Acute Care and Complex Transitions
Senate HS Committee
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Aging & Disability Services Administration

Hospital Decompression versus Acute care transitions

Hospital Decompression

- Began as a COVID-related initiative
- Objective: make room in the hospitals

Acute Care Transitions

- Evolution from decompression to supporting individuals returning to the community or to another clinically appropriate setting
- Problem: people are getting stuck in acute care settings such as hospitals
- Objective: support person and families in a place of their choice, including step-down and home and community settings

Values for this work

- The right service at the right time
- Use a person-centered approach and positive support practices

Values for community collaboration

- Avoid re-creating systems that already exist;
- Understand the situation from multiple perspectives;
- Use culture of safety approach – blaming and shaming doesn't lead to accountability;
- Define current roles and responsibilities AND be open to playing new roles;
- Acknowledge that the ideal set of services for a person may not be available
  - Explore changes to service models and new MA benefits
  - Acknowledge informed choice is necessary and service options are often limited.

Role of Counties and Lead Agencies

County-delegated role includes:

- Assessment, eligibility determinations
- Authorizing services, including rate exceptions
- Ensuring service plan meets safety needs and preferences
- Final placement decisions (with person or legal representative)
- Monitoring of plan, case management
- County mental health authority

Role of DHS

- Statewide leadership and alignment (short and long-term solutions)
- **Support, not supplant**, county roles in assessment and support planning
  - Increase speed and access to state grant dollars to facilitate transitions
  - Develop provider network (community of practice) for providers that support people with complex needs
  - Take an active role in coordinating across DHS policy areas to facilitate and expedite discharges
  - Data collection and analysis

DHS Incident Command Structure (ICS): A Short-Term Solution

- Pace results that emphasize outcomes
- Organize people in positions with one flow of information
- Work from a common plan for everyone to use and reference to meet common objectives
- Weekly updates to Commissioner Harpstead and Governor's Office

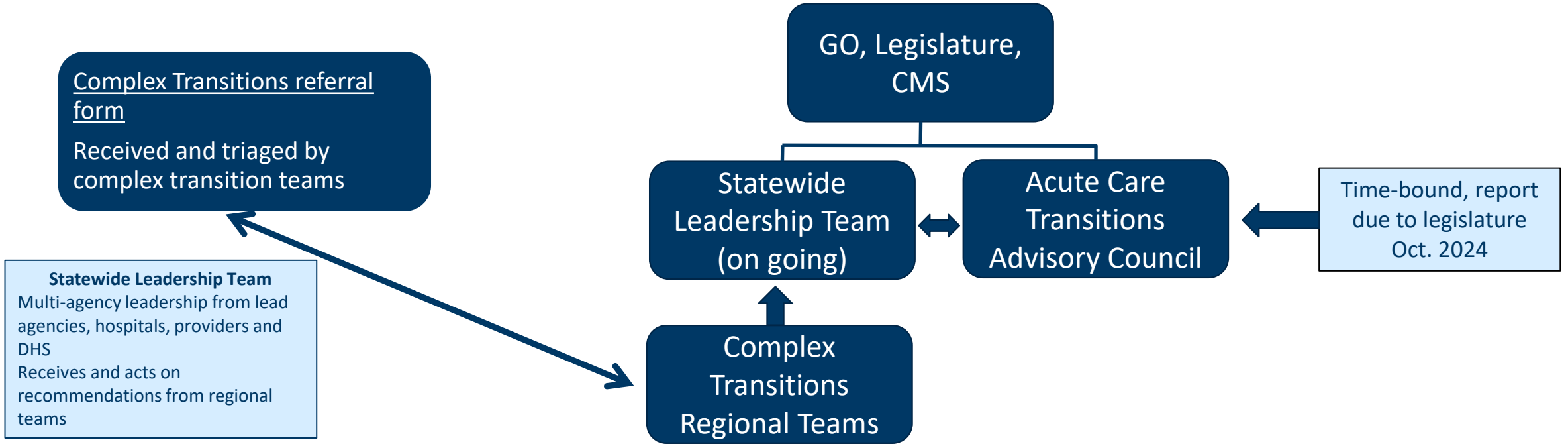
DHS Incident Command Structure (ICS): A Short-Term Solution

- Hospital Referral Form launched in late November of 2023
- 7 new contracts executed to access Transition Funds
  - Providers able to serve 26 individuals with the additional resources
  - 2 contracts in process for execution this week
- Direct Care & Treatment (DCT) Community Connections Event on 2/14
  - Identified 13 individuals from DCT to present for potential provider matches
  - 22 community providers have been invited to attend
- Partnership with culturally-specific provider association to expand access to culturally-responsive services.

