Report on the Utilization of the Community Behavioral Health Hospitals

Chemical and Mental Health Services Administration

March 30, 2012

Legislative Report

Minnesota Department of **Human Services**

Report on the Utilization of Community Behavioral Health Hospitals

March 30, 2012

Minnesota Department of Human Services
Chemical and Mental Health Services Administration
PO Box 0988, Saint Paul, MN 55164-0988, (651) 431-2500
http://mn.gov/dhs

Cost to Prepare Report
Minnesota Statutes, section 3.197 requires disclosure of the cost to prepare reports. The cost of this report was approximately $15,000.

Contents

Report on the Utilization of Community Behavioral Health Hospitals

Executive Summary

The 2011 Legislature directed the Minnesota Department of Human Services (DHS) to prepare a report on how the Community Behavioral Health Hospitals (CBHHs), operated under DHS's State Operated Services Division, will be fully utilized to meet the mental health needs of the regions in which the hospitals are located. DHS met with and surveyed the Adult Mental Health Initiatives (regional planning groups) to identify their priority recommendations regarding the CBHHs and summarized their ranked priorities in this report. DHS also collected 2011 data to more clearly characterize the patients currently served by the CBHHs, and analyzed capacity and usage data to quantify utilization of the CBHHs.

DHS's analysis of CBHH data and Adult Mental Health Initiative recommendations indicates that the CBHHs have grown into an important element of non-metro Minnesota's continuum of care for people who need acute psychiatric in-patient care. Ninety-five percent of CBHH patients are from non-metro counties. A large number of those patients are committed to the Commissioner of the Department of Human Services (over 50% of CBHH patients). Patients under civil commitment are more likely to require comprehensive and complex assessment, treatment, and discharge planning.

The seven CBHHs operated at 69% of licensed bed capacity and 84% of their service capacity in calendar year (CY) 2011.[1] These utilization rates are gradually increasing, with the January 2012 rates averaging 79% of licensed beds and 91% of service capacity. The CBHHs can continue to increase their service capacity by addressing the factors that reduce utilization, especially shortages of psychiatrists and advanced practice registered nurses.

Regions rely on the CBHHs differently, depending on the distance to the nearest CBHH or community hospital with a psychiatric unit and on the complement of community services that are available locally to support people with serious mental illness. Regions also vary in their priority recommendations to DHS about the CBHHs. Although there was significant variation in the rankings, the top three priorities identified were the following:

- Local, reliable, and timely access to a secure facility for people who have exhibited violent or aggressive behavior
- Discharge based on joint planning among the patient, the local mental health authority, natural supports, community providers, and CBHH staff
- Access to, and retention of, basic needs while a patient is at the CBHH and after discharge

Although utilization of the CBHHs is increasing (and could continue to increase with improvements currently being implemented by DHS), the Adult Mental Health Initiatives in non-metro Minnesota still face a serious gap in the state's mental health continuum of care: access to psychiatric beds for adults who have serious mental illnesses and who are aggressive or violent. The CBHHs lack the physical plant, staffing, and security to serve this population. When an appropriate in-patient psychiatric bed for this population is not readily available, it can result in turmoil for hospital emergency departments or

[1] Each CBHH is licensed for 16 beds. Service capacity is a daily measure of actual bed capacity given the acuity of the current treatment milieu, staff availability, etc.

psychiatric units, unsafe conditions for patients and staff, and patients ending up in jail instead of receiving the mental health services they need.

Addressing this gap requires consideration of the entire continuum of care, of which the CBHHs are a part. Other important factors affecting the continuum include the availability of beds at local community hospitals, the Anoka Metro Regional Treatment Center, and Intensive Residential Treatment Services, and available community resources.

The availability of in-patient psychiatric beds for people with serious mental illness and aggressive or violent behaviors is dependent upon the flow of patients through the system, the transitions that patients make between levels of care, and the range of housing and support services available in the patients' local communities. Making sure that beds are available when needed, and that patients' transitions back to the community are smooth, requires the development of complex relationships among the levels of care, with "front door" and "back door" challenges that can only be solved if the problem is approached at multiple levels simultaneously.

DHS has already been acting on the recommendations from stakeholders, and proposes both short-term and mid-term strategies for pursuing joint solutions. This work falls into four categories:

- Implementing short-term changes to improve access to the CBHHs and the Anoka Metro Regional Treatment Center to achieve streamlined, collaborative admissions.
- Implementing short-term changes to coordinate discharges from the CBHHs and the Anoka Metro Regional Treatment Center to assure appropriate, collaborative discharges and open some beds currently being filled by patients who are no longer in need of a hospital level of care.
- Continuing to implement operational improvements to policies, services, and treatments to increase utilization and respond to the priorities identified by the regions.
- Instituting a two-tier collaboration process. Statewide, DHS will facilitate coordination among all stakeholders to review goals, formulate a shared safety net concept, integrate mental health into Minnesota's health care reform efforts, review and revise service arrays and quality standards, devise funding models to support the services, and establish the technological and logistical systems needed to administer and evaluate the system. Regionally, DHS will help organize regional collaborations to improve the existing continuum of care while planning and implementing changes brought by the statewide collaborations, federal requirements, and the evolving marketplace.

The preparation of this report has been a useful step in DHS's process toward clarifying and improving the role of the CBHHs in non-metro Minnesota's mental health continuum of care. Pursuing short-term operational improvements and collaborating to loosen the front and back doors of State Operated Services facilities have already begun to strengthen DHS's relationships with some of the stakeholders who will be involved in ongoing collaborations. The ultimate result of this work—an integrated network of community-based services to support people's mental health needs at all levels of care—will help Minnesota assure that all people with mental illnesses have access to the right care in the right place at the right time so they can pursue their recovery in their home communities.

I. Introduction

As directed by the Laws of Minnesota 2011, First Special Session, Chapter 9, article 8, section 8, the Minnesota Department of Human Services (DHS) has prepared this report to address the utilization of the Community Behavioral Health Hospitals (CBHHs) in Minnesota (see Appendix 1 for the exact legislative language). The legislation directs DHS to gather input from the regional planning work groups for adult mental health on their recommendations for the appropriate utilization of the CBHHs and to respond to this input with a description of how the CBHHs will be fully utilized to meet the mental health needs of regions in which the hospitals are located. The regional planning work groups referred to are the Adult Mental Health Initiatives—16 groups of counties and other stakeholders coordinated under the auspices of the Adult Mental Health Division of DHS (see Appendix 2 for a list of the 16 Initiatives and the counties in each).

This report reviews the history of the CBHHs and describes the patients these hospitals currently serve. It then summarizes the recommendations that DHS has received from hundreds of stakeholders from across the state during the past three years regarding the CBHHs and the adult mental health services delivery system in Minnesota. This input was collected by the Adult Mental Health and State Operated Services divisions of DHS's Chemical and Mental Health Services Administration. The report then presents current data on the priorities of the Adult Mental Health Initiatives, gathered in December 2011 and January 2012. The report synthesizes all of this input to identify a DHS approach for CBHH utilization.

DHS proposes several short-term changes to address the priorities identified, including operating improvements in the CBHHs and changes that will improve patient flow through State Operated Services. It also includes a two-tier (statewide and regional) collaboration process for working with stakeholders on some of the more systemic changes that will be needed, especially as health care reform re-shapes the mental health services landscape. The approach grows out of a vision of a community-based, recovery-driven, integrated system of care for people with mental illness. This vision aligns with the vision articulated by the Minnesota Mental Health Action Group: ". . . a comprehensive mental health system that is accessible and responsive to consumers, guided by clear goals and outcomes, and grounded in public/private partnerships."[2] The approach is built on the principles of 1) shared responsibility for Minnesota's mental health safety net; 2) providing the right care in the right place and at the right time; and 3) coordinated, integrated care for Minnesotans with mental illnesses and related conditions.

II. Community Behavioral Health Hospitals

A. History of the CBHHs

Minnesota has been part of a 50-year transformation of the nation's public mental health system from a centralized, institution-based system to a recovery-oriented, community-based system in partnership with the Federal government, the state legislature, counties, tribes, mental health care providers, consumers, and other stakeholders, This transformation was based on evidence that integrating prevention, treatment, and recovery services for people with mental illnesses into their lives in their communities is the most effective way to support resilience and recovery.[3] The transformation has involved: 1) the closing of almost all of Minnesota's large residential treatment centers; 2) the

[2] *Road Map for Mental Health System Reform in Minnesota*, Minnesota Mental Health Action Group, June, 2005, p. 5.
[3] *Road Map for Mental Health System Reform in Minnesota*, pp. 14-16.

development and delivery of a wide range of community-based services to support people with mental illnesses in their local communities; 3) increased funding from the legislature; and 4) shifts of funding and staff from state operated services to community-based treatment providers.

In 2003, Minnesota began planning for the creation of ten community-based behavioral health hospitals to replace the in-patient adult mental health services at the state's historic and institutionally-based regional treatment centers in Brainerd, Fergus Falls, St. Peter and Willmar. These community behavioral health hospitals (CBHHs) were designed to serve adults who required short-term in-patient psychiatric hospitalization until they could be discharged home or to a less intensive service in their community that would better serve their needs. It is important to note that the CBHHs were designed to provide specialty acute psychiatric care, with limited physical health care capacity.

The CBHHs were opened between 2006 and 2008. The ten original CBHHs were opened in Alexandria and Fergus Falls (in lieu of the Fergus Falls Regional Treatment Center); St. Peter and Rochester, (in lieu of the St. Peter Regional Treatment Center); Wadena, Baxter, and Bemidji (in lieu of the Brainerd Human Services Center); and Annandale, Cold Spring, and Willmar (in lieu of the Willmar Regional Treatment Center). Changes have occurred at three of the sites in the last three years. Cold Spring was closed in 2009 due to a lack of available staffing and duplication of services already available in the St. Cloud area. Willmar and Wadena were converted to statewide Intensive Residential Treatment Services (IRTS) in 2011 to provide a medically monitored residential level of care to patients who no longer needed an acute level of medically managed care but who were not yet stable enough to return to existing community services.

