and their families?

- **Consider differences between rural and metro – allow <u>local</u> control, development – give us the dollars**
- Listen to consumers!
- See consultation statement regarding psychiatrists in #1 (Design system where State psychiatrists can partner/consult/train local physicians and the other private mental health professionals in the region.) ***(Increase access to psychiatric services.)***
- Utilize some of the CBHH beds as either IRTS or longer term stay
- **If Region 4 South crisis beds are full, let us have access to an open CBHH bed.**
- Tiered system of care – acute, super IRTS, IRTS ILS, independent.
- Train local crisis intervention people (warm-line type) that would be available 24/7. Many times hospitalization and emergency room visits could be avoided if there was just someone to talk to during off-service hours.
- **Continued communication with consumers**; examples: LAC, Conversations
- **Listen to consumers on formal/informal usage of services**
- More local education to help develop partnerships
- Brainstorm on gaps in service coverage (disparity in coverage, services due to low income)
- Continue to work on effective communication.
- Consider RFP process rather than State provision
- Contracting for staff to purchase what you need
- Public/private partnerships – explore how we can do this.
- Develop a system of **better communication between CBHH, CM, community providers**
- Partner with community services to keep people in community after hospitalization or before (nursing)
- **Takes good communications;** create more contracts for CBHH (beds), more mental health support groups, **more communication between consumers and professionals. *(consumer education/support groups)***
- Coordinate/partner with Veterans Administration – funds/needs

- **Law Enforcement – Doctor to doctor consultation with ERs.**
- Increased access to outpatient – may decrease emergency calls.
- **Transportation assistance would be valuable.**

Addendum:
Received via e-mail after the meeting from an unidentified social worker in Douglas County:
Question #1 –
What do you believe State Operated Services (SOS) needs to do in this region?

- *(Services for) Aggressive/violent/"nearly MI&D" patients who cannot be served in small foster care settings and are repeatedly hospitalized or are in jail.*
- *Good quality residential programs that can address co-occurring mental health and chemical dependency treatment – long term.*
- *Access to psychiatric treatment/APRNs*

Question #3:
How do we create a system of public/private partnerships that best serves individuals and their families?

- *Douglas County has had some success in developing specialized foster care for persons who have complex health care needs and have serious and persistent mental illness. These are funded by CADI and sometimes TBI waivers; elderly waiver caps are a barrier to serving an MI patient in this kind of setting.*

Parking Lot:

- What is the step-by-step process for admitting?
- Utilize Cold Spring – i.e., specialized hospital for step down services, treatment of aggressive behaviors, long term care
- Re-evaluate admission criteria for individuals with co-occurring illnesses
- Develop partnerships with private providers – change restrictions to meet the needs rather than the provider having to meet the restrictions.

SOS Redesign Stakeholder Meeting
Region 1 – Thief River Falls, Minnesota
February 10, 2010

Participants: 30

Dave Anderson, Director of Roseau County and member of the Adult Mental Health Initiative for Region 1, introduced Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration. Dave briefed the participants on the purpose of today's meeting, which is to seek stakeholder input in the redesign of the Department's State Operated Services, and requested a brief introduction of the participants at today's meeting.

Charlie thanked the group for their attendance at today's meeting and noted that the CMHS Administration is comprised of four divisions; Alcohol and Drug Abuse Division, Adult Mental Health, Children's Mental Health and State Operated Services. He noted there are approximately 4600 employees within CMHS. Charlie also spoke to a number of quality initiatives currently underway within the CMHS Administration and called attention to the last sheet in the handouts which identified the "7 Goals for Achieving Excellence" that Dr. Read Sulik, Assistant Commissioner for CMHS, established for the administration when he came to the Department in the fall of 2008. These goals are:

- Eradicate the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and additions.

Dr. Sulik's overarching goal is to apply these 7 goals to reduce disparities in access and outcomes for minorities and to engage staff and stakeholders in the process. Charlie also shared that the CMHS Administration will undertake a "visioning process" later this spring or early summer regarding the programs and services administered by Chemical and Mental Health Services and Dr. Sulik will again be seeking input from stakeholders as he develops a vision for where CMHS will be in 2015. In the meantime, quality, efficiency, and partnership are three words that Charlie asked people to keep in mind during today's meeting.

Charlie then briefly spoke to the fiscal issues facing the Department and the mandate presented by the 2009 Legislature to redesign the inpatient mental health system at the Anoka-Metro

Regional Treatment Center (AMRTC) as well as State Operated Services' Minnesota Extended Treatment Options (METO) program in Cambridge.

Charlie addressed the fact that he is well aware that there are rumors that decisions have already been made by the Department and State Operated Services and that meetings such as this are just "window dressing." He clarified that no decisions have been made and that the Department is serious about seeking input from our stakeholders. He noted that, although there is a number of staff from the Department at today's meeting, they are here to listen and listen only. They are available to address questions but will not interject their opinions in the break out sessions that participants will be asked to form later in the day.

Charlie then introduced Mike Tessneer, CEO of State Operated Services. Mike informed that group that SOS has been very closely tracking utilization data of AMRTC and our CBHH hospital system since their inception and stressed that this information is telling us that we need to change the way we do business. He spoke to the average length of stay at the community behavioral health hospitals (CBHH) compared to the old regional treatment center model and noted that the CBHH hospitals are serving 3 times the number of clients served in the RTC system and patients are averaging much shorter lengths of stay. He acknowledged that he is aware of some of the issues regarding access to CBHHs in this region and noted that he will address that later, but first wanted to call attention to the handout that shows "criteria for continued stay" data for the SOS system. He noted that SOS data shows us that there were roughly 3500 hospital days where individuals in one of the CBHH beds did not meet acute care inpatient hospital criteria; that is, they were in need of a level of service other than inpatient hospitalization, but remained in an acute care bed. This data reflects an inappropriate use of resources that could be redirected to other more appropriate levels of care.

Mike then spoke to the utilization of the LOCUS tool that is administered to determine appropriate level of care and noted, that in general, patients at LOCUS 6, and some LOCUS 5s, are determined to be in need of acute inpatient level of care. The data shows us that, that on any given day, roughly 50% of the people in our hospitals need hospital level of care; and the rest could benefit from a different level of care. This could include an array of community support services (i.e., crisis beds, ACT, IRTS, outpatient clinics, etc.). Mike noted that both of these data sources tells us that we need to restructure the services we provide to more appropriately address the needs of the clients coming to us for services.

Mike also shared that, as Charlie mentioned earlier, later in this meeting participants will be asked to break into small workgroups to address the 3 questions that are listed on the agenda for today's meeting. The information gathered from that process will be compiled with information gathered from other meetings being held across the State and utilized to make decisions about the SOS redesign process. Mike shared that earlier today a meeting was held with the mental health center, the local hospital, and Region 1 county directors and at that meeting a decision was reached to meet on a monthly basis.

In response to a question from the audience regarding access to the CBHH, and if the CBHH is under utilized, why are callers told the CBHH is "full" or "can't take a referral" Mike clarified

that they may get this response if the acuity level of existing patients does not allow another admission or if there is not adequate psychiatric coverage to allow another admission.

Terry DeMars, Director, Northwest Medical Center-Mental Health Division, Merit Care, Thief River Falls, spoke to the desire in this region to partner and collaborate with the State and all other providers, both public and private, to provide the most appropriate level of services to the clients served and noted that, maybe unlike other areas of the State, this region is not concerned with the stated fears of "competition" among its providers.

Mike then introduced Sharon Autio, Director, Adult Mental Health Division, who referenced the handout entitled "Mental Health Acute Care Needs Report." Sharon informed the participants that this March 2009 report to the Legislature was mandated by the 2008 Legislature in response to a request from Prairie St. John to build additional inpatient hospital capacity in the metro area. The Legislature instructed the Department of Human Services to convene a workgroup of stakeholders from the child, adolescent and adult mental health systems and staff of the Department of Health's health economics program to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. The workgroup was also charged with developing recommendations on how to best meet the acute care needs of children, adolescents and adults as well as an examination of current and future workforce issues and recommendations to address any shortages. She noted that a "steering committee" of 17 individuals representing key stakeholder organizations was formed and in turn, provided oversight and direction to three subcommittees. The subcommittees – Adult, Child/Adolescent and Workforce – met monthly for four months and then prepared individual reports with recommendations for review by the Steering Committee. Of note was that, not surprisingly, the Workforce Subcommittee found that it takes about one year to recruit a psychiatrist or advance practice psychiatric nurse in the State; and this was true if you were in the Twin City area or greater Minnesota. She also noted that in looking at social workers licensed to work in behavioral health, 60-70% work in the metropolitan area which contributes to the shortage in greater Minnesota; especially rural areas.

Sharon then spoke specifically to the adult mental health section of the report and noted that what was found statewide is that there is no formula to determine how many in-patient acute care psychiatric beds are needed but one study shows that the issue was not the need for more beds but an access issue. It was a front door issue; i.e., people ending up at the ER and being admitted to the hospital. She addressed the Monday-Friday, 8 a.m. to 4:30 p.m., system of mental health care that has emerged in the State, and acknowledged that this region has done a number of creative things to address this particular issue. Sharon then spoke to back door issues; people no longer in need of inpatient hospital care but who are in need of a service not readily available in the community. She addressed the co-occurring needs of individuals with MI and CD issues, the individuals with a history of aggressive or violent behavior that community providers were reluctant to serve, and spoke to the need to identify ways to communicate better and to provide better hand-offs from provider to provider. She also noted there is a need to address the "new" people who are in crisis and entering the system, but are not previously known to the local county human service agency.

Sharon also called attention to the handout which the Northwest 8 AMHI submitted with their 2010-2011 AMHI application and noted that, not surprisingly, housing, transportation services, and psychiatric shortages were identified as needs in this area.

Sharon then turned the meeting back to Charlie Cook, who instructed the participants to break into 3-4 smaller groups to address the 3 questions on the agenda for today's meeting. He informed them that they would have about 40-45 minutes and asked that participants think strategically, be innovative and creative. He also cautioned that any budget pressures facing us today are from last year's budget shortfall and cautioned that we are not yet addressing anything that may come out of the coming budget forecast or the 2010 Legislative Session.

After responding to the questions in the break-out sessions, the groups were asked to "report out" by group. The information below is a list of items identified within the small workgroups and "themes" identified in the report-out are **bolded.**

Group 1:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **Simplify admission process**
- **Regionalize admission process**
- **Improve communication with referral source**
- Flexibility with length of stay
- **Second level of care (rather than only acute)**
- Improve access to primary care during their stay
- Provide transportation

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't shut down CBHH-Bemidji or other northern CBHHs

Question #3 – How do we create a system of public/private partnerships?

- Improve marketing – **establish relationships with rural ERs**
- Determine mission and then collaborate
- Private partnership umbrella under a hospitals' services – less regulations
- Consider partnership for management of CBHH
- Work with Merit Care TRF – when they are full can they have access to beds? Would get 100's of more referrals in NW8

Group 2:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Need more CADI waivers for housing
- Foster homes (corporate moratorium)
- Board & Lodge – with special services
- **ACCESS to CBHHs – local decision for admission**
- **Reduce barrier to admission**
- Use CBHHs for crisis stabilization
- **CBHHs to work <u>with</u> us and acknowledge our expertise**

Question #2 – What do you need SOS not to do in this region?

- Too quick to discharge
- We do not have a need for more out-patient services

Question #3 – How do we create a system of public/private partnerships?

- **Local decision for CBHH admits and discharges**
- SOS to develop "step-down" housing; e.g., Board & Lodging with special services
- Give us the money!!
- Many Minnesota clients go to North Dakota due to SOS barriers – this creates State to State problems.

Group 3:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Increase beds in this region
- Step down from CBHH to individual living – 90-day stay
- **Call the CBHH direct**
- **Increase SOS user friendliness**
- Need to be fully staffed
- A way to deal with aggressive people
- Dual diagnosis units
- Child and adolescent beds

Question #2 – What do you need SOS not to do in this region?

- Do not leave us hanging – "call us back!"
- Don't send people too soon
- Don't eliminate beds and facilities
- **Do not deny admission for minor medical conditions**

Question #3 – How do we create a system of public/private partnerships?

- **Share intake system with private and state hospitals**
- **More dual diagnosis beds or (some at all would be nice)**
- Doctors should be able to communicate in the English language
- Doctors should respond when "on-call"
- State partner with step-down units on liability issues

Group 4:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- **More (easier) access to psychiatric beds – "no excuses" admission policy on open beds**
- Transportation to acute care (including coordination)
- Supported housing opportunities; step-down, long term, etc.
    - Remove moratoriums on new foster care development

Question #2 – What do you need SOS not to do in this region?

- **Not to lessen access to CBHHs by admission criteria**
- Stop reducing funding to regional AMHIs – stop changing rules on carry-over money/funds.

Question #3 – How do we create a system of public/private partnerships?

- Cross training/education/relationship between state and counties.
- Willingness/assistance in removing barriers to developing a range of housing options
- **Serve people – not the process. Effective, efficient, flexible and consistent!**

Charlie again thanked the group for their participation in today's meeting and noted that the information gathered in today's meeting will be compiled into a report and returned to the AMHI for distribution to the participants at today's meeting. He noted that this information, as well as information gathered from similar meetings being held across the State will then be used to compile the report to the Legislature that is due at the end of the month. Before adjourning the meeting, Terry DeMars thanked staff of the Department of Human Services for convening this meeting and for traveling to Thief River Falls.

Addendum:
In preparation for today's meeting, the Northwest 8 AMHI conducted an independent survey of stakeholders in the region. The questions as presented in the survey (listed below) are different than the questions posed at today's meeting; however, the feedback from that survey is included in this report as Attachment 1.

