An association of resources and advocacy for children, youth and families
www.aspiremn.org

Minnesota's In-Home Family-Centered Children's Mental Health Services: Assessing Current Capacity and Identifying Means for Growth
Fall, 2024

Executive Summary

The crisis in access to children's mental health care continues unabated with significant consequences for children and families who are going without greatly needed care, and safety net systems that are boarding children with acute mental health needs due to a lack of access to necessary intensive services. In-home family-centered children's mental health models are highly effective at supporting the child *and* the family system. Caregivers and natural supports for children and families form critical parts of the solution to this crisis. Service models that value and equip caregivers and build upon natural supports offer a practical treatment option for the child and family to sustain mental wellbeing for short and long-term horizons.

Based on numbers collected from a statewide survey (appendix b) and in-person symposium presentation we have identified capacity to serve a limited 1,600 families between various service models. Every service reported having a waiting list – except for services whose design requires immediate access.

This white paper uses data captured through survey and symposium to:

- evaluate the current capacity of Minnesota's in-home family-centered children's mental health services
- identify strategies that have sustained in-home services despite significant barriers
- prioritize solutions for growth in in-home children's mental health models

Despite broad recognition of the effective nature of in-home family-centered children's mental health models, significant barriers prevent access to care, creating a serious statewide shortage within the provision of in-home service delivery, today.

The barriers reported are consistent and clear: insufficient reimbursement rates, the absence of clear alternative funding in lieu of reliance on current rate structures, and the related lack of access to staffing needed to deliver care. Additional barriers include complex regulatory and reporting requirements, scheduling barriers for staff and families as these models require engagement during non-business hours, and transportation.

Models that remain available share basic characteristics of financial support from partners and use of existing service components from Children's Therapeutic Services and Support (CTSS) and other existing fee for service elements. Interestingly there were no reports of delivering the Minnesota State Medicaid Plan model of Children's Intensive Behavioral Health Service (CIBHS – formerly Intensive Treatment in Foster Care) though many organizations have been certified to do so, and one provider described sustaining Youth ACT services (defined in Minnesota's Medicaid plan as Intensive Rehabilitative Mental Health Services or IRMHS).

Recommendations demonstrate the immediate steps that can be taken to sustain fragile existing service capacity and mid-term strategies that can support the development of future services to meet the needs of children and families.

Methodology

A statewide survey was conducted from June 20 through July 10, 2024, using an online survey platform to collect data from providers and counties engaged in delivering children's mental health services. Survey data collected information on service capacity, barriers to care and opportunities to expand timely service delivery to support children and families.

On September 12, 2024, a symposium was held with twenty statewide provider organizations and partner counties who continue to deliver in-home family-centered intensive mental health care despite the many barriers. The discussion was designed to assess where and how services are being sustained with the goal of identifying the creative strategies that have sustained access to critical in-home services.

Analysis in this paper draws from survey data and symposium insights to broadly assess the state of in-home care throughout Minnesota and identify targeted solutions to expand service models at this key time.

Introduction

In-home family-centered mental health services are crucial for providing support to children and their families in their natural environments. The intensive models promote family preservation and equip the family system with skills to support their child and family in their home environment, resulting in significant long-term benefits.

Minnesota's children's mental health crisis has continued unabated – with children and youth needing to wait weeks and months to address immediate needs and escalating crisis that results too often in boarding in hospitals, detention and with counties. Throughout the discussion on how to build a quality service continuum that delivers the right care at the right time in the right setting, a key refrain has been the need to expand effective in-home intensive mental health models. We see in the following discussion that Minnesota has minimal capacity to meet the significant need for this level of care, in all geographies across the state. This paper concludes with practical recommendations for increasing capacity within short-term and medium-term timeframes.

Current Capacity

The reported overall capacity to serve families across service models is 1,597 families. Though this number is likely an undercount due to limitations in the methodology, it does speak to the significant limits in statewide capacity. Many organizations contributed data on previous service capacity that has been suspended due to barriers in funding, workforce, and training needed to sustain the models. Every reporting organization shared the leadership sentiment of disappointment and lament at not being able to sustain critical in-home services based on the awareness of the great need and the profound impact in-home services provide to improve the wellbeing and treatment outcomes for children. All respondents referred to barriers that prevent delivering care to families in need. Importantly, within our current children's mental health service system there are only structural *disincentives* to delivering in-home care.