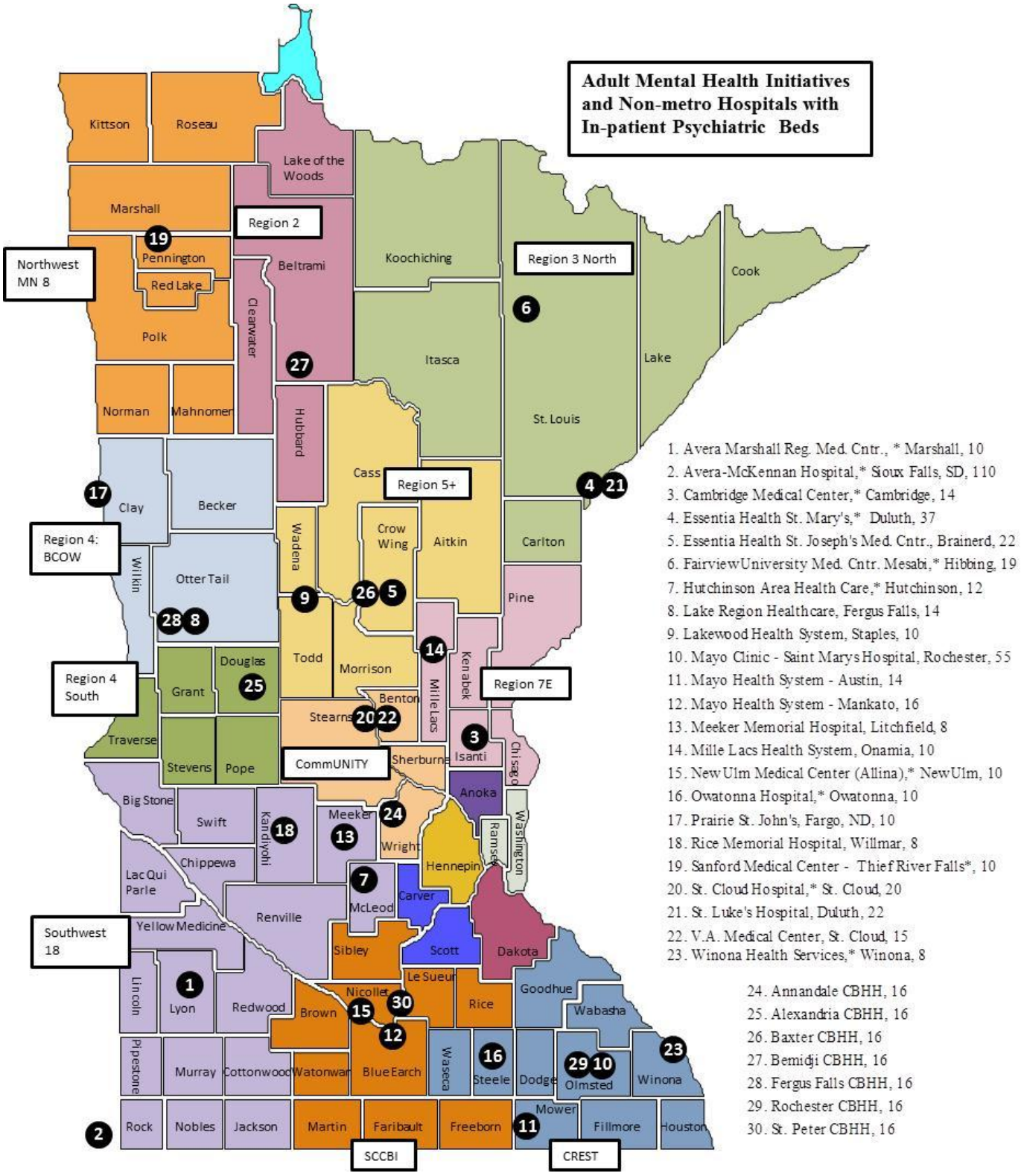
Many hospitals (in addition to the CBHHs) provide in-patient psychiatric care to Minnesotans. Table 1 lists these hospitals, their locations, and their adult psychiatric bed capacity. A few out-of-state hospitals are listed because they are very close to Minnesota borders and commonly serve Minnesotans. There are approximately 1,110 in-patient psychiatric beds at hospitals on this list, with about 500 of these in non-metro areas.[4] Hospitals with an asterisk after their names are hospitals that contract with DHS to pay for extended stays (past 7-10 days) for recipients of Medical Assistance, individuals dually eligible under Medical Assistance and Medicare, and uninsured individuals.

[4] In most cases, the numbers of psychiatric beds presented here is from the Minnesota Hospital Association's *2010 Hospital Annual Report*. In the few cases where this data was not presented in the report, DHS staff made phone calls in February, 2012, to ascertain the number of beds.

Table 1: Hospitals with Adult In-Patient Psychiatric Units

Hospital Name	City	Adult Psychiatric Bed Capacity
Abbott Northwestern Medical Center (Allina)*	Minneapolis	63
Avera Marshall Regional Medical Center*	Marshall	10
Avera-McKennan Hospital*	Sioux Falls, SD	110
Bethesda Hospital	St. Paul	12+
Cambridge Medical Center (Allina)	Cambridge	14
Essentia Health St. Mary's Medical Center*	Duluth	37
Essentia St. Joseph's Brainerd	Brainerd	22
Fairview Southdale Hospital*	Edina	18
Fairview University Medical Center-Mesabi*	Hibbing	19
Hennepin County Medical Center (includes forensic unit)*	Minneapolis	114
Hutchinson Hospital*	Hutchinson	12
Lake Region Healthcare	Fergus Falls	14
Lakewood Health System	Staples	10+
Mayo Clinic St. Marys Hospital	Rochester	55
Mayo Health System- Austin	Austin	14
Mayo Health System- Mankato	Mankato	16
Meeker Memorial Hospital	Litchfield	8
Mercy Hospital*	Coon Rapids	36
Mille Lacs Health System	Onamia	10
New Ulm Medical Center (Allina)*	New Ulm	10+
North Memorial Medical Center	Robbinsdale	26
Owatonna Hospital (Allina)*	Owatonna	10
Park Nicollet Methodist Hospital	St. Louis Park	30^
Prairie St. John's	Fargo, ND	53
Regina Medical Center	Hastings	14+
Regions Hospital*	St. Paul	96
Rice Memorial	Willmar	8
Sanford Medical Center*	Thief River Falls	10
St. Cloud Hospital*	St. Cloud	20
St. Joseph's Hospital*	St. Paul	38
St. Luke's Duluth	Duluth	22
United Hospital*	St. Paul	44
Univ. of MN Medical Center-Fairview-Riverside*	Minneapolis	115
V.A. Medical Center	St. Cloud	15
Winona Community Memorial Hospital*	Winona	8
Total		1,113
*Hospital with DHS contract for extended stays +Geriatric unit ^Eating disorders unit		

The map on the following page shows the locations of the CBHHs and the other hospitals that provide in-patient psychiatric care to Minnesotans outside the metro area. It will be useful to consider all of these hospitals in determining the appropriate role of the CBHHs in the entire continuum of care in Minnesota.



*Hospitals with DHS contracts for extended stays for recipients of Medical Assistance, individuals dually eligible under Medical Assistance and Medicare, and uninsured individuals.

B. Services Provided by the CBHHs

Each of the CBHHs has 16 beds and employs about 35 full-time equivalent staff (full-time, part-time, intermittent, consultants, and contractors), including physicians, psychiatrists, psychiatric nurses, clinical nurse specialists, nurse practitioners, physician assistants, licensed independent clinical social workers, licensed social workers, psychologists, dieticians, human services technicians, and occupational therapists. The CBHHs provide the following services:

- Assessment of mental, social, and physical health
- An individual treatment plan, including medication management and 24-hour nursing care
- Person-centered stabilization and treatment
- Family, group, and individual counseling sessions
- Illness management and recovery treatment (IM&R)
- Integrated dual diagnosis treatment for mental health and chemical dependency treatment (currently at the St. Peter CBHH; to be rolled out to all CBHHs in 2012, with full implementation completed in 2013).
- Individualized discharge and aftercare planning for transitioning back to an appropriate setting in the community
- Coordination with outpatient support

C. Patients Served in the CBHHs

This section describes the patients who are currently being served in the CBHHs. Section VI looks at the conflicting opinions about who the CBHHs should serve—with what services—in the future.

1. Demographics

The CBHHs provide acute in-patient psychiatric care. Most patients have serious mental illnesses including schizophrenia, bipolar disorder, severe depression, panic disorder, and obsessive-compulsive disorder.[5] The CBHHs admitted 1,488 people in CY 2011. The people served were 45% female and 55% male. The patient population consisted of:

- 84% Caucasian
- 8% Native American
- 4% African American
- 2% Latino/Hispanic
- 1% Asian
- 1% Other

2. Region of Origin

Ninety-five percent of CBHH patients were from non-metro Minnesota in CY 2011.[6] Table 2, below, shows CBHH admissions by region, with the metro area divided into East Metro (Ramsey, Washington, and Dakota counties) and West Metro (Hennepin, Anoka, Scott, and Carver counties). These regions reflect the DHS Adult Mental Health Initiative regions, shown on the map on page 9.

[5] Federal agencies define "serious mental illness" as diagnosable mental, behavioral, or emotional disorders that last more than one year and interfere significantly with thinking and social functioning.

[6] Throughout this report, "metro" refers to the seven counties comprising the Twin Cities metropolitan area (Hennepin, Ramsey, Anoka, Washington, Scott, Carver, and Dakota); "non-metro" refers to the other 80 counties in the state.