Northwest 8 AMHI Survey Questions:

1. *What do community stakeholders want State Operated Services (SOS) to do to address local mental health needs?*

2. *As the State Operated Services (SOS) changes its mission, what services would you recommend that the State Operated Services (SOS) avoid providing in this region?*

3. *What kind of partnerships would make the State Operated Services (SOS) system work better in your area?*

Attachment #1
2/5/10

State Operated Services (SOS) Survey
Northwest Adult Mental Health Initiative
February 10, 2010

Survey Questions:

1) What do community stakeholders want State Operated Services (SOS) to do to address local mental health needs?

Consumer

- I would want to go to the hospital in Thief River Falls if I had to be hospitalized.
- State needs to find more psychiatrists who are wiling to work in this area or they need to allow psychiatrist to cross state lines
- I get my mental health services provided by VA. If I needed to go to the hospital for mental health needs I would like to go to the closes hospital in my area which would be Thief River Falls.
- Address transportation issues in rural areas target to appointments and basic needs – groceries etc.
- To provide community services and have more services in small towns. To have more groups in small towns and more available transportation.
- Need rides to appointments
- Have someone in Ada able to meet with and write out subscriptions instead or going to Crookston being it's hard to get a driver
- If I needed to go into the hospital for my mental health I would go to North Dakota. I would like the State to be able to work with other states to provide services to me.
- Keep myself out of the hospital. Keep everyone out of the state hospital. More jobs for work at those hospitals to patient out of the hospital. Work harder to keep people that work in those state hospitals. Find work for them to keep patients out of those state hospitals!
- Activities; get to-gethers for the people, example of bowling, skating, to have more groups with a variety of subjects
- More activity and community integration
- To vocalize the programs available
- Increase access to hospitals and group homes, etc.
- More coping skills classes
- Add some more programs
- Quicker way to get on SSI. Too long of a process
- To keep the services that they have now so we are important
- Give us the info needed and keep us informed
- Insurance
- Keep doing what you're doing
- Not to take the medical away from people on GA

- OP service programs and treatment to continue and most independent: part-time employees multiple volunteer programs
- To help coverage for meds and groups and to have living sustainability for individuals
- Outpatient support service to continue to be independent self sufficient

Law Enforcement

- Make the intake process more efficient. We wait hours when accessing system; and don't always end up even going to SOS system because it is very cumbersome
- Put more of them across the state to eliminate long transports
- Eliminate to central pre-admission and let law enforcement deal directly with the CBHH of their choosing.
- To remain open and to be accessible 21/7 to all users
- Our biggest problem in Roseau is the geographical location to us to open beds on "holds." When TRF is full that means our transports take more time because everything is south of us. This translates to a greater cost for us because of travel time. Many times this means less officer coverage for our area. It would be beneficial to us if TRF had more beds available to accommodate the 154 turned away in 2009. I believe we do a good job on evaluating a person prior to placing them on a hold. We will sometimes bring them to the Roseau hospital and have Behavioral Health evaluate them prior to bringing them to the appropriate facility. By that I am saying that we are not just using "holds" as a way to deal with someone. Furthermore, I am also saying there is a greater need in our area then beds available.
- By far the biggest hurdle we encounter when dealing with mental health holds is finding a bed in our area. The closest facility to us is TRF and seldom do they have a bed available. Our situation is that because of our geographical area we are often transporting patients a long way. This typically means that our city's protection suffers because we only have one or two officers working at any given time.
- The SOS is too dependent on the medical side. It is like they are looking for any medical reason not to submit then person into SOS. It takes too long to process someone. We need more available beds in this area.

Hospital Emergency Rooms

- Ensure adequate beds are available to send our mentally ill patients to who may also have other acute illnesses at the same time
- Place our patients at closest appropriate facility without the run around and length of time it takes to get a response

County Case Manager

- Suggest local facility that could provide beds if given the resources needed
- Have synergy teams available to providers in our area to increase the success of placements.
- Assist with placements when called. Realize that care coordinators have exhausted local resources and are calling for help as a last resort. Do not put up more road blocks!
- The mental health division of NEMC in TRF turned away about 150 referrals for inpatient mental health services last year. They had to do so because they were filled to capacity. Meanwhile, CBHH facilities across the state were operating at 50% capacity. What does this mean? It tells me that people in NW MN want local mental health services. We should make it available to more people. As a case manager, I clearly prefer a local admissions

process. Our local hospital has that. CBHH facilities do not. They should. So what happens to the mental health patients that are turned away from our local hospital? Many, perhaps most, are referred for services in ND hospitals. I find it embarrassing that a significant outcome of SOS is the practice of outsourcing mental health services to the state of ND.

- Do whatever is needed to make services available to those in need
- Easier access to CBHH: in the past the admission criteria has been so restricted. We have come to the point of not trying for an admission as it is very time consuming which doesn't work when a mental health client needs hospitalization.
- Not require so many medical tests in order to admit a client into CBHH. It's tough to get all the necessary medical clearances before a client can be admitted, especially in rural hospitals/areas that don't have labs/equipment to do the tests. Would be helpful to allow rural communities to access the CBHH's without having to go through Central Pre-Admission, because we still end up having to go through the regional/local CBHH's for paperwork, discharge planning etc.
- Create stabilization sites/beds, to meet the intermediate needs of client who may be experiencing an acute crisis, which jeopardizes their current placement, i.e. foster homes, community setting but don't necessarily meet the criteria for 72-hour hold. Stabilization site would be approximately 24-36 hours of time spent in stabilization bed, don't need to revoke a provisional discharge, or need length of time for a formal "admittance," but safe, structured place to stabilize, before returning to community setting.
- Meet with local doctors/hospitals/law enforcement/court officials to educate on mental health process/stabilization/services available to CBHH's, and the process to get client involved/admitted into CBHH. Why it may be important to sign off on 72-hour hold when a client violates their provisional discharge, how that may be safety risk to community/client, i.e. eloping from facility. There is misconception from community doctors and law enforcement on CBHH's.

Provider Case Manager

- To have come more often at Bridges and make it easier for us.
- Accessibility. At this point, referral sources say there are so many roadblock's to getting a patient admitted to an SOS bed, they don't even try.
- The consumers I work with express a need to be close to home and a local hospital. If they have a mental health relapse, however, sometimes just a few days or overnight may be what they need. More crisis beds for this purpose are needed in this part of the state.

Administrator

- I would like to see SOS work as a partner with the counties and not as an outside entity working only with other doctors to decide admissions. I would like to see a regional admission process so counties and the local CBHH can develop some strong working relationships where trust could be established both ways.
- I would like the CBHH to be a safety net for the most severely mentally ill folk who have no where else to go.
- I would like the CBHH to help with the discharge process and to help find homes for clients to transition into and not just get a call stating get them out. Some of these individuals have records that make it difficult to find a home for and any assistance would be appreciated.

- I would like the CBHH to be a place to also be a crisis stabilization center (similar to NW apartments) for individuals that don't quite meet hospitalization but need to cool down, this could be for a few hours, but no more then a few days.

Elected Official

- It is important to work with local players as they know what is needed and can work on a cost effective system.
- To be included in restructuring
- Listening to the ones needing the help

Other

- Reach out to rural hospitals and ER's to provide education on admission and form a relationship. Out of state providers have done that and now consumers are going to non MN hospitals through inter-state compact and then if committed, moved immediately to a MN hospital. Hence, losing any continuity of care.
- Treat clients for a longer period of time. Often these people need a little longer then 19 days.
- Have services available in northern Minnesota close to our home
- Provision of a true safety net for individuals who need an intensive level of services due to danger to themselves or others. This seems to be very difficult to access since the state hospitals have closed.
- More local bed availability for holds and longer term placement options for high need individuals.
- State Operated Services has not been consumer focused
- Find out what the various needs are and what can be consolidated into one convenient location. Units must work together and cooperate and get many needed services into one location
- Eliminate the dense thicket of barriers that make admission to those facilities so incredibly difficult, time-consuming, and annoying that people avoid using the state system if they have any other alternative
- Start providing long-term care for those patients needing long-term psychiatric hospitalization – not every patient can be treated and discharged to the community in a matter of days or weeks, some actually require longer term care in a hospital based setting – which it appears the state has virtually eliminated as a treatment option.
- Stop using "lack of medical coverage" as a reason to refuse admitting patients – instead of making excuses, solve the problem and get the medical coverage necessary to provide appropriate treatment – including treatment for psychiatric patients who also have medical issues
- Stop refusing to admit "forensic" patients from local jails
- On the rare occasion when they actually do admit a patient, these facilities need to do a much better job of coordinating follow-up aftercare in local communities with local providers
- The state appears to have completely forgotten the idea of providing a "safety net" for patients whose particularly complex needs cannot be appropriately and safely met by local and regional treatment providers. There is a critical need for long-term care for those patients whose illness stubbornly refuses to respect the treatment model currently in vogue.

- Facilities which would address improved patient care for acute dual diagnosis/mental health issues are needed. Currently, CD facilities will not admit if there are suicidal concerns. Psych facilities will not admit if there is intoxication.
- Take clients when in need
- Set up inpatient care for difficult clients, such as those with traumatic brain injuries or behavior issues.
- Set up nursing home care/assisted living for those same clients.

Unknown:

- Make the SOS facilities more easily accessible. Right now patients in rural areas are delivered to hospitals in Grand Forks or Fargo because it is easier to get them admitted there.
- Address transportation issues and provide easier access and admission to CBHH's.

2. As the State Operated Services (SOS) changes its mission, what services would you recommend that the State Operated Services (SOS) avoid providing in the region?

Consumer

- Don't want home visits or surveys
- To cut back on mental health services in small towns because they are limited as it is. No cutbacks
- Talk to too many people about our case
- To shut down any of the programs
- Don't cut the budget
- We don't want to cut programs
- Cut programs that serves mental health programs
- Help with housing needs
- Not to take away from mental health as it is now
- Take us out more; more trips to certain places that would keep us busy
- Take money away
- Don't take away benefits
- Take medical away from people on GA by July
- To keep on having support groups and to provide housing and coverage for therapy and meds
- Dictate which services I need and can use for my individual illness

Law Enforcement

- Coordinate with local services
- I don't know if there should be any SERVICES that should be avoided/cut. In our part of the state mental health services are hard enough to get access to sometimes on a 24-/7/365 basis, especially if there are transport or admissions issues to be dealt with.
- Unsure as to all the services you provide to this region.
- I am not sure what SOS currently does.
- I honestly don't know how to answer this question. How do you avoid providing necessary service?

Hospital Emergency Rooms

- Beds with stringent restriction

County Case Manager

- Reduce services
- We have so few services now. Why would we avoid services being provided in our region??
- The admissions process to CBHH facilities is cumbersome, superfluous, and pardon the pun, crazy. Simplify the admissions process. Simplify the admissions process. Simplify the admissions process. They say that if you want your message remembered, you should repeat it three times, but let's not take any chances. Simplify the process.
- What mission changes? We need to know what is being considered as a change! In our region, we seem to have enough outpatient services, so again, we need inpatient crisis beds.
- None, provide more 72-hour hold beds and stabilization beds

Provider Case Manager

- To cut back on suicide in small towns. People trying to take their own lives
- Don't try to fix what isn't broken – don't duplicate or compete with private facilities that are already providing needed services. There is enough need to go around.
- Take away funding for mental health services.

Administrator

- I do not want the CBHH to duplicate services but offer new services that help fill gaps in our system, such as, hospital beds when TRF is full and stabilization site. I do not see the need to psychiatric, psychological assessments or IRTs facility as a need in the region but more of a duplication.

Elected Official

- Anything that would not be cost effective.
- The broad vast land area needs to be considered as to not throw money out the window in traveling time and cost
- Avoid careless spending by building something that won't be long term

Other:

- Have, I wish our family member could be closer to our home like Erskine or Moorhead or Crookston
- The concept of CBHH is good. However, the difficulty in accessing the services is not. If this is to be a viable service in our area it needs to be much easier to access.
- Please include us in a decision that directly affects us. Consumers and family members need to be part of this process of restructuring
- They don't need to <u>reduce</u> mission, or <u>avoid</u> providing certain services – THEY NEED TO START ACTUALLY <u>PROVIDING</u> THE SERVICES WHICH WERE INITIALLY INDENTIFIED AS THE HEART OF THEIR MISSION, i.e., treating psychiatric patients in emergency and long-term situations (as opposed to creating barriers to admission).
- It was my understanding that SOS would accept patients needing inpatient psychiatric care. We have had very few transfers to SOS because of the new changes on SOS's part to accept patients that have been cleared in ED as medically stable. The roadblocks make it very time consuming and every hope of transfer has not worked out very often.
- If SOS was designed to accept and treat acute mental health needs they should do so!

- Avoid a central access number for other providers. Use that number internally if one facility needs to know about possible access to a sister facility, but let local providers contact local facilities directly.
- Avoid the shuffle – get clients in, in a timely manner

Unknown:

- Early release of patients before they are ready to leave

3. What kind of partnerships would make the State Operated Services (SOS) system work better in your area?

Consumer

- Farm out to local offices – CSP or county workers – someone more familiar then us
- If they would send someone to Ada so the patient doesn't have to go there all the time.
- Psychiatrists could work in MN or ND
- To work with local businesses to see what is needed and find a way to get it for them.
- Am very happy with Northwestern Mental Health Center. Everyone works very hard to help people with their mental health issues.
- I am very satisfied with the services provided by NWMHC and its employees.
- More input from medical field – with the hospital – increase private institutions and more beds for MI people
- Happy with the services through NWMHC services and staff
- More community involvement
- Independent living
- To communicate with other systems
- Keep what they already have and establish more
- More choices
- I don't know
- Just to keep up the programs that they have available
- Service to service contract so each program knows of local activities and programs: volunteer – resource centers – CSP – NWMHC – LAC – NAMI
- NAMI – LAC – groups. Local police and ambulance colleges, schools, local business
- LAC – NAMI participation, client and professional

Law Enforcement

- Work with local systems (such as NWMC in TRF) more effectively. Share funding with other providers so people needing services can get them locally.
- The SOS's need to partner or develop options for mentally ill and dangerous with chemically dependant or intoxicated.
- Partnership with current mental health services programs making the admission requirements the same and expand the number of spaces available for clients that need these services. This may make it easier, more effective and efficient for clients to benefit from programs. It probably also makes it easier for law enforcement, the courts, families, and the public to better serve each others needs and concerns.
- I am not fully aware of the services that the SOS provides or what is broken in their system. But I would think that if the SOS has only a 50% occupancy rate then why not partner with TRF Meritcare to provide more beds.
- I also wonder if the state would partner with TRF to provide funding for more beds.
- Loosening your criteria to allow law enforcement and medical "holds"

- I am not sure what SOS does
- The SOS is not user friendly at all. It is not friendly to mental health, medical or law enforcement or to the person who we are trying to help. It is far too bureaucratic.