Short-term goals and strategies

- Utilize Community Connections Event Feedback
- Internal triage by DCT
- Recommendations for follow-along services
- Training for DCT staff
- Collaborative meeting with Anoka Metro Regional Treatment Center (AMRTC) and Forensic Mental Health Program (FMHP) staff
- Integrated flow charts
- Ongoing collaboration

Long-Term Solutions: Regional Teams



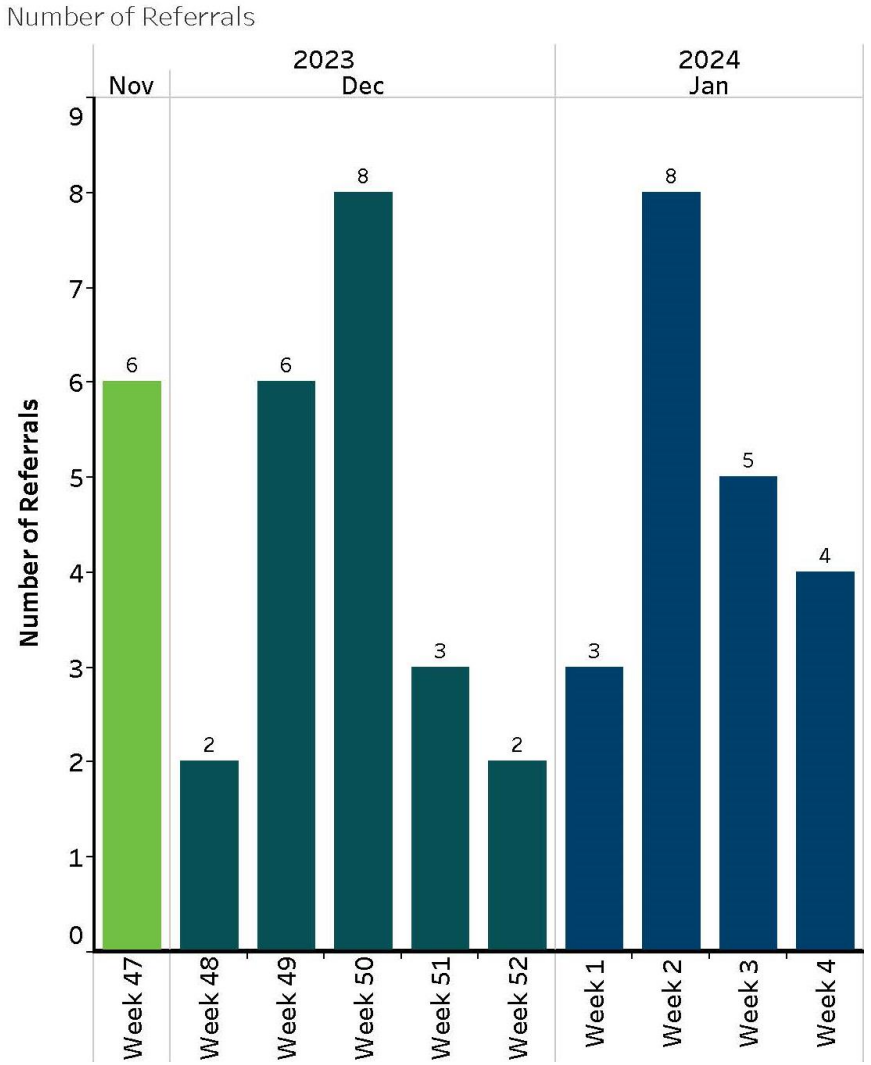
Complex Transitions Regional Teams

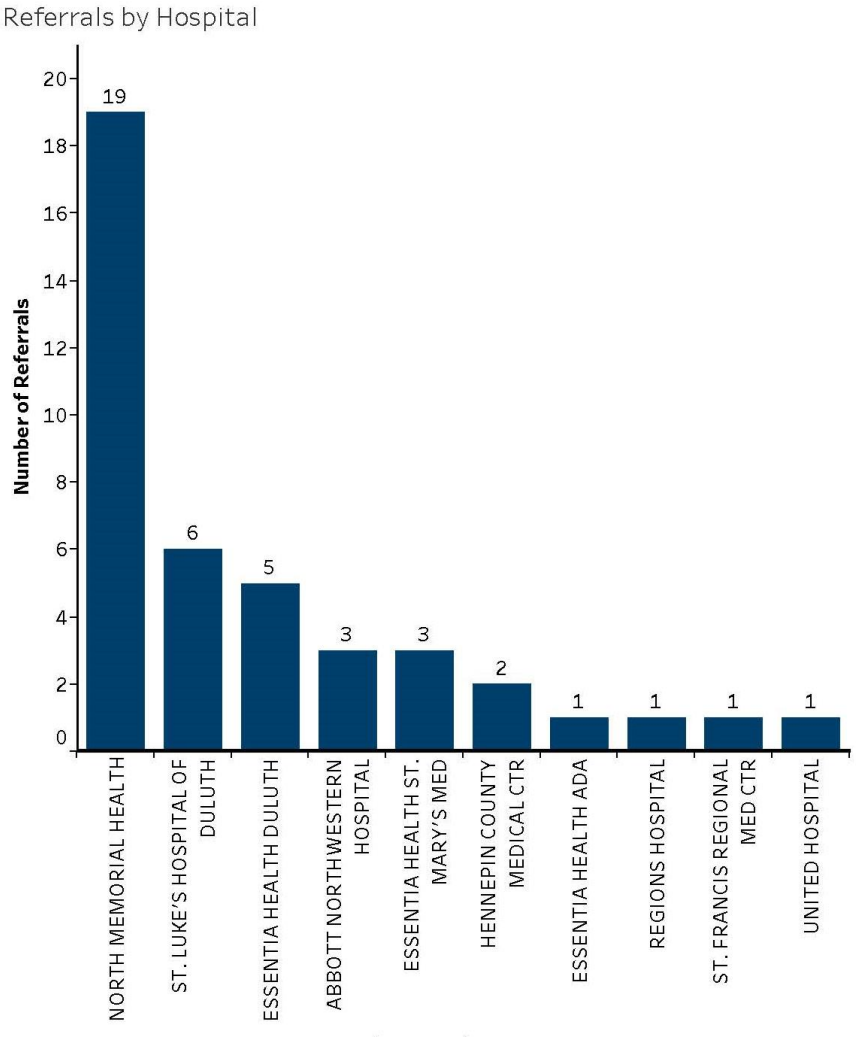
- Person-specific technical assistance, referred by hospital systems and lead agencies; connect support/care teams with existing services and resources.
  - Escalate extraordinarily complex person-specific situations to Statewide Leadership Team