Table 2: CBHH Admissions by Adult Mental Health Initiative Region, CY 2011 (1,488 total admissions)

	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Total	% of Patients	% of Pop.[7]
Northwest 8	3	0	0	0	6	1	6	16	1.1%	1.7%
Region 2	3	0	0	0	9	26	119	157	10.7%	1.4%
Region 3	2	2	1	2	1	18	55	81	5.5%	5.7%
BCOW	25	2	0	0	109	14	22	172	11.8%	2.9%
Region 5+	25	1	1	7	18	88	49	189	12.9%	3.3%
Region 7 East	7	2	0	15	1	10	1	36	2.5%	3.0%
Region 4 South	97	1	1	2	38	4	3	146	10.0%	1.3%
CommUnity	14	8	1	92	5	7	0	127	8.7%	7.5%
SW 18	27	47	1	62	26	5	3	171	11.7%	5.3%
South Cen. Comm. Based (SCCBI)	3	77	14	10	2	2	0	108	7.4%	5.7%
CREST	3	43	115	10	6	3	1	181	12.4%	7.8%
East Metro	6	2	2	8	2	2	4	26	1.8%	21.8%
West Metro	1	17	5	17	3	8	2	53	3.6%	32.6%
Subtotal	216	202	141	225	226	188	265	1463	100%	100%
Indian Reservation	0	0	0	0	2	0	5	7		
Other/Out-of-state	0	2	3	1	0	0	3	9		
Unknown	0	3	0	0	1	2	3	9		
Total	216	207	144	226	229	190	276	1,488		

Table 2 shows the non-metro origins of CBHH patients and illustrates the diversity among regions in their reliance on CBHHs. Northwest 8, Region 3, and Region 7 East, for example, have smaller percentages of CBHH patients, probably because they do not have CBHHs in their regions. On the other hand, Region 2 and Region 4 South have much higher percentages of CBHH patients, relative to their populations. The Bemidji CBHH became an important part of the Region 2 mental health system because the region previously sent patients to Fergus Falls or Brainerd, which are two hours or more away. Region 4 South previously sent patients to the Fergus Falls Regional Treatment Center. The region does not have a community hospital with in-patient psychiatric services and they now rely heavily on the Alexandria CBHH.

3. Legal Status at Admission

About five percent of CBHH patients enter voluntarily, as shown in Table 3. About a third of patients enter the CBHHs on civil commitments (475 patients, or 32%), a court having determined that the patients cannot take care of their basic needs and/or are a danger to themselves or others. The 475 figure

[7] This column presents the percentage of Minnesota's population that lives in the region. This information is helpful context for interpreting the percentage of CBHH patients from each region.

under-represents the number of committed patients, however, because patients' legal status can change over the course of their treatment. The table shows patients' most recent legal status before their admission to the CBHH. The "commitment" category does not include people who were admitted under an Emergency or Judicial Hold but who were committed either before they entered the CBHH or after they were admitted. An additional 228 patients fell into this category, so a total of 703 patients, or 53%, were under commitment sometime during their treatment. This percentage provides insight into one role that the CBHHs are playing in local communities: serving committed patients.[8] The patients under civil commitment are more likely to have complex needs or challenging behaviors that require comprehensive assessment and treatment. The discharge process for these patients is also more complex because it involves the development of a provisional discharge plan with the counties, tribes, providers, and other concerned persons.

Table 3: CBHH Admissions by Legal Status, CY 2011 (1,488 total admissions)

	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average %	Total #
Voluntary[9]	5%	1%	6%	2%	4%	8%	7%	5%	69
Emergency Hold Order[10]	69%	39%	30%	44%	56%	49%	74%	54%	796
Judicial Hold Order[11]	7%	10%	19%	5%	16%	13%	4%	10%	147
Commitment[12]	19%	49%	45%	49%	25%	30%	15%	32%	475
No Entry	0%	0%	0%	0%	0%	1%	0%	0%	1
Total Admissions	216	207	144	226	229	190	276	100%	1,488

4. Length of Stay

A total of 1,472 patients were discharged by the seven currently-operating CBHHs in CY 2011. Typically, the length of stay at the CBHHs is twenty days or less (Table 4), which allows patients to stabilize and prepare for transition back to their communities (with appropriate supports). There are several factors that can contribute to longer stays:

- the complexity of patients
- the need for comprehensive discharge planning
- a lack of adequate coordination among service providers, county staff, tribes, patients, families, and other concerned persons
- a lack of appropriate community settings

Less populated non-metro counties often struggle to support a robust service array that meets a wide variety of specialized needs on limited budgets.

[8] In preparing this report, DHS tried to find data on the percentage of committed patients at community hospitals with in-patient psychiatric units, but the attempt was unsuccessful. Such data could be useful for regions as they consider the future role of the CBHHs in the continuum of care.

[9] Patient voluntarily seeks treatment, motivated by self, family, or friends or to avoid commitment.

[10] A medical professional (usually an emergency room doctor) can put an emergency hold on the patient for up to 72 hours to allow for assessment and treatment.

[11] A judge can put a judicial hold on the patient for up to 72 hours for assessment and treatment.

[12] A court has committed the patient to the Commissioner of Human Services, who has responsibility to find appropriate placement and treatment for the patient.

Table 4: CBHH Discharges by Length of Stay, CY 2011 (1,472 total discharges)

	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average %	Total #
01-10 days	48%	46%	34%	39%	45%	38%	60%	45%	668
11-20 days	16%	20%	29%	29%	29%	21%	15%	22%	328
21-30 days	16%	17%	14%	17%	11%	16%	9%	14%	204
31-40 days	6%	6%	6%	6%	7%	6%	7%	7%	96
41-50 days	5%	4%	5%	4%	4%	6%	5%	5%	68
51-60 days	3%	2%	4%	2%	1%	7%	2%	3%	42
61 plus days	6%	7%	8%	3%	4%	5%	1%	5%	66
Total Discharges	214	200	143	220	229	187	279	100%	1,472

One way of measuring the system's success in achieving these smooth transitions is to look at the number of days that patients stay in the CBHHs when they no longer require a hospital level of care (these are called "non-acute bed days").[13] The number of non-acute bed days in the CBHHs has fallen from a monthly total of 980 in August of 2010 to 284 in February of 2012. At the per diem cost of $1,162/day at a CBHH, the 3,938 (annual) total non-acute bed days in CY 2011 could be valued at about $4.6 million, almost all of which came out of the State Operated Services appropriated budget. The non-monetary cost to patients and families is even more significant, as community re-integration and recovery were delayed.

The factors that prevent a patient from leaving a CBHH at the appropriate time are sometimes referred to as "the back door" issues affecting hospital utilization. The "back door" metaphor is based on a continuum-of-care model that envisions a patient entering the front door of a CBHH (through Admissions) when in need of acute in-patient psychiatric treatment, receiving stabilization and treatment services while in the CBHH, and then being discharged back to the community in a setting that provides appropriate integrated services that support recovery. The goal is an integrated continuum of care that has the necessary services and coordination so that patients can make smooth transitions to the right care in the right place at the right time.

5. Living Arrangements Before Admission

About three-quarters of CBHH patients enter a CBHH directly from their homes or the homes of friends and family (Table 5).

[13] Non-acute bed days are determined from weekly reviews of patient records. The numbers are not perfect indicators because some patients could be reviewed a week after they no longer meet a hospital level of care, and some patients' status changes more than once over their course of treatment. The data has been collected in the same way since August of 2009, so overall trends are probably reliable.

Table 5: CBHH Patients' Living Arrangements Before Admission, CY 2011 (1,472 total discharges)

Living Arrangement before Admission	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
Assisted Permanent Housing[14]	8%	8%	17%	10%	7%	9%	14%	10%
Intensive Residential Treatment Services (IRTS)	0%	8%	3%	5%	6%	1%	1%	3%
Temporary Housing	0%	2%	1%	4%	1%	6%	2%	2%
Chemical Dependency Treatment	0%	1%	0%	0%	2%	1%	2%	1%
Home[15]	84%	72%	66%	64%	80%	66%	69%	72%
Anoka Metro Regional Treatment Center	0%	1%	0%	0%	0%	0%	1%	0%
Corrections	0%	0%	1%	0%	0%	1%	1%	0%
Another Hospital	2%	0%	10%	1%	3%	0%	0%	2%
No Permanent Address	1%	8%	1%	12%	1%	5%	7%	5%
Other or Unknown	3%	2%	1%	5%	0%	12%	3%	4%
TOTAL Discharges	214	200	143	220	229	187	279	1,472

6. Living Arrangements After Discharge

About 50% of CBHH patients are discharged directly to their homes or the homes of families or friends (Table 6).

Table 6: CBHH Patients' Living Arrangements After Discharge, CY 2011 (1,472 total discharges)

Discharge Location	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
Assisted Permanent Housing[16]	11%	14%	23%	15%	10%	18%	20%	16%
Intensive Residential Treatment Services (IRTS)	12%	21%	19%	22%	15%	13%	5%	15%
Temporary Housing	0%	0%	0%	4%	1%	1%	1%	1%
Chemical Dependency Treatment	4%	9%	4%	6%	15%	1%	9%	7%
Home[17]	59%	41%	47%	42%	49%	53%	49%	49%
Anoka Metro Regional Treatment Center	3%	3%	1%	1%	7%	4%	7%	4%
Corrections	3%	2%	1%	1%	1%	1%	1%	1%
Another Hospital	1%	1%	1%	2%	1%	1%	2%	1%
No Permanent Address	0%	2%	0%	0%	0%	1%	6%	1%
Other or Unknown	5%	9%	3%	6%	0%	8%	0%	4%
TOTAL Discharges	214	200	143	220	229	187	279	1,472

[14] Includes assisted living facility, foster care, nursing home, board and care, and board and lodge.
[15] Includes own home or home of friends or family.
[16] Includes assisted living facility, foster care, nursing home, board and care, and board and lodge.
[17] Includes own home or home of friends or family.