Hospital Emergency Rooms

- For inpatient needs, we generally try to send our patients to Thief River Falls. Please partner with them to provide more beds with fewer restrictions so patients with other illnesses can still be transferred there.
- We have a great relationship with NWMHC. They assist us anytime we request. If TRF is full we turn with dread to the SOS. Not a smooth process

County Case Manager

- More available services in the area
- More services in our region
- I would like to see SOS partner with our local hospital to increase their capacity to serve the needs of mental health patients in NW MN. Of course, the local hospital should maintain and control the admissions process
- Connections with local hospitals/doctors/law enforcement/courts and education regarding provisional discharge plans, why it's important to address acute mental health behaviors with stabilization beds to use as a prevention measure, so you wouldn't have to go into 72-hour hold/hospitalization or revoke provisional discharge. Create 1 or 2 contact people that the NW region could contact to get CBHH admission instead of having to go through central pre-admission.

Provider Case Manager

- As a referral source from community based facilities – if someone needs a lengthy hospital stay, if there are no payment sources in a community facility, if community facilities are full; coordinate services that each facility may be able to share. e.g. medical services, specialty psych services
- We are very close to hospitals in North Dakota and many consumers use their hospital. Mental health would benefit consumers

Administrator

- Regional admission so you work with people who know you, regular quarterly meetings to work on the admissions process and educate each other on roles. Be part of our AMHI instead of an outside factor. For the CBHH's to stop believing that counties are not doing their jobs and just trying to pawn off clients who are difficult wasting time and money but realize we call when it is the last resort and we are out of options.

Elected Official

- Partner with local organizations that have proven to be a good service. They would know what works best for our area
- That somehow mutual agreement could be reached between the state and the communities it would serve

Other:

- Again, with local hospitals, ER's and Law Enforcement. Those agencies are so burned by past experiences of central admissions that they nearly refuse to attempt admissions to SOS
- More real input into what is/is not working
- Use one facility for all mental issues. Change entrance criteria to more meet needs
- I have not seen any effort by this system to become "partners" with area service providers. The state system as a whole appears to maintain an aloof stance of self-imposed isolation. It is not "user-friendly" from any perspective, including that of patients and other providers.
- A partnership that actually works to accept a patient – not deny a patient.
- Direct access phone contact with staff at the admitting facility (rather than a central phone number) would seem to serve patient needs better.
- Uncluttered and competent

Unknown:

- Easier accessibility with our MH services as far as placement.
- Longer length stays for certain patients
- Change the central pre-admission process to provide easier access to services.

4. Other:
   - Psychiatric hospitals unaware of community services. EXCEPTION TRF – who are great to work with. Individuals feel like they leave hospital without good plan other than "follow up appointment" with someone. Often struggle with transportation to these appointments and end up not going due to roadblocks. Many group members felt services individual (but mot importantly, group) had kept them out of the hospital. Some comparisons of rural vs. urban services. Felt there was a log in getting services initially, but tended to be more long lasting and responsive to needs once involved with services.
   - have Bemidji and Fergus Falls hospitals accept patients with dementia
   - SOS should work with community providers, and now the needs can be met most efficiently and cost effectively.

SOS Redesign Stakeholder Meeting
Region SW 18 – Marshall, Minnesota
February 12, 2010

Participants: 71

Leah Lundgren, Chair of the Consortium and Social Services Supervisor of McLeod County Social Services, opened the meeting, welcomed the participants and thanked them for participating in today's meeting. She introduced Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, who also thanked the participants for agreeing to participate in today's discussion. He informed the participants that the CMHS Administration is made up of 4 divisions; Alcohol and Drug Abuse, Adult Mental Health, Children's Mental Health and State Operated Services. He noted that the purpose of today's meeting was to seek input about the redesign of State Operated Services (SOS).

Charlie shared that SOS is facing a $15M shortfall in the current biennium, which ends on June 30, 2011, and noted that utilization data that will be shared with them later highlights some inefficiencies within the system that SOS feels needs to be addressed. He noted that in addressing this shortfall, as well as the redesign, SOS will not sacrifice quality, will look at efficiencies and is truly interested in developing partnerships to reduce systemic issues across the system of care. Charlie informed the group that CMHS has been meeting with each region of the State and before starting the discussion at today's meeting wanted to dispel any rumors that decisions have already been made and these meetings are "window dressing." He clarified that decisions have not been made and it will be input from meetings such as this that will impact any decision making on the part of the CMHS Administration and SOS.

Charlie also shared that, under Dr. Read Sulik's direction, the CMHS Administration is working with the Minnesota Council For Quality, an organization that uses the Malcolm Baldridge measures of organizational leadership and quality, to engage in a survey of the CMHS Administration. And, later this spring or early summer the CMHS Administration will undertake a "visioning" summit to look at where the administration should be in 2015; not only for adult mental health services but children's mental health and alcohol and drug abuse services.

Charlie called attention to the handout which outlines Dr. Sulik's "7 Goals of Excellence" that he established for the CMHS Administration when he joined the Department in late 2008. These goals are:

- Eradicate the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;

- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and additions.

Dr. Sulik's overarching goal is to apply these 7 goals to reduce disparities in access and outcomes for minorities and to engage staff and stakeholders in the process.

Charlie called attention to the 3 questions listed on the agenda and noted that later in the meeting, participants will be asked to address these specific questions during a break out session. He noted that the information gathered from today's meeting will be summarized in a report and that report will be combined with the reports from similar regional meetings and used in the development of a report to the Legislature to be submitted at the end of this month.

Charlie then introduced Mike Tessneer, CEO of State Operated Services, who reiterated Charlie's comments about the importance of the input of the individuals attending today's meeting. Mike informed the audience that any changes within SOS need to have input from the individuals using the service as well as stakeholders participating in meetings like this one being held around the State. He briefly addressed some of the contributing factors to the $15M budget shortfall for the current biennium; (i.e., administrative budget cuts, unallotment, unfunded COLA, unreimbursed dental services, maintenance of the Brainerd campus, etc.) and stressed that the intent is not to change the quality of services provided, but to achieve savings through efficiencies across our system to better meet the needs of our clients.

Mike then called attention to the handout that reflects SOS monitoring of individual not meeting criteria for inpatient acute hospital care. He noted that during calendar year 2009, the CBHH-Willmar had approximately 900 bed days where individuals were in an acute care inpatient hospital level of care bed but were no longer in need of that level of care. He noted that in many cases the appropriate level of care needed may not be available in the community and lack of that availability may have contributed to the need for hospitalization. Mike addressed the handout that described LOCUS level of care data (a tool used by clinicians to measure acuity of a patient's symptoms) which shows SOS that roughly half the individuals in our beds are at LOCUS level 6 (in need of inpatient acute hospital care) and the other half are in need of a lesser level of care but remain in the hospital in an acute care bed. In response to a question about the "no data" information Mike explained that LOCUS level for the patient may not have yet been established during their stay.

The final handout referenced by Mike addressed total admissions, discharges, average length of stay, and current census for the CBHH system and Mike shared that although the CBHH system is staffed to support 120 beds, data shows that on any given day approximately 80 of those beds are being utilized. Mike noted that SOS has looked at the possibility of providing additional services, based on the needs of each individual region, to address some of the unmet needs. These services could include any number of an array of services; i.e., specialized residential, outpatient, medication monitoring, consultative services; but he again reiterated Charlie's statement that no decisions have been made. Mike did share that although SOS has begun

discussions about the potential availability of enhanced services and preparations for potential partnering with the regions once their care needs have been determined, he reiterated that we can not do this alone and asked the participants to think about how they would like to see State Operated Services operate in this region.

In response to a question from the audience about average daily census and if it is lower than we expected and, if it is, do we have any explanation of why that has happened, Mike shared that during the planning for the CBHHs, planning was also underway for the development and implementation of ACT teams, IRTS and other enhanced community-based support services. At their inception, it was anticipated that it would take about 2 years for those services to settle in and impact utilization of the inpatient hospitals. He noted that the current CBHH system is admitting and treating almost 3 times as many individuals as were treated in the old RTC system with much shorter lengths of stay. In response to a question regarding the data source, Mike noted that State Operated Services' Quality Management Office has been tracking this information since the opening of the community behavioral health hospitals.

A question was also raised about the availability of services for individuals who are mentally ill and aggressive. In responding, Mike shared that this issue has been raised in every meeting and is an area that SOS continues to look at to determine the best way to provide services to that population. He shared that SOS cannot do it alone and will be looking to this region to help us determine the best way to provide those services in this region.

Mike then introduced Sharon Autio, Director of the Adult Mental Health Division, who took a moment to acknowledge the accomplishments of the Adult Mental Health Initiative in this region. She then called attention to the summary report of the March 2009 Report to the Legislature entitled "Mental Health Acute Care Needs Report." Sharon shared that this report was mandated by the 2008 Legislature in response to a request from Prairie St. John to establish a 120 bed inpatient hospital for adults in the east metro area of the Twin Cities. The mandate to the Department was to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities, to develop recommendations on how to best meet the acute mental health needs of children, adolescents, and adults; and an examination of current and future workforce issues. She spoke to the formation of a 17 member steering committee composed of hospital representatives, county representatives, advocacy groups, a psychiatrist and other mental health providers from across the State. Three work groups were established to address adult, children and workforce issues. She briefly summarized the findings of the work force group and noted that of the 415 psychiatrists practicing in the State of Minnesota, over 70% work in the metro area. She also noted that the work group learned, not unsurprisingly, that recruitment of a psychiatrist or an advanced practice mental heath nurse took roughly one year.

She then addressed the key findings of the report that addressed front and back door issues and noted that of 2000 "episodes" of crisis services statewide during the last year; only 30% of them resulted in a hospital admission. She called attention to the key highlights of the subcommittee report and noted that one identified need is the creation of a "chronic care model" of care for the mental health system. Sharon also noted that Minnesota has established an 8 a.m. to 4:30 p.m. Monday through Friday system of care and shared that a 3 month review of the Minnesota

Hospital Association's bed tracking system found that inpatient mental health beds start filling up on Friday afternoon and by Monday morning there is not an inpatient bed available in the system. She also addressed the category of individuals who are in need of a different level of services due to their complex medical conditions and/or aggressive behaviors and noted the need for an integrated mental health/substance abuse treatment program for dually diagnosed individuals.

Sharon briefly reviewed the contract bed agreement with Avera McKinna in this region and shared data for Calendar Year 2008 and 2009 through September. She noted that the average length of stay in the contract beds is 25-28 days.

In concluding, Sharon called attention to the unmet needs data submitted by the SW 18 Adult Mental Health Initiative last fall. She applauded the region on their work in consumer and family involvement and acknowledged the cooperation of providers, consumers, and family members in planning for this area of the State. She also acknowledged their creative ACT teams; especially the South Winds ACT team, their work on supported employment, and the illness and management recovery work that is being done in this region.

Sharon then turned the meeting back to Charlie who noted the number of State employees in the room. He noted that the State employees in attendance at today's meeting are here solely to listen and will not be interjecting their ideas into the discussion of the 3 questions that are listed on the agenda for today's meeting.

Unlike the break-out process that was used in other meetings held throughout the State, it was the consensus of the participants in Region 12 that they would not break into small groups but rather preferred to address the 3 questions as a group. The established parameter was that each person wishing to speak would have 2 minutes. Tom Ruter, CMHS Stakeholder Liaison, recorded comments from the group. Twenty four individuals contributed to the points outlined below.

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Why can't you make part of the CBHHs dedicated to the young aggressive males – what do we do with them? And what about returning veterans?
- Need treatment and programs that are more individualized
- Consumers' regular psychiatrists needs to be involved during inpatient hospitalization
- Therapy – one-to-one talk therapy during hospitalization; not just medicate and then release.
- Wellness recovery planning -- peer facilitated recovery and illness management skills to learn how to live with their illness
- Be provided with alterative therapy
- Consumers have a say in the type of treatment
- Extensive discharge planning and follow-up to prevent re-hospitalization
- Specialized residential services available after the "acute" phase of treatment
- Keep the good social workers and the Local Advisory Council (McLeod County consumer)

- Promoting local relationships for access to CBHHs. CPA is highly inefficient in this region. No ability to access local CBHH directly.
- State should do what no one else can do – be the safety net. Promote or develop services in collaboration with local providers; particularly for the highly aggressive individuals
- Facilities to serve individuals in need of "high" supervision; not necessary inpatient care
- Address concerns of jails – mentally ill people don't belong in the local jails because "they broke something" – they are in need of "treatment" (Law Enforcement)
- Quicker/faster placements; individuals are looking for help (Law Enforcement)
- Need State to step in for persons with "specialized needs" (medically fragile; aggressive; behavioral issues)
- Need to find ways to bridge gaps between State lines to share resources
- Mentally ill and aggressive and individuals needing more than 14 days of hospitalization
- CADI slots, funding – mental health is getting squeezed out.
- Match criteria on stabilization with community standards -- patients may be considered "stable" in a hospital setting; but is that "stable" an acceptable level in the community; i.e., foster care.
- Transitional program from the CBHH – step down program
- Exemption to CADI – don't squeeze out those with mentally illness
- Design dual diagnosis services (MI/CD treatment is difficult to find)
- Educate/share information about available services
- Address differences between urban and rural methods of providing care
- Transportation issues (in rural areas, transports take staff away from primary duties)
- Housing issues
- Education on discharge criteria -- there is not a clear understanding between referring levels of care
- Support and enhance existing EBT programs for individuals with borderline personality disorder
- Centralized pre-admission doesn't work; law enforcement gets spitting mad because it takes so long.
- CBHHs should all be certified
- A redesign should make sure there is a common sense redistribution of hospitals doing acute care
- Crisis services – copy the St. Cloud mobile crisis teams

- PCA and CADI – need more flexibility
- Use health care model for mental health care (chronic and longer term – the old Rule 36 worked good)
- Discharge from CBHHs needs to be reviewed for practicality to the needs of the individuals being served
- Look seriously at CBHHs providing primary care with CD secondary care
- Don't cut back on social worker visits; support services like early intervention – (consumer)
- Minnesota 10 x 10 model – reducing mortality and morbidity by 10 years in 10 years -- physical care, mental health care, engage family members in the therapy and treatment, medication compliance

- Stable housing and available funding
- Support for families upon discharge
- Develop employment opportunities
- Continue dialog between SOS, county and judges in the area regarding the legal issues affecting individuals with mental illness.
- A way to access available resources, or learn about available services, in a timely manner – Lyon County.