- Builds sustainable regional approach with lead agencies and regional providers to address gaps and barriers to successful transitions to community life.
- Increase capacity for data collection on people who are stuck
- Provides policy and funding recommendations to statewide leadership team based on analysis of person-specific data.
- 3 regional teams with ability to add more as needed.
- Includes representatives from hospitals, lead agencies, DHS, other state agencies, and providers.

Acute Care Transitions Objectives: Updates 02/13/24

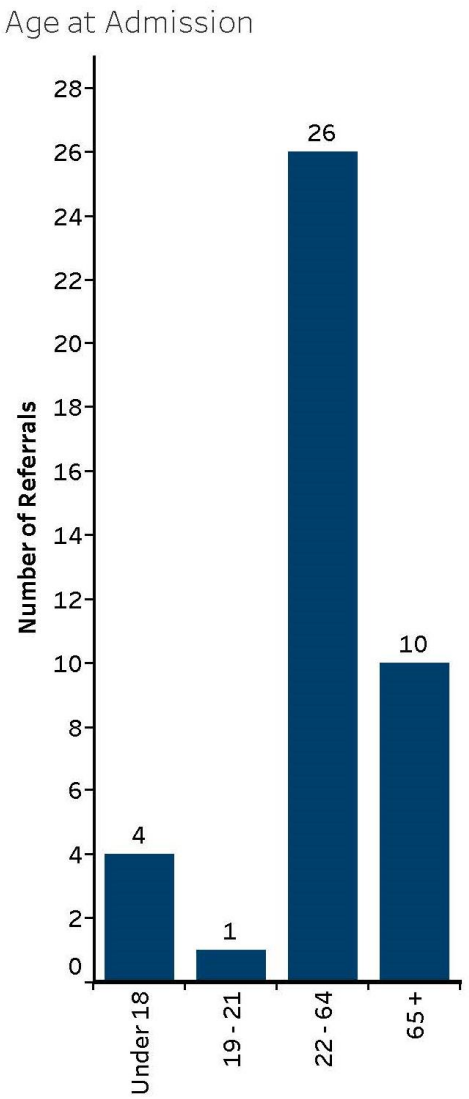
February 2024	Recruit	Interview	Hire	Onboard
Manager	✓	✓	✓	✓
Supervisor	✓	✓	✓	Starting on 2/28
Lead	✓	✓	✓	Started on 2/14
6 Complex Transition Coordinators	✓	Interviews scheduled for week of 02/26/24	Work Out of Class Concurrently	