7. Type of Discharge

Table 7 shows the types of discharges of patients from the CBHHs in CY 2011. About half of the patients are discharged back to their communities with no legal requirements; another third must fulfill conditions while back in the community in order to avoid further commitment.

Table 7: CBHH Patients' Discharge Type, CY 2011 (1,472 total discharges)

	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
Court Discharge[18]	1%	1%	1%	1%	2%	1%	3%	1%
Death	0%	0%	0%	0%	0%	0%	0%	0%
Direct[19]	63%	40%	38%	41%	56%	49%	65%	51%
Other	3%	1%	1%	1%	0%	1%	3%	1%
Provisional[20]	26%	51%	57%	51%	28%	44%	20%	37%
Transfer[21]	7%	9%	4%	6%	14%	6%	10%	8%
Total	214	200	143	220	229	187	279	1,472

D. Conclusion: Patients Currently Served by the CBHHs

This review of the patients currently being served by the CBHHs illustrates several points that will be important to consider in plans to achieve optimum utilization:

- CBHHs serve predominantly non-metro counties (95% of patients are from non-metro Minnesota).
- Regions use the CBHHs in different ways.
- Most CBHH patients enter the hospital under some kind of court-ordered legal status, which adds complexity to their discharge planning.
- Due to patient complexity, legal requirements, insufficient care coordination, and lack of accessible, appropriate local placements in some communities, patients' stays in the CBHHs can sometimes last much longer than the 1-20 day norm.

III. Past Stakeholder Input Regarding the CBHHs

In the past four years, DHS's Chemical and Mental Health Services Administration (CMHSA) has issued a series of legislative reports about the transformation of its State Operated Services Division's role in Minnesota's mental health continuum of care.[22] The reports were informed by input and analysis from hundreds of stakeholders who worked individually and in groups to make recommendations to DHS. The recommendations were comprehensive, from philosophical comments about the definition of "safety net" to specific directions such as, "set up a loan repayment program to recruit psychiatric professionals." Most of the recommendations were made regarding the entire

[18] A patient is discharged by a court order, with no legal limitations.
[19] A patient is discharged with no legal limitations.
[20] A patient must fulfill conditions while back in the community in order to avoid further commitment.
[21] A patient is transferred to another State Operated Services facility.
[22] *Mental Health Acute Care Needs Report*, Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, March, 2009; *Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience and Recovery of the People We Serve*, Chemical and Mental Health Services Administration, March, 2010; *Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services,* Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, December, 2010.

continuum of care (e.g. the need for better transportation services across the state), which may apply to the CBHHs as one of the providers in that continuum. As part of the preparation of this report, DHS summarized the recommendations that related specifically to the CBHHs as follows:

- **Assure access to, and retention of, basic needs.** While the patient is at a CBHH, the CBHH and community supports should work to retain and facilitate access at discharge to all basic needs (such as stable housing, income supports, employment, food assistance, and health care).
- **Provide assessment and co-occurring treatment services at all CBHHs.** Assess and provide co-occurring treatment services while patients who have mental illnesses, substance abuse disorder, developmental disability, brain injury, or history of aggression are at the CBHH.
- **Come to system-wide agreement about the criteria for admission to the CBHHs.** Communicate with the communities the distinction between commitment and CBHHs' "Continued Stay" criteria.
- **Provide culturally competent assessment, planning, and treatment in the CBHHs.** Expand CBHH cultural awareness and expertise to provide care for the diverse populations they serve.
- **Collaborate to create discharge plans.** Starting at admission, a discharge should be planned with the patient, local mental health authority, natural supports, community providers and CBHH staff.
- **Follow Evidence Based Practices (EBP).** The CBHHs should use Evidence Based Practices (Assertive Community Treatment, Supported Employment, Integrated Dual Diagnosis Treatment, Dialectical Behavioral Therapy, Permanent Supportive Housing, and Illness Management and Recovery) and align these services with evidence based services in the community.
- **Expedite the transition from emergency departments to CBHH admission.**[23] Ensure that the transportation method used is prompt, respectful, and appropriate.
- **Provide reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior.** This may require specialized staff, increased staffing levels, unique facility design or more capacity at a centralized location to meet regional needs.
- **Establish a local/regionalized admissions and screening system.** Communities should have direct contact with CBHH admissions people who are knowledgeable about all community resources and consumer/patient information.
- **Use LOCUS as one tool for utilization management and not as an exclusive discharge tool.** The use of LOCUS needs to be consistent with established standards for the tool.
- **Strengthen partnerships between CBHH and community providers**. The goal is a relationship that facilitates integration of CBHHs and community services, including counties and tribes, and that identifies and solves problems in admissions, treatment provision, discharge planning and follow-up.
- **Physical care, including primary and chronic health care, should be available and/or provided in an integrated approach at the CBHHs.** This will require collaboration with community based mental and physical health providers to establish levels of care to address the range of patients' physical challenges.
- **Plan for physical health care follow up after discharge.** Assure that people being discharged from a CBHH have the level of physical medicine care they need for living in the community

[23] Many CBHH patients enter the CBHHs through local hospital emergency departments, and require transportation from the community hospital to the CBHH.

and that the care is integrated with community behavioral services, such as home and community based services (e.g., the CADI Waiver).

- **Establish regional control of CBHHs as a State Operated Service.** Regions should be integral to the decision-making process if CBHHs are to be significantly re-configured or if their management/ownership is to change.
- **Establish uniform information processes with community providers.** Assure that all documentation, communication, data collection, and utilization management information is gathered and shared in a manner consistent with the practices of community providers.
- **Use Certified Peer Specialists at all CBHHs.**

IV. Updating and Prioritizing Stakeholders' Recommendations

A. Adult Mental Health Initiative Priorities

The recommendations listed in Section III reflect significant input from a range of stakeholders about utilization of the CBHHs within the larger context of the entire continuum of care. To update this input and focus specifically on the CBHH utilization issue for this legislative report, DHS submitted the list of recommendations (in the previous section) to the 16 Adult Mental Health Initiatives for review and prioritization. To represent the priorities of Minnesota's American Indian tribes, the American Indian Adult State Advisory Council on Mental Health was included in the prioritization process. The recommendations were cast into a worksheet that allowed the Adult Mental Health Initiatives and the American Indian Adult State Advisory Council on Mental Health to rank the importance of each recommendation (using a total of 100 priority points), add additional recommendations if necessary, and make comments on each recommendation. The Adult Mental Health Division consultants worked with all of the groups to review this list, make any changes or revisions they felt were necessary, and rank the recommendations using the 100-point rating system.

The results of the prioritization process are shown in Table 8. Because 95% of CBHH patients are from non-metro Minnesota, this table separates the non-metro Adult Mental Health Initiatives' (and the American Indian Adult State Advisory Council on Mental Health's) priority data from that of the metro Adult Mental Health Initiatives. The East Metro category includes Washington, Ramsey, and Dakota counties. The West Metro category includes Hennepin, Anoka, Scott, and Carver counties.

Table 8: Priority Ratings of CBHH Recommendations by Adult Mental Health Initiatives

Recommendations (in priority order)	NW MN 8	Region 2	Region 3: North	BCOW	Region 5 +	Region 7 East	Region 4 South	CommUNITY	Southwest 18	SCCBI	CREST	American Indian State Advisory Council	Average of Non-metro Initiatives[24]	East Metro	West Metro
Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior.	14	6	7	11	0	15	12	20	55	35	30	25	17	0	8
Discharge based on joint planning.	8	15	7	8	20	30	8	13	0	35	15	15	13	23	9
Access to, and retention of, basic needs.	10	12	11	5	15	0	23	16	0	0	10	15	11	10	13
Regional control of CBHH as a state operated service.	15	9	15	14	10	0	6	2	0	30	15	0	9	8	6
Partnership between CBHH and community providers.	10	7	3	15	0	20	6	6	15	0	15	0	8	20	4
Expedite the transition from emergency departments to CBHH admission.	14	10	11	9	3	0	16	2	10	0	5	0	7	3	10
Assessment and co-occurring treatment services at all CBHHs.	6	7	10	1	10	0	6	2	0	0	10	0	7	10	9
Local/regionalized admissions and screening system.	14	6	7	19	6	0	5	3	20	0	0	0	6	0	5
Physical care, including primary and chronic health care, is available and/or provided in an integrated approach at the CBHHs.	1	1	8	1	10	15	4	6	0	0	0	0	4	0	8
Physical health care follow up after discharge.	1	3	0	3	0	0	4	2	0	0	0	0	3	3	8
LOCUS is used as one tool for utilization management and not an exclusive discharge tool	1	3	2	0	4	5	1	11	0	0	0	15	3	0	5
Culturally competent assessment, planning, and treatment in CBHHs.	1	9	5	1	5	0	2	1	0	0	0	20	3	4	3
Uniform information processes with Community Providers.	1	3	7	6	10	5	2	2	0	0	0	0	3	0	3
Come to system-wide agreement about the criteria for admission to the CBHHs.	1	4	2	1	5	10	1	1	0	0	0	0	2	0	1
Evidence Based Practices (EBP).	2	3	0	2	0	0	2	9	0	0	0	0	2	0	5
Use of Certified Peer Specialists at all CBHHs.	1	0	5	4	2	0	2	4	0	0	0	0	2	3	1
Other: (from Region 2) Streamline or provide lab tests required for CBHH admission.		2													
Other (from American Indian State Advisory Council): All patients are treated respectfully (trauma-informed services, verbal and nonverbal de-escalation, recovery-based)												10			

According to the non-metro Adult Mental Health Initiatives and American Indian Adult State Advisory Council on Mental Health, the most pressing CBHH-related priorities are:[25]

- Local, reliable, timely access to a secure facility for people who have exhibited violent or aggressive behavior

[24] This average includes data from the American Indian Adult State Advisory Council on Mental Health.