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Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't need SOS to compete with inpatient hospitalization – we need SOS to be the safety net for individuals who can't safely be treated in the local community hospital
- When the CBHH needs help, law enforcement should not be told how to do their job. Need their available "equipment" to handle the situation.
- We'll do the community stuff but we need the state's help with the small but aggressive individual

Question #3 – How do we create a system of public/private partnerships?

- To the degree possible, local psychiatrists to gain admission privileges to CBHHs
- Woodland Centers has a very successful residential crisis service which is collaboration between SW 18, counties and the provider. Highly successful as a step down and diversion from inpatient
- Consumer, county, state work together
- Develop telemedicine
- "SHAC" like relationship in the regions
- Eliminate red tape -- A way to access available resources in a timely manner

Tom Ruter wrapped up the meeting by again thanking everyone for their participation and reiterating that the information gathered at today's meeting will be shared with the AMHI for distribution to the participants. This information will also be combined with the information gathered in meetings in other regions of the State and used in preparing the report to the Legislature to be submitted at the end of the month.

SOS Redesign Stakeholder Meeting
Region – Waite Park, MN
February 16, 2010

Participants: 44

Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, opened the meeting by thanking the participants for inviting DHS to today's meeting. He informed them that the CMHS Administration is made up of 4 divisions; Alcohol and Drug Abuse, Adult Mental Health, Children's Mental Health and State Operated Services. He noted that the purpose of today's meeting was to seek input about the redesign of State Operated Services (SOS).

Charlie informed the participants that, partly as a result of the 2009 Legislative Session and the administrative cuts to the Department of Human Services, SOS is experiencing a $15M dollar shortfall in this current biennium. He noted that SOS utilization data has shown that inefficiencies do exist within our system and it is hoped that by addressing those inefficiencies it will identify potential savings to help cover that shortfall. Charlie asked that during today's exercise participants look at quality, efficiencies, and partnerships that need to be developed around the State to impact and enhance the mental health service delivery system.

Charlie noted that today CMHS is here to address the SOS redesign; however, later this spring or early summer, Dr. Read Sulik, the Assistant Commissioner of CMHC, who has shared his interested in creating a broader vision for the services and programs provided by CMHS, will hold "summit meetings" to again seek involvement from stakeholders in a "visioning process." Charlie shared that when Dr. Sulik joined the Department in late 2008, he introduced his "7 Goals for Achieving Excellence" to the CMHS Administration. These goals are:

- Eradicate the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and additions.

Dr. Sulik's overarching goal is to apply these 7 goals to reduce disparities in access and outcomes for minorities and to engage staff and stakeholders in the process.

Charlie then called attention to the "rumor" that SOS has already made their decisions and meetings such as this are "window dressing." He informed the participants that the rumor is not true and that this is one of 14 meetings being held across the State to gather input from our stakeholders, and reiterated that the input from these meetings is critical to our decision making. He noted that later in today's meeting participants will be asked to break into smaller groups to address the 3 questions on the agenda. A report of this meeting will be developed and it will be shared with the AMHI Coordinator. The information gathered today, along with the information received from the other meetings held statewide, will e used in compiling the draft report. Before submittal to the Legislature in early March, the draft report will be shared with the State Mental Health Advisory Council and the SOS Governing Board.

Charlie then introduced Mike Tessneer, CEO of State Operated Services, who indicated that he would be sharing SOS utilization data as well as addressing the budget issues facing SOS. He emphasized that like any other health care system, when utilization data shows you are not utilizing your services and resources efficiently, it is a call to action to look at what can be done to better use available resources to ensure the most appropriate level of care. He called attention to the handout referencing patients who do not meet criteria for continued hospital level stay and noted that during calendar year 2009, there were over 3500 patient days where a patient was not in need of acute inpatient hospital level care but remained in an acute care SOS hospital bed because they needed a level of care that was not readily available to them. He proposed that these are resources and dollars that could be utilized elsewhere in the continuum of care for mental health services.

He then referenced LOCUS data and noted that this data gives us a sense of the acuity level of the patient upon admission to the CBHH. He noted that a LOCUS 6 level indicates the need for acute inpatient hospitalization and is a "physician managed" level of care; some LOCUS level 5 patients need inpatient hospitalization but are not seen by a psychiatrist on a daily basis. Mike shared that about half of the capacity we are currently providing within the CBHH system are to individuals who could benefit from a lower level of care. This would include any of an array of community support services (i.e., crisis beds, ACT, IRTS, outpatient clinics, etc.) that may or may not currently be available in their region.

The final material referenced by Mike was the fiscal year to date data on admissions, discharges, average length of stay, and current census. Mike noted that for the CBHH-Annandale, the average length of stay is 10.9 day with an average daily census of 7; in other words, Annandale is a 16-bed hospital running less than half full. He noted that the CBHH system as a whole (160 beds, staffed at 120) is running an average daily census of 80 patients and that has been pretty consistent for the last year and a half. This tells us we have under utilization and potential resources that could be redirected to a different and/or more appropriate level of care.

In response to the information shared, there was a question from the audience wondering why, if the CBHHs are underutilized, individuals in this region are experiencing difficulty in getting access to the CBHH, even patients committed to the State for treatment. Mike noted that those are exactly the type of issues he would like them to identify in the break out sessions to be held later in the meeting. We are here today to find out what is needed from SOS in this region to meet the needs of the community. Mike also noted that, at this meeting, and similar meetings

around the State, we are seeking ideas on how SOS should be utilizing our available resources. He shared that SOS leadership has been thinking about this for some time and one of the areas SOS has given some thought to is how long it takes a patient to connect with a community provider once they leave the hospital. He proposed that it might make sense to have the CBHH psychiatrist follow that patient in the community until he is able to connect with the community practitioner; however clarified that that may or may not be needed in this region – that is just one of the ideas SOS has been analyzing against our utilization data.

Mike then moved on to the budget shortfall and noted that, just like every other health care organization, we are operating under budget constraints. At this point in time, SOS is facing a $15M shortfall in the current biennium. He briefly noted some of the contributing factors to that shortfall (administrative budget reductions across the Department of Human Services, unreimbursed dental services, unfunded cost of living increased negotiated under our labor management contracts, maintenance of the Brainerd campus, the Governor's recent unallotment action, etc.). He shared that SOS is attacking this problem in a number of different ways and has recently conducted an administrative operational review that has resulted in some changes (i.e., review of psychiatric on-call practices, implementation of flex staffing, etc.) as well as a review of all non-salary activities. But, the redesign of SOS is another way to potentially address the problem. Our goal is not to reduce quality or services but to identify efficiencies that will enable us to operate smarter and that is why we are asking for input on the 3 questions identified on the agenda for today's meeting.

Mike then introduced Tom Ruter, CMHS Stakeholder Liaison, and shared that, in the absence of Sharon Autio, Director of the Adult Mental Health Division, Tom would be presenting Sharon's agenda item. Tom referred the audience to the handout entitled "Mental Health Acute Care Needs Report" and provided a brief background on the mandate of the 2008 Legislature to the Department to convene a workgroup of stakeholders to develop recommendations to reduce the number of unnecessary patient days in acute care facilities, to develop recommendations on how to best meet the acute mental health needs of children, adolescents, and adults; and an examination of current and future workforce issues. He spoke to the formation of a 17 member steering committee representing key stakeholder organizations, which in turn provided oversight and direction to three subcommittees. The three subcommittees, comprised of steering committee members and other stakeholder representatives, looked at the identified issues above and made recommendations to the full steering committee. Tom briefly addressed the findings of the three subcommittees, including the one addressing work force issues and noted that the workforce subcommittee found that it takes about a year to recruit psychiatrists, advanced practice registered nurses and licensed social workers skilled in the area of mental health. He called attention to the last two pages of the report summary which spoke to the need for a long-term care chronic care model and noted that Sharon likes to note that Minnesota has developed a mental health system that operates an 8 a.m. to 4:30 p.m. Monday through Friday system of care that, unfortunately directs people to access their ER after 4:30 p.m. on Fridays. He referenced an example that Sharon gives in which she notes that a 3 month review of the inpatient bed tracking system shows that beds are usually available in the system from Tuesday through Friday morning but then sharply decrease through the afternoon and weekend and by Monday morning there is not a bed available in the system. Tom also shared that another critical piece identified in the recommendations was the lack of consistent treatment plans, coordinated discharge

planning, and engagement of family members and consumers in the discharge process. Tom shared that the entire 39 page report is accessible through the web site listed on the last page of the summary and noted that Sharon has indicated that this report is receiving a lot of attention by the Legislature.

Tom then turned the meeting back to Charlie Cook, who instructed the participants to break into 3-4 smaller groups and, for the next 40-45 minutes, address the 3 questions listed on the agenda for today's meeting. Charlie asked again that in responding to the questions, participants think strategically, be innovative and creative and noted that before concluding the meeting there would be a brief "report out" from the groups. Charlie also called attention to the State employees in the room and shared that they would not be participating in the discussion groups. They are available to answer questions but will not interject their opinions into the discussion.

After responding to the questions in the break-out session, Tom Ruter called the meeting back to order for a group report out.

Group 1:
Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Location/facility for persons with mental illness with aggressive behavior
- Location/facility for persons with mental illness and developmental disabilities
- Location where committed patients can stay (swing beds) (specialized residential)
- More access to TBI services
- More knowledge and better understanding of community resources
- Maximize CMS dollars (Medicaid)
- Better relationships between CBHHs and other providers
- Community partnership network needs to be replicated
- Break down silos within SOS/DHS

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Do no harm
- Don't ruin the things that are working
- Don't replicate what private sector can/is doing
- Don't mix general psychiatric with neurocognitive/developmentally disabled

Question #3 – How do we create a system of public/private partnerships?

- Re-examine central admissions and how it relates to counties, SOS, private sector and their inter-relationships
- Re-examine who is a part of the public/private partnerships
- Educate SOS about services, funding, timelines
- Re-examine moratorium for adding beds
- Re-establish crisis waiver dollars for this population
- Use the existing Mental Health Initiatives to foster relationships

Group 2:
Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Help out when clients are not psychiatrically stabilized
- Help support foster homes
- Need SOS to actively bridge/coordinate services between SOS stay and foster home
- Involve case managers/counties in case planning upon discharge – (disregard for county concerns/persons needs)
- Provide patients with psychiatric appointment or medications when released from SOS
- Adequate psychiatry coverage at CBHHs
- Difficult/dangerous patients are being discharged as at "maximum therapeutic benefit" – no place for them to go!
- Need help with DD – splitting hairs on diagnosis so as not to admit.
- Need to know where a committed person will go prior to their hearing
- SOS needs to stop determining what the court order says (i.e., stay of commitment vs. commitment) in order for us to receive appropriate placement.
- Some easy admits/referrals.
- Get Rule 20's out of jail right away – they need treatment not incarceration
- Not enough planning/transition
- Placement challenges: Medically fragile, behaviorally assaultive, developmental disabled, "maximum benefit gains" person

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Medication changes at SOS without consultation and coordination with treating physicians
- Multiple assessments for client within short period of time. Not client-centered/detrimental to patient).
- Too much focus on LOCUS – not enough emphasis on common sense
- Don't create facility that is single LOCUS based (i.e., LOCUS 5)

Question #3 – How do we create a system of public/private partnerships?

- Good private/public partnerships in place now but not enough coordination or notice ("come get" on weekends; "come pick up")

Group 3:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Locked residential (step down)
- Locked facility for CD commit – awaiting commitment
- Dual diagnosis – DD/MI; TBI/MI
- Services for very aggressive, very ill
- Different level of care within same location as LOCUS changes (eliminate too so much movement)
- Access to practitioners and continuity of care; prescriptions and access to meds
- Chronic and voluntary clients – frequent flyers at CBHH – need more appropriate services
- Behavioral/setting – consistency (DBT) structured – Axis II
- <u>Access</u> to CBHH beds; not able to get beds and ERs not prepared to deal with acute MI – they are not long-term

    - Single access for State to find placement without barriers
    - Time is an issue
    - Courts/judges want to know where client is going – we don't have this information
- Disconnect between commitment and LOCUS
    - Causes questions for placement, which in turn is a timing issue
- Medication management while stabilizing after medication changes
- Assistance in working with mentally ill individuals in jails
- ACT Teams are getting full – tougher to get individuals in
- Transition between "critical" to "going home" – funding issue as much as service issue
- Delay in receiving funding
- Need to work closer with financial
- Access if we want SOS foster care?
- SOS to provide extended medications after discharge (funding follows)

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Case management
- Compete with private practice
- Do not send no longer eligible "letter" -- Just committed and receive letter they are no longer in need of care and billing starts

Question #3 – How do we create a system of public/private partnerships?