Models Described

Services that leverage existing Medicaid fee for service reimbursed services either in full or in part are:

- In-Home Children's Therapeutic Services and Supports (CTSS) focusing on skills and family psychotherapy benefits
- Bridging Services (Collaborative Intensive Bridging Services)
- High Fidelity (HiFi) Wraparound
- Youth Assertive Community Treatment (Youth ACT) described in the MN Medicaid State Plan as Intensive Rehabilitative Mental Health Services or IRMHS

Defining Intensive In-Home Services include treatment interventions and related ancillary services provided to children and families with multi-system involvement who can gain significant family stabilization through an intensive team-based intervention that provides treatment, skill building and meets family needs to sustain care for their child and strengthen their family system. Services are delivered in the variable settings of the child's home and community with a frequency and duration of direct support and indirect team engagement that includes consultation, collaboration and supervision to direct individualized care that support the child and equips the family system to achieve stability and wellbeing.

Each of these services requires leveraging fee for service funding elements and often creatively seeking reimbursement from county or grant funding that provides funds that fill the financial loss generated by insufficient funding from the fee for service model or delivers funding for the ancillary services that are not reimbursed by Medicaid.

Models that are uniquely grant funded include:

- DHS grant funded Youth Care Transition Team
- Hennepin County Family Response and Stabilization Service (FRSS)

Primary barriers were repeated throughout the data and include:

- reimbursement rates do not compensate for the costs of care, as outlined in the Minnesota Health Care Programs Fee-For-Service Outpatient Services Rate Study
- travel as a specific barrier from a reimbursement/time/staffing perspective
- inability to hire and retain the sophisticated workforce and expansive teams required to deliver in-home models
- the intensive training, supervision, and consultation required to sustain intensive models is costly and reimbursement both does not meet the costs, and, these required elements are not always reimbursed by MN Medicaid
- an absence of alternative funding mechanisms to support these models

Creative Solutions Sustaining In-Home Care

The symposium discussion focused significantly on understanding how services have sustained despite the significant decrease in capacity statewide and related pressures on all providers in this ongoing crisis.

Creative solutions that have sustained in-home care include operational best practices that organizations have adopted or structural partnerships to assure services can be delivered, including:

- Financial partnerships with counties/payors that include payment for ancillary services
- County collaboration with service design and funding including grant funding to support services

- Significant and ongoing training and shadowing support for new staff
- Caseloads that are balanced between intensive in-home services and less intense services
- Use of Family and Youth Peer Specialists
- Use of fleet vehicles to minimize wear on staff vehicles

Data shared on current capacity includes:

1. **Service Providers and Capacity**
    - A variety of provider organizations are contributing to service delivery – from small community-based providers who serve in a distinct geography to larger statewide organizations, and, some counties are also participating in direct services.
    - Many providers operate below capacity due to staffing shortages and financial constraints.
    - Several provider organizations reported discontinuing the provision of in-home services in their area or have placed a freeze on receiving intakes for in-home services due to capacity limitations.

2. **Data Insights**
    - **Survey Data** highlights a consistent lack of capacity and extended waitlists, reflecting insufficient resources.
    - **Symposium Discussion** emphasized the disparity between available services and community needs, calling for innovative solutions. Providers observed that other services such as outpatient services or School Linked Behavioral Health services are not sufficiently available to fill the gap for the much needed care and see an significant need in requested/referred in-home services models of care.

Challenges and Barriers

1. **Funding Shortfalls**
    - Limited financial resources hinder workforce expansion and service improvements.
    - Exploration of diversified funding streams is critical.

2. **Staffing Issues**
    - High turnover rates and difficulties in hiring skilled professionals.
    - The field is shrinking with fewer new professionals, an aging cohort of professionals.
    - Greater Minnesota has been reported as a mental health dessert – making hiring licensed mental health professionals an increasing impossibility (appendix a).
    - Need for competitive salaries and support for required training including supervision and consultation critical for intensive in-home models.

3. **Regulatory and Compliance Hurdles**
    - Complex regulations create administrative burdens on service providers.
    - Calls for streamlined processes to support expansion efforts.

Best Practice Strategies for Growth

1. **Enhancing Workforce Capacity**
    - Develop recruitment strategies focused on attracting and retaining qualified staff.
    - Support comprehensive training programs to enhance service delivery.

2. **Regulatory Reform**
    - Advocate for changes to simplify compliance and promote provider participation.
    - Partner with DHS and payors to ensure supportive regulatory environments.

3. **Financial Strategies**
    - Secure increased funding for in-home models by prioritizing funding within legislative investments, county partnership and encouraging other creative funding strategies from payors and other community sources.
    - Explore alternative funding models like value-based care.

4. **Community Engagement**
    - Engage families in program design to ensure alignment with community needs.
    - Maintain strong partnerships with local community organizations to assure awareness of intensive in-home services.