[25] The legislation governing this report directed that each Adult Mental Health Initiative's priorities be included in the report. Appendix 3 contains a list of each Adult Mental Health Initiative and its CBHH priorities. The lists include the four top-rated priorities, plus ties. This information is a presentation of the data in Table 8, in list format.

- Discharge based on joint planning
- Access to, and retention of, basic needs while a patient is at the CBHH and after discharge.

There is significant variation among the responses, however. Rankings for the highest priority, "Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior," ranged from 0 points to 55 points. In fact, every single priority was ranked a "0" by at least one region. These differences reinforce a message that was expressed in prior input to DHS, that improvements to the continuum of care should be undertaken at the regional level.[26] Each region has its own unique complement of clients, providers, and services, and thus each has a unique relationship with the CBHHs. Working with regional groups, with ongoing input from statewide stakeholders, will yield solutions that improve the entire state's continuum of care.

B. Statewide Stakeholder Priorities

All Minnesota counties have Local Advisory Councils that include mental health services stakeholders such as consumers, family members, providers, and local officials. This report assumes that the Adult Mental Health Initiative priorities reflect consideration of those viewpoints. However, in preparing this report, DHS also sought the input from the State Advisory Council on Mental Health, a statewide group that represents a variety of stakeholders. Following the process used for the Adult Mental Health Initiatives, the State Advisory Council on Mental Health distributed the forms to its members, who filled them out individually. The results were compiled, and averages for each item were calculated. The results are shown in Appendix 4.

V. Analysis of Utilization of the CBHHs

The recommendations about the CBHHs made in prior reports yield many important suggestions for improvements, but also highlight the importance of looking at the larger contextual issues in the continuum of care, of which the CBHHs are just one part. If the question of CBHH utilization is considered within the context of the entire continuum of care, there are really two distinct questions that arise:

1. Are the CBHHs being used to capacity?
2. What is the appropriate role of the CBHHs in the continuum of care (i.e., what populations should they serve, with what services (hospital, IRTS, etc.), in what communities)?

The first question is addressed in this section; the second question is addressed in Section VI.

A. Are the CBHHs Being Used to Capacity?

Utilization can be operationalized as a percentage of available beds in the CBHHs that are filled each day. However, "available" can be defined in several ways. This report looks at three definitions: the number of beds budgeted in the State Operated Services budget; the number of licensed beds physically existing in the units, and the number of beds that professional staff deem available each day (service capacity).

---

[26] *Road Map for Mental Health System Reform in Minnesota*, Minnesota Mental Health Action Group, June, 2005, p. 13; *Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services,* Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, December, 2010, pp. 19, 30, 51, 53.

1. Utilization Rates Based on Beds Budgeted in State Operated Services Budget (14 beds)

In CY 2011, the budget for the CBHHs was based on projections of 14 beds filled in each CBHH each day. The numbers of beds actually full each day for the CBHHs currently in operation, averaged over the year, are presented below in Table 9.

Table 9: Average Number of Filled CBHH Beds, CY 2008-2012

Year	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
2008	8.6	11.1	10.1	8.9	8.2	9.7	6.7	9.0
2009	7.7	9.3	8.2	7.3	7.6	8.7	7.5	8.1
2010	10.2	11.5	9.2	10.5	9.3	11.8	10.7	10.5
2011	11.5	11.7	9.0	12.3	10.3	12.0	10.9	11.1
1/2012	14.8	13.2	11.2	14.4	12.2	11.6	11.0	12.6

To determine utilization rates, the number of filled beds is divided by 14. The utilization rate based on the assumption of 14 bed capacity is shown in Table 10 below.

Table 10: Percentage of Filled CBHH Beds (Based on 14 budgeted beds), CY 2008-2012

Year	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
2008	61%	79%	72%	63%	58%	69%	48%	65%
2009	55%	67%	59%	52%	54%	62%	54%	57%
2010	73%	82%	66%	75%	67%	84%	77%	75%
2011	82%	84%	64%	88%	74%	85%	78%	79%
1/2012	106%	94%	80%	103%	87%	83%	79%	90%

2. Utilization Rates Based on Number of Licensed Beds in Each Facility (16 beds)

Each CBHH is licensed to operate 16 beds, the maximum allowable for a facility to be reimbursed through Medicaid. If 16 is used as the denominator to determine utilization, the utilization rates are presented below in Table 11.

Table 11: Percentage of Filled CBHH Beds (Based on 16 licensed beds), CY 2008-2012

Year	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
2008	53%	70%	63%	55%	51%	61%	42%	57%
2009	48%	58%	51%	45%	47%	54%	47%	50%
2010	63%	72%	58%	66%	58%	74%	67%	65%
2011	72%	73%	56%	77%	65%	75%	68%	69%
1/2012	93%	83%	70%	90%	76%	73%	69%	79%

These percentages indicate that two of the CBHHs operated significantly below their licensed bed capacity in CY 2011: Rochester and Fergus Falls, at 56% and 65%, respectively. Their utilization rates have gradually increased, as seen in the January 2012 rates, but there is still room for improvement (see Section V-B for more discussion of the Rochester CBHH).

Both the 14-bed and 16-bed capacity assumptions provide general standards to evaluate utilization against, but they don't take into account the specific conditions existing in each CBHH on a given day.

Assessing usage based on consideration of localized factors affecting bed availability (service capacity) provides a third utilization measure.

3. Utilization Rates Based on Assessment of Available Beds in Each Facility (Service Capacity)

CBHH Medical Directors assess the number of beds available for occupancy every day. Factors that impact the number of beds considered available include:

- Availability of licensed independent practitioners (psychiatrists or psychiatric mental health advanced practice registered nurses). There continues to be a significant shortage of licensed independent psychiatric practitioners in Minnesota, particularly in non-metro Minnesota.[27] As of April, 2011, there were only 257 adult psychiatric Mental Health Advanced Practice Registered Nurses in the entire state of Minnesota; as of February, 2012, there were 521 psychiatrists.[28] One recent study estimated that approximately 26 psychiatrists are needed per 100,000 of population,[29] which would mean that non-metro Minnesota would require about 690 psychiatrists; in February, 2012, non-metro Minnesota had 169 licensed psychiatrists, about a quarter of the recommended number.[30] The CBHHs must compete with other hospitals and clinics for these specialists, and it can often take up to 12 months to fill vacant positions.
- Acuity of patients in the treatment environment, limiting the number of patients who can be safely served (mostly related to violent behavior because there is no security at the CBHHs).
- Beds closed due to physical plant issues (rooms may be unavailable due to emergency maintenance or scheduled repair of rooms).
- Availability of adequate physical health care staff, especially nurses and licensed independent practitioners. A number of local health care labor markets have shortages of health care staff.
- Beds unavailable because they are being held for planned admissions. Local courts, community hospitals, counties, and tribes coordinate transfer of care to CBHHs, so beds are sometimes held for incoming patients whose court hearings are scheduled for the next few days.

Based on these factors, doctors assess the capacity of each CBHH each day and get permission from State Operated Services Medical Directors to set service capacity. The capacity is then reported by Central Pre-Admission (the centralized intake department of State Operated Services). Averaged across the years, their reports provide a snapshot of the beds considered available given all of the factors that determine patient and staff safety and an optimal treatment milieu.

Table 12: Average Service Capacity of CBHHs as Reported by Central Pre-Admission, CY 2008-2012

Year	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
2008	12.0	15.0	12.9	12.0	11.8	15.5	11.2	12.9
2009	12.0	13.9	10.2	13.1	11.1	12.4	14.3	12.4
2010	12.8	14.9	10.5	13.5	10.9	13.7	13.3	12.8
2011	13.4	14.4	10.3	14.7	12.5	13.7	13.7	13.2
1/2012	15.6	14.8	12.0	16.0	12.0	14.0	12.8	13.9

[27] "Mental Health Workforce Report," *Road Map for Mental Health System Reform in Minnesota*, Minnesota Mental Health Action Group, June, 2005, pp. 135-142; "Workforce Subcommittee Report," *Mental Health Acute Care Needs Report*, Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, March, 2009, pp. 29-34.
[28] Minnesota Board of Nursing, 2011; Minnesota Board of Medical Practice, February 22, 2012.
[29] Konrad, Thomas, et. al., "County-Level Estimates of Need for Mental Health Professionals in the United States," *Psychiatric Services*, October, 2009, p. 1312.
[30] Minnesota Board of Medical Practice, February 22, 2012.

Using Central Pre-Admission's definition of "available," the utilization of the CBHHs can be figured by dividing the number of actual beds filled by the number of beds available. Those utilization percentages are presented in Table 13, below, that shows that the CBHHs operated at about 84% of service capacity, on average, in CY 2011.

Table 13: Percentage of Filled CBHH Beds (Based on Central Pre-Admission's Service Capacity Assessment), CY 2008-2012

Year	Alexandria	St. Peter	Rochester	Annandale	Fergus Falls	Baxter	Bemidji	Average
2008	71%	74%	79%	74%	69%	63%	60%	70%
2009	64%	67%	80%	56%	68%	70%	52%	65%
2010	79%	77%	87%	78%	86%	86%	80%	82%
2011	86%	81%	87%	84%	83%	87%	80%	84%
1/2012	95%	89%	93%	90%	102%	83%	86%	91%

There is no national benchmark for optimum utilization of psychiatric health hospitals, so it is difficult to say what an appropriate bed utilization percentage for the CBHHs would be.[31] The 65% lower threshold identified in the legislation mandating this report is being exceeded under all three measures of utilization by all CBHHs except for the Rochester CBHH (discussed below). DHS is examining opportunities to "open the front door" of the CBHHs (i.e., increase capacity to take more patients), by addressing the factors that limit service capacity (see Section VII, below).