- Develop licensing/standards for treatment foster care
- Funding for the above
- Study and re-evaluate the PMAP system
- Efforts to make continuity of care a priority
- SOS could assist in packaging services
- Create partnership to develop crisis plans; for example: DD/MI – can't return

Tom Ruter concluded the meeting by again thanking the participants for their attendance and for their input into this process. He noted again that the information gathered in today's meeting will be compiled into a report and that report will be used in compiling the final report to the Legislature, which will be submitted in early March. Charlie Cook also reiterated that if anyone had any additional ideas they would like to share, they should feel free to forward them on to him or Mike Tessneer.

SOS Redesign Stakeholder Meeting
Region 9 – Anoka, MN
February 19, 2010

Participants: 24

Bill Pinsonnault, Director of Anoka County Human Services, opened the meeting and requested introductions. He introduced Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration. Charlie informed the participants that the CMHS Administration is comprised of the Alcohol and Drug Abuse Division, Adult Mental Health, Children's Mental Health, and State Operated Services with roughly 4300 employees responsible for roughly $900M dollars. Charlie called attention to the handout which outlines the "7 Goals for Achieving Excellence" that Dr. Sulik introduced when he came to the Department in late 2008. These goals are:

- Eradicate the stigma, misunderstandings and misperceptions of mental illness and addictions;
- Improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions;
- Establish best practices and quality standards of care and practice across all providers;
- Break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts and corrections, social services, housing and employment;
- Reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions;
- Promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions; and
- Reduce the severe wide-ranging consequences of mental illness and additions.

Charlie also noted that the Dr. Sulik has engaged the Minnesota Council For Quality (MCFQ) to evaluate the CMHS organization. This evaluation is based on the Malcolm Baldridge Quality Award; and, although the CMHS Administration is not applying for the award at this time, it is seeking to increase the quality of the services provided by CMHS. Charlie noted that in addition to this activity, a number of "achieving excellence" work groups have been established to address the 7 goals of excellence.

Charlie then turned his remarks to the budget shortfall and shared that when Mike Tessneer and Dr. Sulik started addressing the shortfalls they noted that there were a number of inefficiencies that could be addressed in the system to help address the budget issues facing SOS. In addressing these issues, Charlie noted that we will not sacrifice quality; therefore he asked that when addressing the questions posed on today's agenda the participants keep in mind three words – quality, efficiencies, and partnerships. Charlie informed the participants that this meeting is one of 14 meetings held across the State to obtain input into this process. He then introduced Mike Tessneer, CEO of State Operated Services.

Mike noted there are several documents in the packets prepared for today's meeting that he will be addressing in today's meeting. He called attention to the one-page handout which addresses "do not meet criteria for continued stay;" calling their attention specifically to the center box which addresses the total utilization of non-acute bed days for SOS mental health programs for calendar year 2009. He pointed out that the data reflects over 21,000 days where patients remained in an acute inpatient hospital bed but were no longer in need of that level of care. He clarified that diagnosis and patient acuity level are evaluated to determine need for acute inpatient hospital care and noted that once stabilized and no longer in need of inpatient care does not mean the patient is no longer in need of services; but rather that they need a level of service that may or may not be readily available to meet their needs; i.e., outpatient clinic, specialized residential care, medication monitoring, etc.

Mike then spoke to the LOCUS tool utilization data and noted that SOS has been utilizing this tool for the last 3-4 years and although not an exact tool, it gives the practitioner an evaluation of the needs of the patient being served. A LOCUS score of 6, and some 5's but few, indicate need for acute inpatient hospitalization. Individuals with a LOCUS 5 score, with appropriate supports, may not require inpatient hospitalization. He noted that LOCUS data for Anoka-Metro Regional Treatment Center (AMRTC) indicates that roughly half of the patients who remain in acute care beds are no longer in need of that level of care.

He then reference the utilization performance data of SOS hospitals and called attention to the data for AMRTC which addresses admissions, discharges, average length of stay (LOS), current census LOS, and readmissions within 30/60/90 days. He noted that the average length of stay for AMRTC is 116 days (vs. 21 days for the CBHH system). Mike shared that this tells us AMRTC is operating inefficiently and those inefficiencies need to be addressed to better meet the needs of the clients being served. He also noted that after a stay of 116 days, most patients leaving the hospital are going to an entire new system of care because their community services are no longer available to them.

Mike then addressed the current budgetary issues facing SOS and shared that during the current biennium (which ends on June 30, 2011) SOS has a $15M budget shortfall in the appropriated services. SOS is doing a number of things to manage that shortfall, including looking across our system to address non-salary administrative dollars, i.e., computers, cell phones, travel, on-call for physicians; and noted that we have addressed a number of potential savings including instituting flex staffing within our system. He noted that even with those measures, efficiencies need to be addressed at AMRTC. Mike also noted that the supplemental budget released this week by the Governor adds an additional $2.8 million cut to SOS; and cautioned that because this is an early legislative proposal, it is far too early to know if this will be enacted but it needs to be kept in mind as DHS addresses the budget issues facing SOS and other areas of the Department. He also briefly spoke to the potential impact of GAMC on SOS and noted that as this is addressed within the Legislature and across DHS, SOS needs to keep that in mind as well.

Mike shared that in this redesign process SOS has looked at a number of things that SOS could do as a specialty health care provider to address the needs of the individuals who are coming to us for services. He reiterated that although no decisions have been made, SOS has explored potential service development such as specialized residential services, step-down medically

monitored residential services with a psychiatrist on call, and possible outpatient services until an individual can access their community psychiatrists. He stressed, however, that we are not interested in competing with current residential providers and SOS is open to partnering with other providers to ensure we are not displacing the current private system. We are only interested in filling the gaps so people can move to a level of care that is more responsive to their needs. In response to a question about the location of a "step down level of medical care" Mike noted that we are not sure. He spoke to the potential of a split service model within a CBHH in greater Minnesota; or in the Twin Cities where SOS maintains an empty unit in Bloomington, or even the possibility of partnering with an existing IRT provider by providing needed psychiatric consultation. In response to a question about the number of available psychiatrists Mike noted that, like every other hospital system, SOS is actively recruiting but feels we have psychiatrists who, through tele-medicine, could potentially be available for a defined number of hours for consultation/evaluation services. Mike also spoke to the availability of SOS psychiatrists with expertise in TBI and cognitive disorders and noted this is a needed resource within the array of needed services.

In response to a question from Jerry Soma regarding the status of CBHH certification by CMS Mike informed the participants that 4 CBHHs have been certificated by CMS; all have been accredited by The Joint Commission; and in response to an inquiry regarding the ability to move patients from AMRTC to a CBHH, Mike noted that the dilemma is we would be moving an acute care patient from one acute care hospital to another acute care hospital and spoke to the issues that arise with third party billers. He noted, however, that by changing the level of care of some of our CBHHs that might be able to be addressed.

Mike also responded to a question regarding the Competency Restoration Program at AMRTC and if individuals in the program are in need of inpatient hospitalization and addressed a question regarding the delay of the development of the Bloomington unit. He noted that individuals in the competency program are still in need of services; however, it is a different set of services than those provided in an acute care inpatient hospital and briefly spoke to the need to determine the best use of the Bloomington unit before committing limited resources.

In response to a question regarding the availability of tele-medicine, and if DHS would be interested in putting up money for the expansion of that program, Mike noted that unfortunately DHS is in an extremely difficult budget arena and although we are utilizing tele-medicine, our ability to expand its use is limited by opening up new billing streams or identifying efficiencies that allows for money to be put into the system.

Bill Pinsonnault spoke to the fact that CBHH system seems to have been very successful in greater Minnesota and maybe we have over built. That model has resulted in shorter lengths of stay and he noted that possibly by changing the level of care, it would provide opportunities in the metro area. Mike spoke to a number of considerations that could be undertaking in the metro area and encouraged the participants not to be restrained by the way AMRTC is currently structured because AMRTC can be utilized in a different way and encouraged them to be creative and innovative as they look at potential service models. Mike then introduced Sharon Autio, Director of the Adult Mental Health Division.

Sharon thanked the participants for inviting the Department to today's meeting and called attention to the summary of the March 2009 Report to the Legislature entitled "Mental Health Acute Care Needs Report." She shared that, in response to a request from Prairie St. John to build a 120 bed acute care inpatient behavioral health hospital in the east metro, the 2008 Legislature directed the Department to convene a workgroup of stakeholders from the child, adolescent and adult mental health systems and staff of the Department of Health's health economics program, to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. She noted that a steering committee of 17 individuals representing key stakeholder organizations provided oversight and direction to three subcommittees – child/adolescent, adult and workforce – which met over the course of four months and prepared individual reports with recommendations for review by the 17 member steering committee. She also noted that the subcommittees included members of the larger steering committee, as well as individuals who were interested in participating. Sharon noted that in addition to the key recommendations of this report, in particular, she wanted to briefly address the work of the work force workgroup which found that there were 417 psychiatrists in the State – 70% of whom practiced in the metro area. She also noted that a recent Health Department analysis of social workers found that approximately 75% practice in the metro area; which also contributes to the challenge of the work force and the need to be more creative about potential partnerships.

Sharon then briefly addressed the key findings and recommendations of the report and shared that there is no national formula that indicates the "correct" number of inpatient beds; that it really depends on the availability of an array of community based support services. She spoke to the Minnesota bed tracker system and the impact of that system on determining availability of beds within the system and spoke to an analysis she conducted over a 3-month period where she found that on Tuesday through Thursday beds were available; by Friday it started to decrease and by Monday there were no beds available. She noted that this speaks to our Monday-Friday 8:00 a.m. to 4:30 p.m. system of care and the need to address that system to enhance weekend and holiday coverage to avoid utilization of emergency rooms for access to mental health services. She spoke to the analysis of crisis services and the impact of that service on our system to help prevent unnecessary hospitalizations.

She also addressed front door/back door issues, including the need to better utilize our crisis services on weekends. Back door problems affect a population of individuals with very complex needs; i.e., co-occurring diagnosis of MI/CD; MI/DD, TBI or multiple medical problems, and finally aggressive or behavioral problems. Sharon spoke to the need for the development of a chronic care model of treatment and support for individuals with behavioral health needs as well as the need to realign funding for individuals with co-occurring diagnosis. Bill Pinsonnault also noted the need for addressing MI/CD clients with pain management issues.

Sharon also noted the "Minnesota 10 by 10 Initiative;" an initiative to reduce morbidity and mortality of individuals with mental illness by 10 years within 10 years – which addresses issues of cardiac disease, diabetes and cancer in individuals with mental illness. In Minnesota, individuals with a mental illness die 25 years soon than individuals without a mental illness. Sharon acknowledged that the Initiative has tackled the issue of integration; has not solved it yet, but has given a great deal of effort to address the issue. She also acknowledged the stellar job of communication that Anoka County has done on this issue.

Sharon then tuned the meeting back to Charlie Cook who requested that the participants break into 3-4 small groups to address the questions identified on the agenda. He informed the participants that a report of the information gathered at today's meeting will be prepared and shared with them. That report will also be utilized in developing the Report to the Legislature scheduled to be submitted in early March.

After responding to the questions listed on the agenda in the break-out session, the groups were called back into session by Bill Pinsonnault. Rod Kornrumpf, SOS Administrator for Adult Mental Health, requested a breif "report out" by group.

Group #1

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Discharge planning with follow-up in place
- Increased accountability for post acute needs – Bloomington/CBHHs?
- Prevention – Engaging with payors to fund
- Develop step down residential beds
- Medical over-site step down beds (where community providers not available to serve individuals w/diabetics, dialysis, cardiac issues, etc.)
- Expand existing step down options such as CFC; IRT, transitional housing
- Develop new options (gap analysis)
- Care navigation/care coordination
- Integrated data systems
- Comprehensive community data base such as bed tracking system

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't increase county share to solve SOS budget problem
- Down sizing beds – diminish capacity or resources

Question #3 – How do we create a system of public/private partnerships?

- Expand work done by Anoka County/Allina/RTC workgroup (e.g., River Oaks utilization)
- Mercy Hospital brought facilitator in to brainstorm – that kind of communication can lead to action and cooperation.

Group 2:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Services for individuals with uncompensated care; i.e., jail transitions, no insurance coverage, level 3 sex offenders, safety net issues – what others can't do)
- Fill transition gaps from SOS to community services (medication, medical care, psychiatry, psychiatry, psychiatry!!!)
- Specialized behavioral needs
- Specialized geriatric needs (memory care)
- Employment as part of treatment plan

- Remove barriers to community reimbursement models to include employment services
- Enforce Jarvis orders in the community
- Fund community services (beyond ACT and MH-TCM) to stay in place while person is in the hospital
- Development of statewide tele-medicine system (community hospitals, MACMHPs)

Question #2 – What do you need SOS not to do in this region?

- Do not become a crisis provider
- Do not fill community gaps because of lack of funding resources
- Using medical model – LOCUS -- on community providers who focus on recovery
- Do not do things the community is doing or could do given the funding
- Do not launch new projects for capitol reinvestment with out first evaluating with the community

Question #3 – How do we create a system of public/private partnerships?

- Work with community providers to develop next steps and get proper rule changes
- Integrate employment services into the models of care
- Create shared vision with medical providers on Minnesota 10 By 10 Initiative – how to fund the support in the community
- Develop transitional care model
- Re-evaluate Central Pre-Admission with community providers
- ITV/tele-medicine partnerships

Group 3:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Alternatives to commitment
    - Specialty groups (i.e., IRTS, corporate foster care)
    - Crisis services – Cronin Building; (State building) licensed as an IRTS; increase beds
    - Transition beds (Annandale)
- Contract beds; expand funding options to include more than MA
- Creating tele-medicine network
- Possibly expanding ACT services
- Stabilization team – front end to avoid hospitalization, commitment, court process
- Funding into front end for prevention
- Better access to Synergy or program like it to follow-up with discharge from AMRTC
- Rework (legislatively) commitment criteria for CD
- C.A.R.E. – expand MI/CD to address pain management and opiate addiction
- Expedite people getting on MA

Question #2 – What do you need SOS not to do in this region?