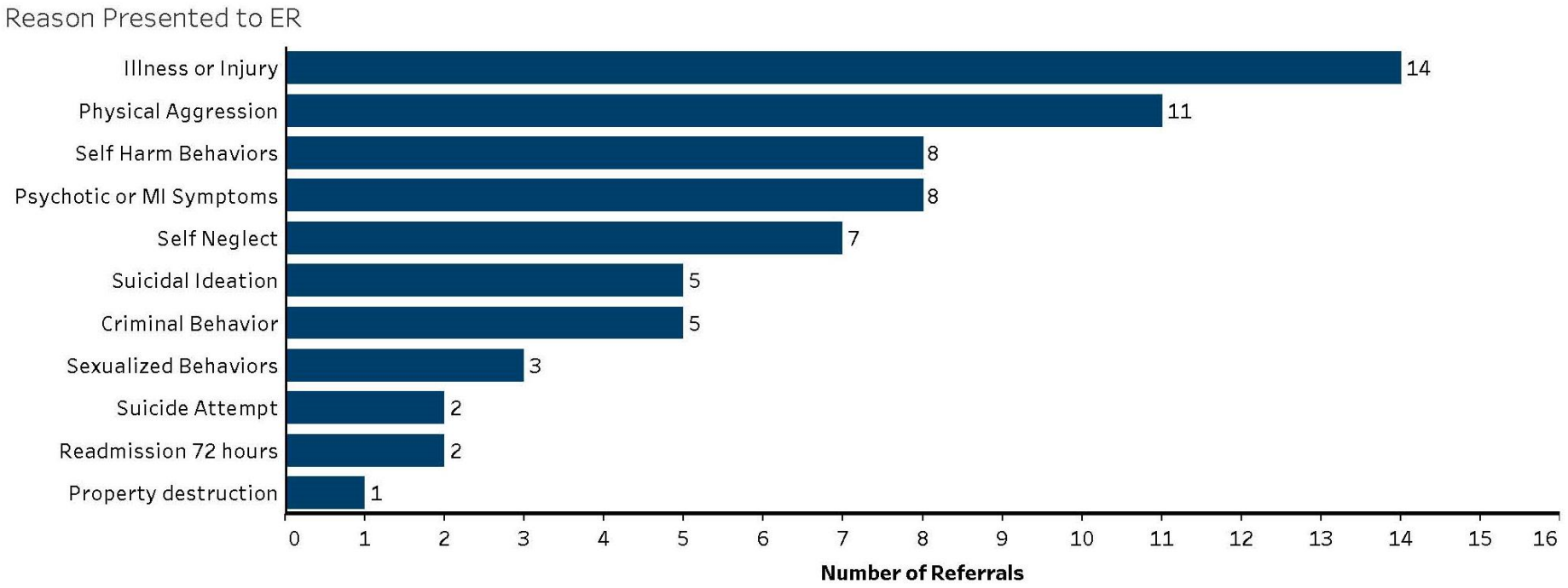
Complex Transitions Referral Data





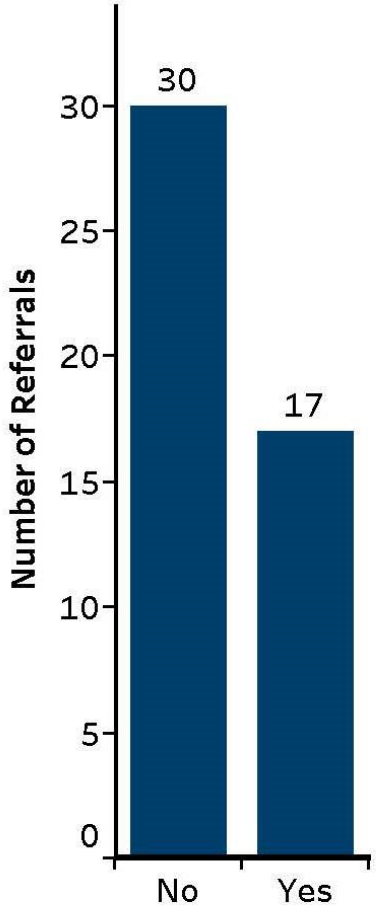
Complex Transitions Referral Data continued