B. The Utilization of the Rochester CBHH

The CBHH in Rochester remains the only non-CMS-certified CBHH in the SOS system and the only CBHH below 65% utilization of its licensed 16-bed capacity. It is currently undergoing certification, and DHS expects the certification to be complete by May, 2012. The Rochester CBHH has had a substantially reduced service capacity (10.3 average daily census), significantly lower than the average of the other CBHHs (13.7 average daily census). The hospital has struggled to attract and retain adequate numbers of licensed independent psychiatric providers and health care staff, due in part to competition from other hospitals in the region.

The Rochester CBHH plays a vital role in meeting the acute psychiatric in-patient needs in the southeastern portion of the state, specifically in the Rochester market. It is widely known that certain hospital providers in that region are very hesitant to accept individuals with serious and persistent mental illnesses into their hospital beds for treatment. To that end, CBHH-Rochester has filled a critical gap in the Rochester region's mental health continuum of care, as evidenced by the fact that the CREST Adult Mental Health Initiative sent 64% of their CBHH patients to the Rochester CBHH in CY 2011.

[31] With help from the Minnesota Hospital Association (MHA), DHS attempted to compare the CBHH rates to those in community hospitals with psychiatric beds. No specific data is kept by DHS or MHA on psychiatric bed utilization, so a crude approximation was the best estimate that could be made. For the non-metro Minnesota hospitals listed in the map on pg. 9 of this report (the VA Hospital in St. Cloud and the two out-of-state hospitals were not included), MHA provided data on the number of days that patients who had mental health diagnoses and who were discharged between January 1 and September 31, 2011 had spent in the hospital. Dividing the total number of days spent in the hospital (58,189) by the number of licensed bed days available in that nine-month period, a 42% utilization rate was calculated. This number should not be taken as a reliable estimate of utilization because there are many factors that this back-of-the-envelope calculation did not take into account.

It is therefore imperative that Rochester become CMS certified in order to remain a financially viable hospital provider. A remaining unanswered question is how many psychiatric hospital beds would fill the needs of that region, a question that needs to be examined in a collaborative regional planning process that considers the community's entire array of services. If less than 16 acute hospital beds is imagined, the remaining space within the CBHH could be considered for conversion to outpatient services, crisis beds, dementia services or any other appropriate, needed gap service in that region.

VI. The Role of the CBHHs in the Continuum of Care

The CBHHs have been operating for about five years, and they are playing an important role in the mental health continuum of care in non-metro Minnesota. They coordinate with counties, tribes, courts, hospitals, and mental health providers to provide acute care services for people who have serious mental illnesses and need a hospital level of care. They represent the Commissioner of Human Services in coordinating care for people who are under civil commitment or who are being held for possible civil commitment. Utilization of the CBHHs has grown fairly steadily since 2008, and may be approaching an appropriate upper limit if the CBHHs are to optimize treatment, maintain patient and staff safety, and offer local beds when they are needed.

While the CBHHs are fulfilling an important function, there is still a significant gap in Minnesota's continuum of care. The non-metro Adult Mental Health Initiatives identified this as their top CBHH-related priority: "local, reliable, timely access to a secure facility for people who have exhibited violent or aggressive behavior." When an appropriate in-patient psychiatric bed for an adult with serious mental illnesses and aggressive or violent behaviors is not readily available, it can result in turmoil for hospital emergency departments or psychiatric units, unsafe conditions for patients and staff, and patients ending up in jail instead of receiving the mental health services they need. It is difficult to estimate how many such beds are needed in Minnesota because there are so many factors that affect that number. Community input indicates that the number of adults with serious mental illnesses and aggressive or violent behaviors is very small, perhaps one or two hundred people in non-metro Minnesota per year. With so few cases per year, it is difficult for non-metro counties to maintain the local services necessary to support this population.

The Anoka Metro Regional Treatment Center (AMRTC) was envisioned to serve this specialized population on a statewide level, although it is continuously full (with a waiting list) and it is not local for much of non-metro Minnesota. AMRTC admitted 450 patients in CY 2011, 140 of them from non-metro counties. The proportion of patients at AMRTC coming from non-metro Minnesota has increased from 15% in 2008 to 31% in CY 2011. Sixty-one percent of those non-metro patients were admitted to AMRTC's Intensive Behavioral unit for people at risk of aggressive or other high-risk behaviors.

A key reason for the waiting list at AMRTC is a second gap in Minnesota's continuum of care: long-term housing with services and security necessary to support this population in local communities. Without these resources, patients who have exhibited violent or aggressive behaviors get "stuck" in AMRTC even though they no longer need a hospital level of care, thereby limiting the number of beds that are available for patients who *do* need a hospital level of care. Much of the state suffers from a lack of permanent housing with services and security for this population, but sparsely-populated counties struggle even more to create and sustain these services locally.

It is difficult to assess the real demand for in-patient psychiatric beds in each region because of the number of people "stuck" in an in-patient bed for lack of a less-intensive alternative and because some

people who may be appropriate for in-patient care could be ending up in a variety of other places, including jails, lower-level treatment facilities, their own homes, or on the streets. The number is also difficult to assess because of changes in the health care marketplace. Health care reform could shift the numbers of people requiring in-patient psychiatric care, the acuity of those people's mental health needs, and the range of providers operating in each region.

There has been significant discussion among DHS, counties, tribes, providers, consumers, and other stakeholders about how to address these gaps in the continuum of care. Some have questioned whether the CBHHs could be reconfigured to serve people with violent histories or current aggression. As currently designed, the CBHHs are not appropriate for this role because their physical plant and their staffing do not allow for the security needed to serve aggressive patients. Moreover, increasing the hospital beds for this population will be a short-lived solution if the "back door" problem of insufficient permanent housing with services and security is not addressed.

This report has shown that planning and decision-making about the appropriate role of the CBHHs must take place at a regional level, taking into account the array of services and relationships in each region. Statewide planning and collaboration will also be needed, however, to address the systemic nature of bed capacity issues.

VII. Conclusion: A Strategy for Achieving the Optimum Utilization of the CBHHs

DHS proposes a four-part strategy for optimizing the utilization of the CBHHs in each region. It continues DHS's ongoing work to address stakeholder recommendations about the CBHHs and their service delivery. It combines short-term (6 months) problem-solving and longer-term (6-12 months) statewide and regional collaboration to achieve an integrated continuum of care across the state. The strategy includes:

- Implementing short-term changes to open the "front door" of the CBHHs and the Anoka Metro Regional Treatment Center (AMRTC) to achieve streamlined, collaborative admissions.
- Implementing short-term changes to coordinate the "back door" of the CBHHs and AMRTC to assure appropriate, collaborative discharges and open some beds currently being filled by patients who no longer need a hospital level of care.
- Continuing to implement operational improvements to policies, services, and treatments to respond to the priorities identified by the regions.
- Initiating statewide and regional collaborations to improve the continuum of care and optimize appropriate utilization of the CBHHs and the entire State Operated Services system of care.

A. Open the "Front Door" of the CBHHs with Streamlined, Collaborative Admissions

The Adult Mental Health Initiatives' #1 CBHH-related priority is local, reliable, timely access to a secure facility for people with serious mental illness who have exhibited violent or physically aggressive behavior. While this priority will require further regional planning to develop a systemic solution, there are some things that DHS can do in the short term to address the Adult Mental Health Initiatives' concerns:

1. Collaboration to Achieve More Local/Regionalized Admissions and Screening

DHS recognizes that the referral, intake, and admissions process at the CBHHs needs to be more collaborative with local communities. DHS cannot "blow up Centralized Pre-Admissions," as has been suggested by some, because the CBHHs serve a statewide, as well as regional, function. However, DHS is committed to collaborating with local communities to develop referral and admission procedures that

assure community providers have support until people are safely admitted to an appropriate level of service. This includes coming to system-wide agreement about the criteria for admission to the CBHHs. DHS is currently working with four Adult Mental Health Initiatives in south/central Minnesota on local triage, referral, and admission procedures. DHS will communicate the progress of this collaboration with other regions and statewide stakeholders for consideration. The goal is to expand regional planning and continue to refine and communicate admission procedures that incorporate the needs of local communities including consumers, counties, tribes, hospitals, law enforcement, and other stakeholders.

2. Support for Local Communities in Identifying Alternatives to Hospitalization

In collaboration with local and statewide agencies, DHS will facilitate development of accessible information on alternatives to hospitalization, and supply consultative support to hospital emergency rooms and crisis teams to assist in the development of alternatives.

3. Increased Bed Capacity for People with Violent or Aggressive Histories

Even after facilitating access and supporting alternatives to hospitalization, there is still likely to be demand for more in-patient beds for people with aggressive histories among the non-metro Adult Mental Health Initiatives. DHS is not in a position to build new facilities, but it may be possible to increase the availability of in-patient beds at AMRTC to serve specialized populations (e.g., people with aggressive histories), in collaboration with local communities. DHS will try to shift more beds toward the clinical capacity to serve the aggressive population. This will require more collaboration with local communities on the "back door" strategies, described below. It will also require better triage at AMRTC intake to make sure that all patients are referred to the best facility to meet their needs.

4. Expedite the Transition from Emergency Departments to CBHHs with Timely, Humane, Efficient Transportation

DHS is contracting with the Minnesota Sheriff's Association for reliable, safe transportation for patients who pose a public safety risk and have met established criteria for the transportation by law enforcement. DHS will form a workgroup to evaluate the feasibility of the recommendations developed by the Transportation Work Group of the 2010 Chemical and Mental Health Services Transformation Advisory Task Force.

5. Improved Recruitment of Psychiatric Professionals and Utilization of Technology

A key limiting factor on the full utilization of the CBHHs is the difficulty of hiring psychiatrists and advanced practice nurses in non-metro Minnesota. DHS will build CBHH service capacity by increasing recruitment resources and developing a comprehensive recruitment strategy for these professionals. This will include leveraging existing relationships with the University of Minnesota Medical School and Nursing School. DHS will also continue to implement tele-presence technology to support tele-health delivery to the CBHHs.