- Do not do away with SOS central pre-admissions or bed locator (web) system
- Don't reduce number of beds at AMRTC – beds need to be available until safety net (to be defined in partnership) services available
- Don't make eligibility more restrictive for access

Question #3 – How do we create a system of public/private partnerships?

- More integration with mental health, CD, and primary care – co-locate services
- Ground level planning -- do it together with all investors at the table (private/county/State)
- Incentivize participation

Rod then wrapped up the meeting by acknowledging the valuable input from the participants at today's meeting and spoke to some of the "themes" coming out of the meetings across the State, the similarities, as well as differences in the regions of the State.

In response to a question from Darrin Helt regarding the process and plan for following up on partnerships, Rod again spoke to the compiling of information gathered from meetings such as this from across the State for the report due to the 2010 Legislature and shared that additional meetings will be scheduled to follow up on the ideas generated by the recent input.

SOS Redesign Stakeholder Meeting
Region 10 – Dakota/Ramsey/Washington Counties
February 19, 2010

Participants: 67

Emily Shift, Dakota County Human Services, opened the meeting and thanked the participants for coming. Emily turned the meeting over to Rod Kornrumpf, SOS Administrator for Adult Mental Health, who shared that he was standing in for Charlie Cook, Chief Administrative Officer for the Department of Human Services' Chemical and Mental Health Services (CMHS) Administration, who was feeling under the weather this afternoon. Rod shared that the charge to today's participants is to talk about the future of SOS within the context of all of the services provided within the CMHS Administration. He noted that although the impetus for this series of meetings held across the State does include budget issues facing DHS and SOS; more importantly, is the desire to address the unmet needs of the individuals served within our system of care.

Rod called attention to the handout that listed the CMHS Administration's "7 Goals for Achieving Excellence" that Dr. Read Sulik introduced when he came to the Department in the fall of 2008. He noted that Mike Tessneer, CEO of State Operated Services (SOS), will address utilization information from SOS and Sharon Autio, Director of Adult Mental Health, will speak to the March 2009 Report to the Legislature which addresses the mental health acute care needs within Minnesota. Rod also briefly addressed the charge that they will be given later in the meeting to break into 3-4 smaller workgroups to respond to the 3 questions on the agenda for today's meeting. He then turned the meeting over to Mike Tessneer.

Mike welcomed the participants and noted that as Rod eluded to in his opening remarks, SOS, like every other health care system, is experiencing similar conversations – what are the service needs of the individuals coming to our doors and what information do we need to ensure they get the most appropriate level of care. Not unlike other health care systems, SOS -- which is Minnesota's specialty health care system -- is coming forth seeking recommendations and input into how we do our business. We don't do this alone, and we can't change it without involving the stakeholders, public/private providers, as well as the individuals who come to us for services.

Mike then referenced the "does not meet criteria" data in the handouts and noted that every hospital admits patients on the basis of a medical practitioners' assessment that the individual is in need of inpatient hospital care and every hospital monitors that level of care. When the patient is no longer in need of "acute" inpatient care, the patient is determined to no longer meet hospital criteria. That doesn't mean they are no longer are in need of services; just that the level of care required to address their needs has changed. Mike noted that in the data for CY 2009 there were over 18,000 patient days where a patient was not in need of acute inpatient hospital level care but remained in an acute care SOS hospital bed because they needed a continuing level of care that was not readily available to them. He proposed that these are resources and dollars that could be utilized elsewhere in the continuum of care for mental health services. In response to the question of who makes that determination and is the criteria the same across the system; i.e.,

CBHHs and AMRTC, Mike responded that a psychiatrist determines need for acute inpatient hospitalization and the same criteria is used systemwide within SOS.

Mike then called attention to the LOCUS utilization data and noted that a LOCUS score of 6, and some 5's but few, indicate need for acute inpatient hospitalization. Individuals with a LOCUS 5 score, with appropriate supports, may not require inpatient hospitalization. He noted that LOCUS data for Anoka-Metro Regional Treatment Centers (AMRTC) indicates that roughly half of the patients who remain in acute care beds are no longer in need of that level of care.

In addressing FY to date utilization information, Mike noted that this data shows total admissions, discharges, average length of stay (LOS), current census LOS, and readmissions within 30/60/90 days and spoke to the data that shows us that almost all of the patients at AMRTC stay longer than medically required and most of them, because of their length of stay, return to a difference set of services than when they came into the hospital. Most of this can be contributed to the fact that the "service/bed" in the community is no longer available because another client has been moved into the slot. Mike noted that in greater Minnesota, once a patient is discharged from the CBHH, access to a community practitioner can take months. He shared that of the areas SOS has given some thought to in potential service development is services that can help the patient transition back into the community – this is NOT to displace the local community providers but to provide services to a client until they can transition to the appropriate services in the local community. The purpose of sharing the data at today's meeting is to share what is driving us to the conclusion that we have to change and to engage input into that change. He cautioned people not to be constrained by how AMRTC is today; but what is needed to better address the needs of the individuals being served. Mike noted that one of the themes the Department is hearing is that we have a lot of good services but we have not been good at hand-offs – we are not taking that as a criticism, but as a call to action to create better partnerships and collaboration.

Mike then addressed the budgetary issues facing SOS and briefly noted some of the contributing factors, including departmental administrative budget reductions, unfunded dental services being provided, unfunded negotiated cost of living increases for staff and the ongoing cost associated with the maintenance of the Brainerd campus. He noted that SOS has aggressively addressed some of these issues, including looking at non-salary administration costs and how they can be trimmed, instituted flex staffing within SOS, reviewed the utilization of on-call and how it could be reduced without impacting patient care, etc.

Mike also briefly addressed the underutilization of the CBHH system and noted when the CBHH system was developed; SOS deliberately over-bedded our system knowing that the implementation of ACTs, IRTs, and ARHMs were simultaneously being developed and their impact on inpatient hospitalization was not yet known. He noted that the underutilization could be looked upon as a good thing because it causes SOS to look at our system and determine where our limited resources can be better utilized. Mike then introduced Sharon Autio.

Sharon thanked Dakota County for hosting today's meeting and noted that she wanted to start by applauding the work of the tri-county initiative (Dakota/Ramsey/Washington) and acknowledging its creativity and innovation. She briefly addressed the "Minnesota 10 by 10

Initiative;" an initiative to reduce morbidity and mortality of individuals with mental illness by 10 years within 10 years and to address the issues of cardiac disease, diabetes and cancer of individuals with a mental illness. In Minnesota, individuals with a mental illness die 25 years soon than individuals without a mental illness.

She then addressed the summary of the 2009 March Report to the Legislature on unmet needs that was included in the handouts for today's meeting. She noted that this report was initiated in response to a request from Prairie St. John Hospital (Fargo, North Dakota) who expressed interest in building a 150 bed inpatient behavioral health hospital in Woodbury, Minnesota. There was a lot of controversy about that request and Sharon noted that in response to that controversy, the 2008 Legislature directed the Department to convene a workgroup of stakeholders from the child, adolescent and adult mental health systems and staff of the Department of Health's health economics program, to develop recommendations to reduce the number of unnecessary patient days in acute care facilities. She noted that a steering committee of 17 individuals representing key stakeholder organizations provided oversight and direction to three subcommittees – child/adolescent, adult and workforce – which met over the course of four months and prepared individual reports with recommendations for review by the 17 member steering committee. She noted that the subcommittees included members of the larger steering committee, as well as individuals who were interested in participating.

Sharon noted that in addition to the key recommendations of this report, in particular, she wanted to briefly address the work of the work force workgroup which found that there were 417 psychiatrists in the State – 70% of whom practiced in the metro area. She also noted that a recent Health Department analysis of social workers found that approximately 75% practice in the metro area; which also contributes to the challenge of the work force and the need to be more creative about potential partnerships.

Sharon then briefly focused on the recommendations of the report as they pertain to adult mental health needs. She noted that there is no national formula that addresses the "correct" number of acute care inpatient beds that are needed; that it really depends on the availability of an array of community based support services. She spoke to the Minnesota bed tracker system and the impact of that system on determining availability of beds within the system and spoke to an analysis she conducted over a 3-month period where she found that on Tuesday through Thursday beds were available; by Friday it started to decrease and by Monday there were no beds available. She noted that this speaks to our Monday-Friday 8:00 a.m. to 4:30 p.m. system of care and the need to better address that system to enhance weekend and holiday coverage. She spoke to the need for providers, especially in the metro area, to refer after hour calls to crisis service providers to help avoid utilization of emergency rooms for access to mental health services.

Sharon noted that the findings of the unmet needs report also addressed both back door/front door issues and one key recommendation was the development of a chronic care model for individuals with mental illness. She shared that components of the mental health system doesn't really "talk to each other" and there is no continuity of care around patients. In addition, we are not good about addressing our client's need for accessing information; however, she noted that the east metro has starting to do some work in this area. She briefly addressed the unmet needs

that were submitted by Dakota, Ramsey and Washington Counties and noted that, not surprisingly the unmet needs were similar within the 3 counties -- housing, transportation, and employment.

In regard to the Adult Mental Health's budget, Sharon shared that although it doesn't look too bad she shared that the Adult Mental Health Division did give up some one-time sources of money as part of the departmental budget reductions and noted that the intent was to clearly keep intensive services available. In response to a question regarding availability of stimulus money for case management, Sharon shared that it is very early in the process and although there may be future federal action, the outcome is uncertain at this point. As the Governor's budget proposal has now also been released, Sharon cautioned that this is just the first step and there will be a lot of legislative activity before the final outcome is known.

Sharon then turned the meeting back to Rod Kornrumpf, who also noted that he wanted to echo Sharon's comments about this region and the work they have done regarding partnerships. Rod reiterated that, as Mike noted earlier, no decisions have been made regarding the redesign of SOS and the input received from this meeting, along with the input gathered from similar meetings held across the State is critical to the process. Rod then asked the participants to break into smaller work groups to address the questions on the agenda.

After the break out session, Rod reconvened the meeting and requested that each group give a brief "report out."

Group 1:
Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Step down services for MI/DD
- More psychiatrists! Out patient
- Can regional hospitals take more intensive services? Why aren't regional hospitals being accessed?
- Integrated provider—all the way around (Mi/CD/Behavioral/DD
- Mobile providers that can prescribe meds and nurses sharing resources/crisis response
- Being able to go back to placement – continuity of care. People losing placement waiting for new.
- More crisis stabilization beds
- Funding for short term crisis beds – quicker access
- Provide facility for long term care regardless of engagement in treatment – a safe place is necessary without cost going back to the county

Question #2 – What do you need SOS <u>not</u> to do in this region?

- We don't want you to not give us more psychiatrists
- Don't duplicate services that are being done – IRTs, crisis, foster care, CRT

Question #3 – How do we create a system of public/private partnerships?

- Synergy consistency – doing it right – review model
- Funding – how do dollars follow consumer; sharing of resources cross counties and state
- State assist in expanding services that are in the community

- Continuity of care
- MI/CD – working together
- Tele-video psychiatry

Group 2:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Uncompensated care
- Improve transition services for psychiatry
- Expand IRTs/beds (transitional) or non-IRTs dollars to go there (old Rule 36) beds
- Keep/expand community options/increase length of stay in community hospital
- Expand services for medically complex patients
- Care for MI/D and Legal 3 sex offenders
- Consider CBHH use for complicated MI/CD folks who are in pre-contempt stage of change
- Consider alternative, less restrictive options for transitional-age people
- Consider possibilities for implementing hard-reduction in the community
- Develop in-between intensive outpatient services
- Improve wrap-around/collaboration with and among community based providers
- Streamline coordination of care in terms of assessment, coordination (treatment plans, diagnostic assessments)
- Develop an SOS diagnostic assessment program – "I need a diagnostic assessment – stat!"
- Fund outreach services by providers for coordination of care (when a person is inpatient for example)
- Use funds to examine current mental health system
- Consider psychiatric "urgent care," diversion teams, psychiatry, transitional housing
- Persons with uncomplicated meds – transfer to psych nurse
- Help build and implement EMACS business plan
- Develop permanent supportive housing in a community setting for people not currently "place able"
- We do want SOS to be 24/7 (like providers)
- We do want incentive dollars for mental health professionals to do 24/7 work to meet acute needs
- Create mental health guardian to speed up implementation of treatment
- Standardize mental health court system for east metro
- Advocate for community commitment and Jarvis implementation – dual commitment to facility and hospital

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Anything a community provider can do.
- No increased "incentives" for people at AMRTC for too long
- Crisis response

Question #3 – How do we create a system of public/private partnerships?

No responses to this question.

Group 3:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Discharge planning right away – connect with existing providers
- Better hand-offs (both mental health/chemical dependency and medical integrated care) while person in hospital – common protocol with payment codes (individualized, practice agreements)
- Integrated medical and mental health treatment while in RTC
- When gaps identified, work with community services and enhance local services – bring resources i.e., supported employment (long term)
- Redirect unused acute care resources to provide community support; i.e., employment, housing, transportation
- When inpatient services no longer needed – discharge person – have dollars, resources follow – individualized flex funding (for example, injectables)
- Let State do what they do well, let community do what they do well – identify and collaborate; identify decision process
    - State – acute care difficult patients
    - Community – medically complex
- Partner with community mental health agencies; i.e., prescribers

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't provide service just because there is a gap created by payment policy mechanisms
- Don't duplicate what others already do

Question #3 – How do we create a system of public/private partnerships?

- Convene and redesign collaborative process
- Support infrastructure such as step-down models in community – true transition
- Waiver for post-hospital transition – time limited
- Look at efficiency – don't keep old models just because
- Olmstead issues – address this prior to lawsuits.

Group 4:

Question #1 – What do you need State Operated Services (SOS) to do in this region?

- Community-based behavioral services to avoid hospitalization
    - Crisis behavioral beds
    - Crisis behavioral teams
- Access to behavioral experts
- Incentives for professionals/psychiatry in mental health field
- Holistic approach of care at AMRTC – including behaviors
- Provide curriculum (required for kids, not adults) for adult foster care

- Housing options needed/transitional and permanent; i.e., corporate foster care moratorium barriers
- Provide training for handling behaviors in community residential – avoiding 9ll

Question #2 – What do you need SOS <u>not</u> to do in this region?