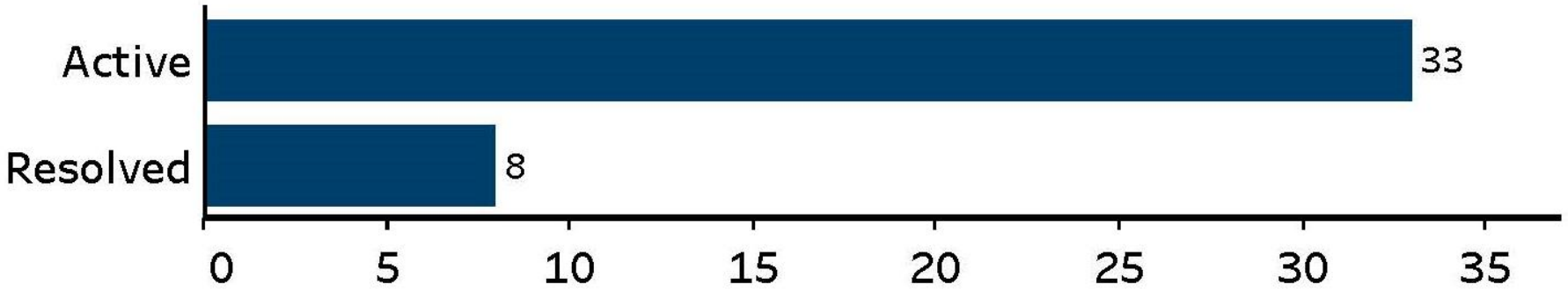


Complex Transitions Discharge Data

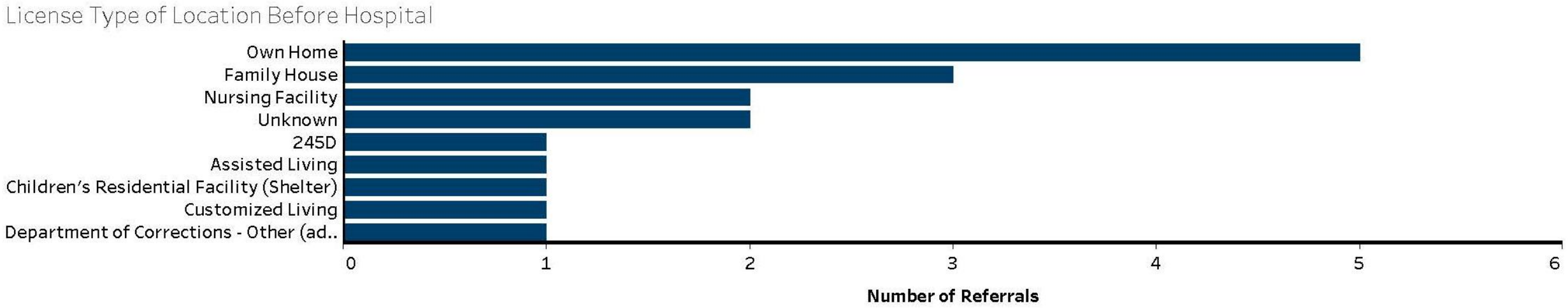
Referrals With Discharge Plans

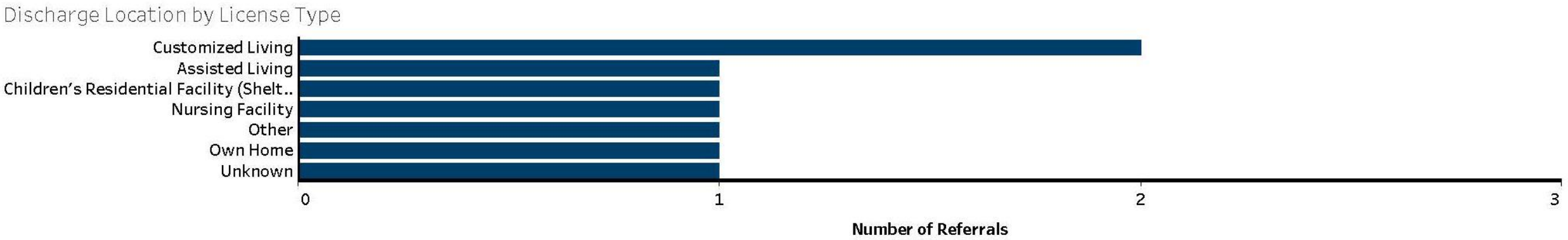


Active and Resolved



Complex Transitions Location Data





Long-Term Goals

- Stable and ongoing funding
  - to support the regional model
  - Flexible funds to lead agencies/regional groups for local solutions
  - Maximization of existing grant funding
- Provider Capacity Building
  - Community of Practice
  - Blending of positive support practices with clinical needs and follow-along supports for the person and provider

DEPARTMENT OF HUMAN SERVICES

Thank You!

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