B. Coordinate the "Back Door" of the CBHHs for Appropriate, Collaborative Discharges

In order to open the "front door" of the CBHHs and the Anoka Metro Regional Treatment Center, it will be necessary to make sure that patients are discharged to appropriate settings in their communities in a timely, coordinated fashion. DHS is eager to collaborate with communities on these "back door" solutions so that more patients are getting the right care in the right place at the right time.

1. Discharge Based on Joint Planning

DHS already has policies that support collaborative discharge planning among the CBHHs, counties, tribes, community providers, and patients and their families, but more management attention is needed

to assure that those policies are followed. Resources have been allocated to assure compliance with existing procedures, and metrics are being developed to track and assess the effectiveness of CBHH discharge planning processes. DHS will also look for ways to collaborate regionally to identify possible joint improvements to the discharge process. DHS is working on a draft of a comprehensive, multi-disciplinary discharge planning document, including discharge criteria, crisis plans, detailed medication information, community support plans, and medical appointments. DHS looks forward to collaborating to establish criteria for discharge that do not rely exclusively on the LOCUS tool. Alternative tools are currently being researched and assessed such as the Brief Psychiatric Rating Scale. Collaboration with community providers will hopefully yield new standards of care for both hospital-based care and community-based care in delivering quality hand-offs.

2. Increasing Community Services

DHS will promote the development of additional capacity to serve patients who have complex needs in Intensive Residential Treatment Services programs and in specialized Mental Illness/Chemical Dependency Rule 31 treatment programs. DHS will continue to work with existing providers to develop residential models that will support the needs of the population.

3. Housing with Supports

Housing with adequate services for individuals with serious mental illness, especially those with aggressive histories, is very scarce in Minnesota. DHS will be funding three supportive housing opportunities in 2012 in partnership with Minnesota Housing. First, the Housing with Supports for Adults with SMI (HSASMI) grants will be issued in 2012 to develop Permanent Supportive Housing (Evidence Based Practice) to serve people needing supportive housing. Second, the Bridges RTC Pilot Programs are being awarded to provide housing options for people leaving the Anoka Metro Regional Treatment Center needing supportive housing in the metro area. Third, the Bridges RTC Pilot will be expanded in the spring of 2012 to provide housing in non-metro Minnesota.

C. Implement Operational Improvements

While the Adult Mental Health Initiatives' primary concern was access to a secure facility for people with serious mental illnesses and aggressive histories, they also identified several other priorities. DHS has been working on these for the past several years in response to past stakeholder input. Significant progress has been made on some of the recommendations, like "implement Evidence Based Practices at the CBHHs;" others have a longer timeline for implementation. While some of the recommendations will require collaborative regional planning for systemic solutions, there are a number of immediate operational improvements that DHS can make now to begin addressing the problems.

1. Assessment and Co-occurring Treatment Services

A pilot for Integrated Dual Diagnosis Treatment in the CBHHs has been completed, and planning for statewide implementation is underway.

2. Physical Care Provided in an Integrated Approach

CBHHs assure the medical stability of their patients. CBHHs have primary care providers as consultative members of their multidisciplinary teams, and they contract with local and regional physical health providers to meet patients' physical health care needs. However, this is occasionally insufficient to meet the physical health needs of very ill patients. In order to expand the availability of physical medicine at the CBHHs, DHS will more aggressively pursue partnerships with local physical medicine providers where possible and continue to expand the utilization of telemedicine services. CBHHs are implementing procedures to screen and treat modifiable risk factors identified in the Minnesota 10x10

Project to improve the lifespan of adults with serious mental illnesses.[32] The CBHHs will also include consideration of patients' physical health care needs in collaborative discharge planning with local communities.

3. Culturally Competent Assessment, Planning, and Treatment

A Cultural Competency Committee has been established by State Operated Services' Adult Mental Health Services, and includes representation from the CBHHs and members of diverse populations. The Committee is developing recommendations to improve mental health care for diverse populations. The CBHHs will develop and implement a work plan in conjunction with the Cultural Competency Committee.

4. Uniform Information Processes

CBHHs share documentation, communication, data collection, and utilization management information consistent with the practices of community providers. However, an integrated electronic health record that could be shared electronically would greatly enhance patient movement and decrease expensive, duplicative efforts. DHS is implementing a web-based mental health information outcomes reporting system in July, 2012 for AMRTC, the CBHHs, and some community-based mental health services. Additional mental health treatment providers will be phased in over a twelve month period. This web-based reporting platform will provide a secure, real time, point-of-care, patient-centric information resource for clinicians and administrators, and will aid DHS in policy planning. DHS is also part of the planning phase for the development of a Health Information Exchange and recognizes the need for health information to be available electronically across organizations within a region or community.

5. Evidence Based Practices

CBHHs already utilize the evidence based practice of Illness Management and Recovery, and are in process of implementing Integrated Dual Diagnosis Treatment and utilization of Peer Specialists (pending funding availability). The CBHHs align with community evidence based services such as Assertive Community Treatment, Supported Employment, and Permanent Housing where the services are available.

D. Collaborate on Statewide and Incremental, Region-Based Solutions

DHS recognizes that collaborating to improve Minnesota's mental health continuum of care must occur at both the statewide and regional levels. Past statewide planning has provided DHS with a great deal of useful input on needed improvements, many of which are underway. DHS proposes to facilitate continued statewide coordination by focusing on health care reform and on gaps in the continuum of care that must be addressed at the state level. Elements of the statewide collaborations envisioned include statewide meetings focused on health care reform and payment reform models and meetings with key stakeholders in order help shape the strategies for Minnesota's mental health system under health care reform.

Some of the questions to be addressed at a statewide level include:

- What is the likely demand for in-patient psychiatric services, both regionally and statewide? What are the sub-populations that require specialized services, where are they located, and how can the state best meet patients' needs for local services considering the difficulty of supporting specialized services in sparsely-populated areas?

[32] Minnesota 10x10 is a statewide initiative to improve the health and wellness of persons with bipolar disorder or schizophrenia.

- What are the appropriate roles for DHS, counties, tribes, providers, and insurers in the shared safety net?
- What are the current evidence-based practices for serving specialized populations, and what are the best mechanisms for assuring that patients receive them? And for patients whose needs are so complex and unique that evidence-based practices do not provide adequate guidance for their care, what service and funding models should be adopted to assure the most appropriate care possible?
- How is health care reform likely to affect the populations being served by the current shared safety net? How can the state best assure that patients' mental health needs are adequately considered in state and federal health care reform planning?
- What new funding models are available for addressing the existing gaps in Minnesota's mental health continuum of care?
- What technological, administrative, and logistical improvements may be needed to administer and evaluate the outcomes of the mental health system in Minnesota?

At the same time that the state as a whole is developing answers to the above questions, regional collaborations are needed to make ongoing improvements in the existing continuum of care and address local opportunities for service or provider changes that could benefit people with mental illnesses and their families. These collaborations would address questions that include:

- What is the current and future regional demand for services, and what mix of providers will the region need to fulfill that demand?
- What gaps exist in the local continuum of care, and what are the best ways to address those gaps in both the short and long terms?
- How can providers, counties, tribes, law enforcement, courts, patients, and families all coordinate the transitions that patients make among levels of care to best promote patients' recovery?
- What are the policy, administrative, and financial barriers that must be tackled at the state or federal level in order to help local communities improve the continuum of care?

DHS's regional collaborations will focus on preparing for health care reform, problem-solving and improving coordination within regions. For example, DHS has been collaborating with four Adult Mental Health Initiatives in south/central Minnesota since October, 2011. A group of stakeholders including local providers, counties, consumers, and mental health centers have been meeting with the Assistant Commissioner for Chemical and Mental Health (Maureen O'Connell) and staff of the State Operated Services and Adult Mental Health Policy Divisions. The meetings began at the request of Adult Mental Health Initiative representatives who had identified a particular gap in the continuum of care in their region. Short-term and longer-term goals have been identified, and two work groups have been formed to develop short-term solutions to achieve those goals.

The decisions and insights gained from the statewide and regional collaborations will be built into the plans and budgets that DHS brings to the 2013 legislative session. They will include identification of the statewide and regional gaps in the mental health continuum of care, system-wide solutions to address those gaps, plans for DHS structure and operations to continue implementation of health care reform, and the use of new tools (organizational, technological, and financial) that health care reform is making possible. The collaborations will also strengthen relationships among DHS, providers, counties, tribes, law enforcement, advocacy groups, and consumers and their families. Stronger relationships will help

assure that the state as a whole remains flexible and responsive to changes in the health care marketplace as they unfold. This legislative report will be used as a document to continue statewide discussions and regional collaborations.

E. Conclusion

DHS's analysis of CBHH data and Adult Mental Health Initiative recommendations indicates that the CBHHs are an important element of non-metro Minnesota's continuum of care for people who need acute psychiatric in-patient care. The utilization rates are rising steadily, and planned improvements should soon bring them near the limit of service capacity. Optimizing and/or evolving the role of the CBHHs in the entire continuum of care, however, will require system-wide efforts and new levels of collaboration at the regional level.

The priorities identified by the Adult Mental Health Initiatives make the need for better collaboration obvious. The state's shortage of in-patient psychiatric beds for people who have exhibited aggressive behavior is a result of complex relationships among the levels of care, with "front door" and "back door" challenges that can only be solved if the problem is approached at multiple levels simultaneously. Joint discharge planning will require stronger relationships among the CBHHs, community providers, county staff, tribes, patients and families in order to work out the logistical, financial, and organizational barriers to smooth, supportive transitions for patients. Likewise, assuring patients' access to basic needs during and after they are at the CBHH will require better communication and coordination.

The preparation of this report has been a useful step in DHS's process toward clarifying and improving the role of the CBHHs in non-metro Minnesota's mental health continuum of care. Pursuing short-term operational improvements and collaborating to loosen the front and back doors of state operated facilities has already begun to strengthen DHS's relationships with the many stakeholders who will be involved in ongoing regional collaborations. The ultimate result of this work—an integrated network of community-based services to support people's mental health needs at all levels of care—will help Minnesota assure that all people have access to the right care, in the right place at the right time so they can pursue their recovery in their home communities.