- Don't build state run hospital (CBHHs) services in metro

Question #3 – How do we create a system of public/private partnerships?

- Look at behavioral/residential homes as alternative to state hospitals
- Need more recovery step-down services, including residential
    - Moves people through system
    - Step-down from corporate, involving current corporate providers, new waiver service
- MI/CD programming – better integration
- Vocational programming

Rod concluded the meeting by again thanking the participants for their input. He shared that the information gathered in today's meeting would be compiled into a report and shared with them. That information, along with the information from other meetings held statewide, will be used to compile the report to the Legislature that will be submitted in early March.

SOS REDESIGN DIALOGUES MEETING

February 22, 2010

Jim (Law Enforcement) stated there is an empty jail available in Carver County which could be called something else.

Read stated that transportation is a big issue and law enforcement should not transport.

Ron Brand stated be careful of the path taken. Nobody wants to go down the path without protections.

Roberta Opheim stated there are empty houses as well as jails and prisons. She is willing to look at all creative solutions. Although, using a current jail or former jail is the same.

Take the violent person out of the situation. We need to have a place for the most violent.

Jim (Law Enforcement) agreed we have to have a place for the violent.

Alan Radke stated that the people who are violent have that behavior for a reason due to the illness they have and the situations they have encountered. Need to have a place to put these complex people that need treatment with a comprehensive approach. Just having a place with high security is not enough.

Many people that have medical conditions have behavior issues. We are concerned about the inappropriate use of law enforcement.

Read asked what is acceptable and not acceptable? What are the quality standards of care for a person with a mental condition?

Dr Geller stated that the last part of the discussion violates the charge. CBHH's operate this way now. How do we operate going forward?

Mike Tessneer stated that hospitals will be within hospitals.

Ron Brand asked how can we avoid hospitalization or re-hospitalization.

Doug Seiler commented we are looking at major priorities, not solutions.

Rick Amado stated the need should be to describe the problem for discharge planning and transportation.

Alan Radke stated the work that has been done by the regional groups' highlights the problem and the need for a solution, but doesn't answer the specifics. These themes fall under an umbrella for a solution.

Read stated the meetings were around what we should be doing and what we should look like.

Roberta Opheim stated people need to get in faster and out faster, not too much and not too little.

Charlie asked what are the important components that need to be changed?

Ron Brand stated at the common themes, I came up with the following list with the budget area:

- Improve discharge and transition process (aftercare).
- Avoidable hospitalizations or re-hospitalizations (unnecessary).
- Co-occurring or medically complex clients.
- How do we respond to new generation of clients
- Partnerships that can augment (enhance) capacity.

Pam stated we should be supporting people with SPMI in community settings. Previous focus has been on hospitalization. Acute episodes are causes for hospitalization.

What about Rule 20 placements of mentally ill people.

Aggressive behavior, have to consider the safety of other patients. People with recorded criminal history. State role as a safety net for these populations.

Richard Amado - we are addressing adults here but not children. Address the resources for early intervention with children/adolescence transition youth.

Roberta Opheim stated the mental health system is separated from medical health system. Re-integration of medical care.

Ron Brand –people stay in Anoka longer than they should. People with mental health issues are in hospitals due to other health issues.

Bill Hudock asked where does the state's responsibilities start and end.

Evaluation care opposed to treatment care. New patients come in with no work up. Focus is on conditions that we can manage. Psychiatrists are not allowed to evaluate.

Rick Amado stated the problem is that we can't have more than one professional billing at a time.

Roberta Opheim stated that too little time (15-25 minutes) goes into an evaluation. Children are admitted because they had an episode at home. We need comprehensive initial assessments.

Rod Kornrumpf stated there is no commonality, a common assessment is needed.

Jeffrey Geller stated the problem is that there are no state operated psychiatric beds that could take more violent or medically acute patients.

Charlie stated that the state needs to establish psychiatric hospitals.

Ed Eide stated give access more psychiatrists to move admissions quicker and the system to access SOS. Medical record/assessment should follow the patient.

Set good quality standards for how assessments are done.

Alan Radke stated currently we do not have a model of psychiatric care in MN.

Have a statewide standard psychiatric evaluation with Medicaid.

Richard Amado stated we need to stay engage with the person and not pass them off. Collaboration with people's medical care.

Hospitals need to speak with the community team.

Alan Radke stated SOS has been working on a collaboration system of care.

Pat asked do we want 24/7 psychiatric hospital or 24/7 psychiatric availability.

Read suggested we have psychiatric levels like the levels of trauma centers.

David stated every hospital should have a mental health plan for their overall health care.

Bill agreed with Read that levels would help. Set levels of 1, 2, 3. The current budget situation may limit the future of care.

Read stated he would like to see the length of stay at hospitals reduced.

Doug Seiler stated hospitals could serve a wider variety of ages. There is a shortage of beds in out state MN.

David Fassler commented on how to avoid unnecessary hospitalization. Set up a regional case management system with flexible funds (motel, transportation, medication, home help, etc.). Enhance community base hospitals or use the general use hospitals. States are moving towards decreasing SOS. No level of care with a free standing hospital. There is a push to have more acute services in general hospitals.

- Mobile crisis team with 24/7 psychiatric access.
- State to take the lead in training to increase the hospitals service capacity.
- Shift funds to the community base to allow for extended stay. Operating subsides with hospitals with Medicaid contracts.
- Comprehensive assessment service.

- Community needs incentive.
- Increase use of certified peer specialists.
- One on one talking is cost effective by reducing unnecessary care.
- Approve hospital stay when CBHHs are at 90% capacity (regional).
- Check list of information.
- Multiple levels of care (extended care, etc.).

1. What do you believe State Operated Services needs to do in this Region?

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	Participants	**90**	**13**	**22**	**38**	**53**	**50**	**75**	**48**	**58**	**30**	**71**	**44**	**26**	**67**
1	Redesign central pre-admissions	X				X	X	X	X		X	X	X	X	
2	Need long term care services for persons with MI or medically/behaviorally complex and dementia	X	X				X	X		X				X	X
3	Establish Statewide 24 Hr. crisis lines/response	X	X					X							
4	Access to transportation	X			X	X	X	X	X	X	X	X			
5	Restore county grants	X													
6	Increase access to crisis, crisis response, crisis stabilization, psychiatric urgent care, transitional housing, respite beds, psychiatric, mobile services	X		X	X		X	X	X	X	X	X			X
7	Use certified peer specialists	X			X		X								
8	Create outpatient psychiatric services	X				X			X						
9	Layoff staff when program closes	X													
10	Create consumer education services (medications, diagnosis, resources, referrals)	X								X					
11	Standardize forms & information across providers (electronic data on key cards, care plans, medical history)	X							X					X	
12	Improve care & timeliness of care	X						X							
13	Reduce use of ITV/Increase use of in person care	X													
14	Create educational services for community providers	X													
15	Create a peer specialist program	X													
16	Improve access to patient records to reduce repetition	X				X									
17	Recruit more professionals/Define the labor force needed	X				X		X							
18	Maintain/Refine the role of the safety net, especially for violent patients	X				X	X	X	X	X	X	X		X	

1. What do you believe State Operated Services needs to do in this Region?

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19	Create training opportunities between state professionals and private professionals	X						X							X
20	Increase flexibility of licensing rules/reduce burdensome rules	X		X		X		X							
21	Improve the accessibility of medical records between providers and the patient	X				X	X								
22	Improve Employee Training	X						X							X
23	Cut the admission process time and make it easier	X				X	X	X	X		X				
24	Continue the Crisis Intervention Training	X													X
25	Improve hours of service	X													
26	Develop more crisis beds	X												X	X
27	Create funding mechanisms to pay of hospital security rather than using local law enforcement	X													
28	Reduce liability	X													
29	Re-evaluate criteria for length of stay and need for hospitalization	X													
30	More treatment orientation at CBHH	X													
31	Develop a service between crisis and IRTS	X		X											
32	Develop partial hospitalization services or provide adequate resources for such service	X						X		X					
33	Increase input from social workers & families before discharge	X					X	X							
34	Develop a specialized care facility for those who are hard to serve/hard to place or a step down facility (detox, elderly, higher behavioral issues, DD/MI Aggressive, Chronic Users)	X		X			X	X	X	X	X	X	X	X	
35	Maintain existing hospitals	X													
36	Re-evaluate admission criteria for co-existing conditions	X							X		X				
37	Provide consultation to clinics, community providers, & PharmDs	X			X										
38	Develop detox services for persons with MI	X													
39	Provide nursing services after hospital stay	X													
40	Allow for longer hospital stays	X													

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41	Split the CBHHs between hospital & lower levels of care	X							X					X	
42	Improve access to closest CBHH (psyc/neuro-psych services)	X		X	X	X		X	X	X	X				
43	Reduce the time law enforcement waits for a decision	X										X			
44	Develop a medical stability assessment capability	X													
45	Create a tiered system of care (acute, super IRTS, IRTS, ILS, Independent)	X		X	X	X	X	X							
46	Expand services to care for medically fragile, aggressive, and incarcerated		X		X		X	X	X	X	X	X	X		X
47	Create specialized, affordable housing with services (long term/short term), including housing for Native Americans and housing to reduce homelessness		X	X	X		X	X	X	X	X	X			X
48	Create a "last resort" facility that can't refuse admission		X												
49	Develop or create more ACT Team's			X	X									X	
50	Use CBHH for wait list at AMRTC			X											
51	Establish timely communication for discharge, including all parties in the discharge process and care			X		X	X	X		X	X	X			
52	Have CBHH's accept individuals on stays of commitment			X					X						
53	Increase the service options for individuals who have dual diagnosis			X	X		X		X		X	X	X		X
54	Use St. Peter as an alternative to Anoka			X											
55	Change catchment areas			X											
56	Shift funds to bolster psychiatry services			X											
57	To provide service when funding runs out				X										
58	Beef up Community Support Services for persons with MI				X									X	
59	Develop new services to replace Personal Care Assistants for people with MI				X										
60	Increase dental services for persons with MI				X										

1. What do you believe State Operated Services needs to do in this Region?

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61	Involve the Native American Community in addressing the needs of Native Americans with Mental Health needs				X	X									
62	Provide more case management/care coordination/care navigation post hospitalization				X	X	X			X			X	X	X
63	Keep Bridge House and/or develop more services like Bridge House				X										
64	Improve access to psychiatry or APRNs				X								X		X
65	Provide crisis intervention training for law enforcement				X			X							X
66	Eliminate barriers to continuity of care				X		X				X	X		X	
67	Remember the unique needs of children				X										
68	Create flexible funding solutions for services				X	X				X			X	X	X
69	Need a permanent commitment of State services				X	X									
70	Services need to support what has already been established				X										
71	Develop more public awareness of services available and how to access them					X	X				X	X	X		
72	Refer directly to CBHH if medical needs have been assessed already					X									
73	Expand services to care for children and juveniles					X	X		X	X	X				
74	Establish forensic services or a more secure facility for very violent acting out behavior or those who are dangerously aggressive					X	X			X	X		X		
75	Utilize all funding streams more effectively					X				X					
76	Provide incentives to new mental health professionals					X		X							X
77	Increase range and timeliness of evaluations					X									
78	Develop support services for parents coping with children with MI or families dealing with adults with MI						X					X			

1. What do you believe State Operated Services needs to do in this Region?

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79	Assist with medication management and establishing a psychiatric appointment upon discharge						X	X		X			X		
80	Improve communication between treating professionals including mental health and chemical dependency services						X	X	X	X	X	X			
81	Be the keeper of knowledge, best practices and resources						X		X	X					
82	Communicate with the courts on commitment issues						X								
83	Reduce the wait in the ER						X								
84	Eliminate exclusionary admission policies						X						X		
85	Maximize Revenue through billing							X					X		
86	Dialog about utility/quality of life with club houses							X							
87	Develop models of care for clients in jails							X		X		X	X	X	
88	Funding for sex offenders should be the responsibility of corrections, not human services							X							
89	Adjust Admission criteria to meet needs							X					X		
90	Sub-acute interventions							X							
91	Prevention/Proactive measures							X						X	
92	Expedited response							X							
93	Set realistic discharge criteria from CBHH							X				X			X
94	Provide funding for Board and Lodge facilities							X							
95	Consider CBHH and community hospitals as the same level of care; nurse to nurse reports							X							
96	LOCUS doesn't always fit for a patients circumstances upon discharge and returning home							X	X						
97	All CBHHs need to be Joint Commission accredited														
98	Need greater stabilization prior to discharge							X				X			
99	Track the number of persons released from MH services who end up in the correctional system							X							

1. What do you believe State Operated Services needs to do in this Region?

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100	Provide training to nursing homes and senior living							X							
101	Provide resources in the area of sex offenders							X						X	X
102	Maintain the expertise in serving hard to serve clients/help fill the gaps with other outliers							X							
103	Reform medical clearance criteria to make admission and transition more seamless and efficient							X	X						
104	Be a collaborative policy maker								X						X
105	Create a centralized database for a consumer's health record, linked to other providers								X					X	
106	Provide seed funding to create a program and when it is well tested turn it over to the private sector								X						
107	Create formal partnerships with community mental health centers, local hospitals, nursing facilities, etc.								X						
108	Have CBHH staff more involved in discharge planning								X				X		X
109	Have each CBHH have their own qualified Rule 25 assessor								X						
110	Train staff in the needs of the geriatric population								X						
111	Provide an adequate supply of medication upon discharge								X						X
112	Address the needs of people with MI who have sexual acting out issues								X						X
113	Work with border states to make services accessible								X			X			
114	Lower the high readmission rate								X						
115	Make it clear that voluntary admissions are okay and holds are not required								X	X			X		
116	Understand the importance of family								X						
117	Establish telemedicine capabilities across the state									X				X	

1. What do you believe State Operated Services needs to do in this Region?

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118	Create a central clearinghouse									X					
119	Decrease the number of difficult cases from greater MN that end up in Hennepin County									X					
120	Eliminate corporate foster care moratorium									X	X				
121	Do not discharge from St. Peter or METO in mass									X					
122	Match or increase allocations to Hennepin County for high need patients									X					
123	Expand the parameters of client's served by C.A.R.E.									X					
124	Create services for geriatric population with chemical dependency issues									X				X	
125	Increase contract beds in the metro region									X				X	
126	Trust Hennepin County eligibility assessments									X					
127	Address lack of 24/7 access									X			X		X
128	Address the needs of undocumented persons									X					
129	Organize the system to address unmet needs									X					
130	Equity across disability groups									X					
131	Fix CADI/DD placements to meet client needs, improve CADI flexibility									X	X	X			
132	Use a health model approach to providing care and treatment									X		X			
133	Allow for board and lodge facilities with special services										X				
134	Increase beds										X				
135	Remove moratoriums on new foster care development										X		X		
136	Develop services for young aggressive males											X			
137	Develop services for veterans											X			
138	Need one on one talk therapy											X			
139	Implement a wellness recovery model											X			
140	Implement alternative therapies											X			
141	Increase consumer involvement in their care and treatment											X			
142	Make sure there is a common sense redistribution of hospitals doing acute care											X			

1. What do you believe State Operated Services needs to do in this Region?

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143	Don't cut back on Social Worker visits											X			
144	Develop employment opportunities											X			
145	Establish a facility for persons with MI and DD and TBI												X		
146	Replicate the Community Partnership Network												X		
147	Break down barriers												X		
148	Involve case manager/counties in case planning upon discharge												X		X
149	Get rule 20's out of jail												X		
150	Develop a locked residential unit												X		
151	Develop a locked facility for CD waiting placement												X		
152	Assess is SOS foster care is needed												X		
153	Discharge planning with follow-up in place													X	X
154	Increased Accountability for post acute needs													X	
155	Integrate data systems													X	
156	Create a comprehensive data tracking system													X	
157	Conduct a gap analysis and fill gaps in the system													X	
158	Establish employment as part of the treatment plan													X	
159	Enforce Jarvis orders													X	
160	Expand C.A.R.E. MI/CD to address pain management and opiate addiction													X	
161	Expedite people getting on MA													X	
162	Improve accessibility to regional hospitals														X
163	Increase integration between providers (MI, CD, behavioral, DD)														X
164	Improve the ability of persons with mental illness to return to their place of origin														X
165	More funding for short term crisis														
166	Provide uncompensated care														X
167	Improve transition services for psychiatry														
168	Improve wrap-around/collaboration with and among community-based providers														X

1. What do you believe State Operated Services needs to do in this Region?

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169	Provide an SOS diagnostic assessment program														X
170	Fund outreach services by providers for coordination of care														X
171	Use funding to examine the current mental health system														X
172	Consider possibilities for implementing harm-reduction in the community														X
173	Standardize mental health court system fro east metro														X
174	Develop a holistic approach to care														X

2. What do you believe State Operated Services should not do in this region?

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	Participants	**90**	**13**	**22**	**38**	**53**	**50**	**75**	**48**	**58**	**30**	**71**	**44**	**26**	**67**
1	Eliminate Central Pre-Admissions	X							X				X		
2	Build local community resources then bail out when dollars get tight	X													
3	Cost-shift to counties	X								X				X	
4	Quit reallocating state staff when programs/services close	X													
5	Dismiss a person's knowledge of their illness	X													
6	Stop providing MSOCs care or do not need more MSOCs homes	X					X								
7	Don't compete for psychiatric/mental health professionals, but work together to meet a region's needs	X							X				X		
8	Do not layoff the most experienced workers	X													
9	Utilize local control for placement	X													
10	Impose DHS decisions	X													
11	Shove patients out of the hospital too early	X													
12	Protect State Employees (Lay off vs. Save Jobs)	X													
13	Put up barriers to what the community needs	X						X	X		X				
14	Utilize evidence-based in rural areas	X													
15	Cut finances for local services	X													
16	Close MSOCs homes to use funding for individuals with higher behavioral needs	X													
17	Saying no to law enforcement	X													
18	Do not override the ER doctor	X													
19	Do not create waits of 2 to 3 hours	X													
20	Change financial compensation for case management and ARMHS - support staff is a must for ongoing recovery	X													
21	Do not brand, categorize, or stigmatize persons with Mental Illness		X												
22	Do not take funding from local resources & services			X		X		X	X		X				

2. What do you believe State Operated Services should not do in this region?

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23	Don't duplicate local services (i.e., forensic testing, IRTs, crisis, foster care, CRT, outpatient mental health, case management)			X			X	X	X	X	X		X	X	X
24	Do not mess with ACT Teams and Crisis				X										
25	Do not mess with Eveleth or Bridge House				X										
26	Do not forget about Native American Populations				X										
27	Do not direct community services					X									
28	Don't go away					X	X								
29	Don't use utilization data as a decision making instrument					X									
30	Back off on barriers for ARMHs Services					X									
31	Discharge the patient without a discharge summary & detailed aftercare plans					X					X				
32	Do not establish one statewide crisis line						X								
33	Increase paperwork						X	X							
34	Perpetuate failed model/safety net						X								
35	Develop long term Rule 36's						X								
36	Compete with the private sector on services						X		X			X			
37	Wait so long to ask our opinions						X								
38	Abandon children & adolescents with mental illness						X								
39	Open enterprise operations that self perpetuate						X								
40	Build services only to capture Medicaid revenue stream						X								
41	Do not abandon the role of the safety net							X						X	
42	Do not dismantle infrastructure							X							
43	Don't let quality suffer							X							
44	Do not band-aid							X							
45	Reduce our State Staffing funds							X							
46	Use only the LOCUS as a determination for hospital care							X							
47	Do not give unfunded mandates							X						X	
48	Don't ignore feedback from case manager, families, providers, etc. when decisions are being made							X							
49	Don't cut community clubhouses or crisis center							X							

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50	Don't pass costs on to others							X							
51	Stop saying, "No"!							X							
52	Do not automatically send transients back to the county of commitment							X							
53	Don't talk about the Baldrige system without explaining it							X							
54	Don't lose sight of the initiative successes							X							
55	Have state staff put additional pressure on county case managers who are working to find a placement								X						
56	Don't limit staff expertise								X						
57	Don't specialize to the point that services for certain populations are available only at AMRTC								X						
58	Don't force care to be provided in neighboring states when it should be provided in Minnesota								X						
59	Don't ask if we have called another hospital								X						
60	Do not use all dollars for crisis. Use for prevention also								X						
61	Close CBHH's									X	X				
62	Don't close AMRTC or downsize beds									X				X	
63	Stop reducing beds until alternatives are developed									X					
64	Don't silo funding streams									X					
65	Don't take on case management									X			X		
66	Don't do crisis for communities									X				X	
67	Don't continue the status quo									X					
68	Should the state be in the dental business? Put pressure on current providers to step up to the plate									X					
69	Eliminate beds										X				
70	Deny admission for minor medical conditions										X				
71	When a CBHH needs help law enforcement should not be told how to do their job. Allow law enforcement to use their equipment											X			
72	Do no harm												X		

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73	Do not mix general psychiatric with neurocognitive/developmentally disabled												X		
74	Stop determining the court order												X		
75	Medication changes at SOS without consultation and coordination with treating physicians												X		
76	Focus so much on LOCUS												X		
77	Send the letter - indicating client is no longer eligible for services and is responsible for their cost of care												X		
78	Close facilities or programs													X	
79	Do not apply a medical model, namely LOCUS to providers who are focused on recovery													X	
80	Do not launch new projects for capital investment without first evaluating with the community													X	
81	Keep Central Pre-admissions													X	
82	Keep the bed tracking database													X	
83	Restrict the number of psychiatrists														X
84	No increased "incentives: for people at AMRTC too long														X
85	Provide service just because there is a gap created by payment policy mechanisms														X
86	Build State run hospitals in the metro														X

3. How do we create a system of public/private partnerships that best serves individuals and their families?

		Region 4 South Hoffman, MN Jan. 12, 2009	Region 7E Cambridge, MN Jan. 25, 2009	Scott/Carver Shakopee, MN Jan. 27, 2009	Region 3 Duluth, MN Jan. 28, 2009	Region 2 Bemidji, MN Feb. 1, 2009	Region 5+ Brainerd, MN Feb. 2, 2009	Region Mankato, MN Feb. 4, 2009	Region 4 Fergus Falls, MN Feb. 5, 2009	Region 11 Minneapolis, MN Feb. 8, 2009	Region 1 Thief River Falls, MN Feb. 10, 2009	Region SW 1B Marshall, MN Feb. 12, 2009	Region Waite Park, MN Feb. 16, 2009	Region Anoka, MN Feb. 19, 2009	Region Dakota County, MN Feb. 19, 2009
	Participants	**90**	**13**	**22**	**38**	**53**	**50**	**75**	**48**	**58**	**30**	**71**	**44**	**26**	**67**
1	Give local entities the funding	X									X				
2	Listen to consumers	X										X			
3	Increase access to psychiatric services	X													
4	Utilize some of the CBHH beds as either IRTS or longer term stay	X													
5	If crisis beds are full, let us have access to an open CBHH Bed	X													
6	Train local crisis intervention people that would be available 24/7	X													
7	Listen to consumers on formal/informal usage of services	X								X					
8	More local education to help develop partnerships (medical professionals & law enforcement)	X		X	X		X	X	X		X				
9	Brainstorm on gaps in service coverage	X													
10	Continue to work on effective communication, including discussions focused at reducing stigma and understand issues to develop solutions	X	X			X		X	X	X				X	
11	Consider RFP Process rather than State provision	X													
12	Contracting for staff to purchase what you need	X													
13	Explore how we can do this	X													
14	Partner with community services	X					X			X					
15	Coordinate/partner with Veteran's Administration	X													
16	If the state provides the safety net, private providers may be willing to take risk on some clients		X												
17	Create an accountable structure		X												
18	Establish wraparound, supportive housing with services		X					X							
19	Create a one stop shop		X												
20	Look at other states			X											
21	Have SOS meet with local developers			X											
22	Redistribute staff to meet local needs			X											
23	Share information about innovative ideas & services			X						X					

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24	Include funding for psychiatry at Bridge House				X										
25	Fund transportation costs				X										
26	Provide training to Dental Clinics on how to manage behavioral issues				X										
27	Combine community health center & community mental health center (merge primary and Mental Health Care)				X										
28	Create Urgent Care Services				X										
29	Establish more collaboration with Tribes, Advocacy, Private Providers and other partners				X	X			X					X	
30	Establish triage services at local Jails					X				X					
31	Redefine safety net on a regional basis					X					X				
32	Establish collaborative approach on staffing/recruitment					X			X						
33	Collaborate on tele-health					X						X		X	
34	Establish CMS Certification of the CBHH						X					X			
35	Establish a shared model of care					X									
36	Fund more early intervention and prevention					X	X								
37	Coordinate with TBI facilities more					X									
38	Establish flexible & adequate funding solutions where the funding follows the consumers					X		X					X		X
39	Invite private sector to meetings to find out what they have to offer (build relationships)						X								
40	Create an incentive for communication						X	X							
41	Create data systems that are effective in improving the care and treatment for persons with MI						X								
42	Include private industry services in the expanded central intake role to assist in the placement needs for holds and commitments						X				X				
43	Develop better partnerships between DHS divisions and corrections/courts						X								
44	Work with religious organizations to educate religious leaders on Mental Illness							X							
45	Be willing to listen and see the differences between greater Minnesota vs. Metro							X				X			

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46	Improve the integration of services including those delivered in jails, by law enforcement, and mental health providers							X	X						X
47	Establish Board and Lodge housing funding							X							
48	Create incentives to those who provide evidence of community collaboration							X						X	
49	Keep patients close to home so partnerships can work							X							
50	Work with the private sector to develop a constellation of needed services: employment, social support, providers, housing, place to volunteer, clubhouse, additional in-home services, transportation							X			X			X	
51	Consistent legal advice							X							
52	Pre-plan prior to a crisis arriving							X							
53	Build upon the successes of the initiatives							X		X			X		
54	Honor and build upon the partnerships that you already have							X	X				X		
55	Develop a holistic treatment approach to care between providers								X						
56	Collaborate on a solution for persons with MI and predatory, aging populations								X					X	
57	Promote, lead, model in collaboration								X						
58	Increase CSP and aftercare services								X						
59	Have floating staff								X						
60	Develop trust between parties								X						
61	Create specialty collaboration teams								X						
62	Improve reimbursement standards to value community/outpatient services								X						
63	Include diagnosis of CD								X						
64	Include consumers and families in focus/study groups								X	X					
65	Loosen up HIPAA regulations for patient care									X					
66	Release more waiver slots and end corporate foster care moratorium									X					
67	Create models of braided funding									X					
68	Don't burden providers with regulations/paperwork that hampers good outcomes									X					

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69	Establish legislative collaboration with providers to identify issues									X					
70	Use Hennepin County forensic care management as expert									X					
71	Create internships with institutions of higher education									X					
72	Connect with homeless shelters									X					
73	Don't keep redoing diagnostics and functional assessments									X					
74	Establish more dual diagnosis beds										X				
75	Improve the responsiveness of the Doctors										X				
76	Partner on liability issues										X				
77	Allow local psychiatrists to gain admitting privileges to CBHH											X			
78	Examine moratoriums on beds												X		
79	Re-establish crisis waiver funding for this population												X		
80	Develop licensing/standards for treatment foster care												X		
81	Efforts to make continuity of care a priority												X		X
82	Co-locate services for persons with multiple diagnosis													X	X
83	Review the model for Community Support Services														X
84	Support infrastructure such as step-down models in community														X
85	Waiver for post-hospital transition														X
86	Establish vocational programming														X