Appendix 1: Legislative Mandate for This Report

Minnesota Laws 2011, First Special Session, Chapter 9, article 8, section 8, as specified below, regarding the utilization of the Community Behavioral Health Hospitals.

> "COMMUNITY MENTAL HEALTH SERVICES; USE OF BEHAVIORAL HEALTH HOSPITALS.
>
> The commissioner shall issue a written report to the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over health and human services by December 31, 2011, on how the community behavioral health hospital facilities will be fully utilized to meet the mental health needs of regions in which the hospitals are located. The commissioner must consult with the regional planning work groups for adult mental health and must include the recommendations of the work groups in the legislative report. The report must address future use of community behavioral health hospitals that are not certified as Medicaid eligible by CMS or have a less than 65 percent licensed bed occupancy rate, and using the facilities for another purpose that will meet the mental health needs of residents of the region. The regional planning work groups shall work with the commissioner to prioritize the needs of their regions. These priorities, by region, must be included in the commissioner's report to the legislature."

Appendix 2: Adult Mental Health Initiatives

The Adult Mental Health Initiatives are regional organizations that were set up in 1995 to implement new and creative models of mental health service delivery to achieve an integrated mental health service delivery system. They are awarded yearly Adult Mental Health Initiative Grant funds by DHS, and are required to submit biennial grant plans for approval. The Adult Mental Health Initiatives include representation from consumers, families, counties, tribes, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units and the Department of Human Services.

There are 16 Adult Mental Health Initiatives, made up of 1 to 18 counties, that choose to work together to plan, implement, and evaluate a mental health system for persons with serious mental illnesses. The Adult Mental Health Initiatives meet either quarterly or monthly. Several have joint powers agreements but most agree on one county operating as a fiscal agent. The Adult Mental Health Initiatives include:

Name	**Counties**
Northwest 8	Polk, Kittson, Mahnomen, Marshall, Norman, Pennington, Red Lake, Roseau
Region 2	Hubbard, Beltrami, Clearwater, Lake of the Woods
Region 3	Lake, Carlton, St. Louis, Cook, Itasca, Koochiching
BCOW	Becker, Clay, Otter Tail, Wilkins
Region 5+	Crow Wing, Aitkin, Cass, Morrison, Todd, Wadena
Region 7 East	Isanti, Chisago, Kanabec, Mille Lacs, Pine
Region 4 South	Grant, Douglas, Pope, Stevens, Traverse
Strength Through CommUNITY	Sherburne, Benton, Stearns, Wright
Anoka	Anoka
Ramsey & Washington	Ramsey, Washington
Hennepin	Hennepin
Southwest 18	Cottonwood, Big Stone, Chippewa, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Yellow Medicine
Dakota	Dakota
Scott and Carver	Scott, Carver
South Central Community Based Initiative	Blue Earth, Brown, Watonwan, Faribault/Martin, Freeborn, Le Sueur, Nicollet, Rice, Sibley
CREST	Olmsted, Winona, Fillmore, Goodhue, Houston, Mower, Steele, Dodge, Wabasha, Waseca

Appendix 3: Adult Mental Health Initiatives' CBHH Priorities

The top CBHH-related priorities of each Adult Mental Health Initiative are listed below. The lists include the top four priorities, plus ties. For more information about how these priorities were identified, see Section IV of this report.

Table 14: Adult Mental Health Initiatives' CBHH Priorities

Initiative	Counties/ Reservations	CBHH Priorities
Northwest Minnesota 8	Polk, Kittson, Mahnomen, Marshall, Norman, Pennington, Red Lake, Roseau, White Earth Reservation	• Regional control of CBHH as a state operated service. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Expedite the transition from emergency departments to CBHH admission. • Local/regionalized admissions and screening system.
Region 2	Hubbard, Beltrami, Clearwater, Lake of the Woods, Red Lake Reservation, White Earth Reservation, Leech Lake Reservation	• Discharge based on joint planning. • Access to, and retention of, basic needs. • Expedite the transition from emergency departments to CBHH admission. • Culturally competent assessment, planning, and treatment in CBHHs.
Region 3 North	Lake, Carlson, St. Louis, Cook, Itasca, Koochiching, Boise Forte Reservation, Fond du Lac Reservation, Grand Portage Reservation, Leech Lake Reservation	• Regional control of CBHH as a state operated service. • Access to, and retention of, basic needs. • Expedite the transition from emergency departments to CBHH admission. • Assessment and co-occurring treatment services at all CBHHs.
BCOW	Becker, Clay, Otter Tail, Wilkin, White Earth Reservation	• Local/regionalized admissions and screening system. • Partnership between CBHH and community providers. • Regional control of CBHH as a state operated service. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior.
Region 5+	Crow Wing, Aitkin, Cass, Morrison, Todd, Wadena, Leech Lake Reservation	• Discharge based on joint planning. • Access to, and retention of, basic needs. • Regional control of CBHH as a state operated service. • Uniform Information Processes with Community Providers. • Assessment and co-occurring treatment services at all CBHHs. • Physical care, including primary and chronic health care, is available and/or provided in an integrated approach at the CBHHs.
Region 7 East	Isanti, Chisago, Kanabec, Mille Lacs, Pine, Mille Lacs Reservation	• Discharge based on joint planning. • Partnership between CBHH and community providers. • Physical care, including primary and chronic health care, is available and/or provided in an integrated approach at the CBHHs. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior.

Initiative	Counties/ Reservations	CBHH Priorities
Region 4 South	Grant, Douglas, Pope, Stevens, Traverse	• Access to, and retention of, basic needs. • Expedite the transition from emergency departments to CBHH admission. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Discharge based on joint planning.
Comm-UNITY	Sherburne, Benton, Stearns, Wright	• Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Access to, and retention of, basic needs. • Discharge based on joint planning. • LOCUS is used as one tool for utilization management and not an exclusive discharge tool.
Anoka County	Anoka	• Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Local/regionalized admissions and screening system. • Expedite the transition from emergency departments to CBHH admission. • Regional control of CBHH as a state operated service.
Ramsey County	Ramsey	• Access to, and retention of, basic needs. • Assessment and co-occurring treatment services at all CBHHs. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Culturally competent assessment, planning, and treatment in CBHHs.
Washington County	Washington	• Partnership between CBHH and community providers. • Discharge based on joint planning.
Hennepin County	Hennepin	• Access to, and retention of, basic needs. • Assessment and co-occurring treatment services at all CBHHs. • Discharge based on joint planning. • Culturally competent assessment, planning, and treatment in CBHHs. • Physical care, including primary and chronic health care, is available and/or provided in an integrated approach at the CBHHs. • Evidence Based Practices (EBP).
Southwest 18	Cottonwood, Big Stone, Chippewa, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift, Yellow Medicine, Upper Sioux Reservation, Lower Sioux Reservation	• Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Local/regionalized admissions and screening system. • Partnership between CBHH and community providers. • Expedite the transition from emergency departments to CBHH admission.

Initiative	Counties/ Reservations	CBHH Priorities
Dakota County	Dakota	• Assessment and co-occurring treatment services at all CBHHs. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Evidence Based Practices (EBP) • LOCUS used as one tool for utilization management and not an exclusive discharge tool. • Discharge based on joint planning. • Local/regionalized admissions and screening system.
Scott & Carver Counties	Scott, Carver, Shakopee Mdewakanton Sioux Reservation	• Access to, and retention of, basic needs. • Physical health care follow up after discharge. • Discharge based on joint planning. • Assessment and co-occurring treatment services at all CBHHs.
South Central Community Based Initiative (SCCBI)	Blue Earth, Brown, Watonwan, Faribault, Martin, Freeborn, Le Sueur, Nicollet, Rice, Sibley	• Discharge based on joint planning. • Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Regional control of CBHH as a state operated service.
CREST	Olmsted, Winona, Fillmore, Goodhue, Houston, Mower, Steele, Dodge, Wabasha, Waseca, Prairie Island Reservation	• Local, reliable, timely access to a secure facility for people who have exhibited violent or physically aggressive behavior. • Discharge based on joint planning • Partnership between CBHH and community providers • Regional control of CBHH as a state operated service.

Appendix 4: CBHH Priority Recommendation Ratings

This table shows the CBHH priorities from the State Advisory Council on Mental Health. The rating worksheet was completed by fourteen members of the Advisory Council. Each member assigned a total of 100 points to the items below. The table presents the average points assigned to each item.

Table 15: Priority Ratings of CBHH Recommendations by State Advisory Council on Mental Health

Recommendations (in Advisory Council's priority order)	Average Rating
Access to, and retention of, basic needs.	12
Evidence Based Practices (EBP).	11
Local, reliable, timely, access to a secure facility for people exhibiting aggression.	10
Assessment and co-occurring treatment at all CBHHs.	9
Discharge based on joint planning.	8
Expedite the transition from emergency departments to CBHH admission.	8
Partnership between CBHH and community providers.	8
Culturally competent assessment, planning, and treatment in CBHHs.	6
Come to system-wide agreement about the criteria for admission to the CBHHs.	4
Uniform Information Processes with Community Providers.	4
Use of Certified Peer Specialists at all CBHHs.	4
Regional Control of CBHH as a State Operated Service.	4
Physical care provided in an integrated approach at the CBHHs.	4
Local/regionalized admissions and screening system.	4
Physical health care follow up after discharge.	3
LOCUS is used as one tool for utilization management.	2
Other: All patients are treated respectfully (trauma informed services, verbal and nonverbal de-escalation, recovery-based)	40 (rating from one member; not included in totals)
Other: Reduce or eliminate the use of seclusion and restraints	30 (rating from one member; not included in totals)