Conclusion and Recommendations

Minnesota remains in a crisis of access to mental health care with some of the most significant impacts being borne by children and families. The conditions for the crisis were set prior to the COVID pandemic and were exacerbated by a dramatic growth in need concurrent to significant loss in capacity to serve. As we strive to meet the mental health needs of children and families and rebuild access to care, we must first attend to the foundational priority of establishing rates that support quality treatment and workforce. We also are compelled to ask: *how do we prioritize growth in the most meaningful interventions for children and families with complex needs?*

Minnesota's in-home family-centered children's mental health services are essential for the state's future children's mental health service array. In-home services require prioritization as a key solution to address the ongoing crisis in access for children's mental health care. Addressing funding, staffing and regulatory challenges is key to expanding these critical service models. By following strategic recommendations, Minnesota can enhance service capacity, ensuring comprehensive mental health support for children and families.

Recommendations

Strategic Funding

1. Increase Medicaid payment rates by 50%[1] for location of "home" and travel for services related to in-home mental health care.

[1] Analysis conducted by MN Region V relating to delivering Collaborative Intensive Bridging Services (CIBS) from 2020-2022 demonstrates that third party payors currently cover 41% of costs for the CIBS in-home model, and, the MN Health Care Programs Fee-For-Service Outpatient Services Rate Study demonstrates and average gap of 40% between payment and cost of community-based care.

2. Fully implement the MN Health Care Programs Fee-For- Service Outpatient Services Rate Study, published January, 2024.
3. Sustain funding and build on services that work: Youth Care Transition Teams, Hi-Fidelity Wrap Around through enhanced Targeted Case Management payments, and county-based investments.
4. Encourage full participation of all commercial health insurance payors in these highly effective models of care.
5. Invest in workforce development to ensure competitive salaries and retention.

Policy and Funding Alignment with Service Needs

1. Allow for reimbursements that support team/paired interventions for effective family support and response to safety concerns as needed.
2. Remove the internal billable consultation prohibition.
3. Review Minnesota's Medicaid State Plan Amendment in-home service models to propose simplification of processes and requirements to support access to care.
    - Provide targeted technical assistance and related funding to support adherence to fidelity standards and funding requirements (eg: applying for enhanced TCM rates to deliver HiFidelity Wrap)
4. Support access to training and funding for family and youth peer specialists – roles that are critical to many intensive in-home models, and, an area for possible continued service growth and impact.
5. Enhance flexibilities for funding provided to counties for the purpose of meeting family and child needs.

Supportive Collaboration

1. Highlight data that demonstrates the impact and outcomes of in-home services.
2. Increase funding opportunities to sustain existing collaboration and support expansion initiatives.
3. Collaborate with stakeholders to tailor services to meet diverse community needs.

APPENDIX A

ADDITIONAL DATA

Scarcity of Services

The data includes services in several counties, but the following Minnesota counties are notably not mentioned, indicating potentially limited access to services:

1. Benton
2. Big Stone
3. Chippewa
4. Cook
5. Grant
6. Jackson
7. Kanabec
8. Lac qui Parle
9. Lincoln
10. Mahnomen
11. Marshall
12. Murray
13. Pennington
14. Pipestone
15. Red Lake
16. Rock
17. Roseau
18. Stevens
19. Traverse
20. Watonwan

These counties may have limited access based on the data provided.

APPENDIX B

Point in Time Survey: Intensive Mental Health Services Capacity for Children and Families

The following point in time survey was conducted by AspireMN in collaboration with counties and partner community-based provider organizations. Respondents were asked to share quantitative and qualitative data in response to requested fields as a point in time as of June 1, 2024.

In-Home Intensive Treatment Setting(s)	Service Provider	Program	Service Description
Children's Intensive Behavioral Health Service (CIBHS – formerly Intensive Treatment in Foster Care)	Dakota County	Dakota County	We contract for pre-teaching foster parents on CIBHS to increase their likelihood of accepting teems with complex needs. n
	Lighthouse	Lighthouse	LCFS does not currently have the staffing capacity to support our CIBHS program. We have waitlists in our outpatient and school-based programs currently and hiring in rural areas is difficult. It has also been challenging to offer this service due to billing/minimum requirements and the amount of travel typically required in rural locations.
	Nexus Family Healing	Nexus Family Healing	We are currently licensed for this program, however, we haven't provided any services under this for the past 2 years. We don't have staff to serve in this program at this time.
	North Homes	North Homes	We are certified but do not currently have a provider
	Northland Counseling	Northland Counseling	Would love to do this, but would need our County to contract with us. There are too many 'political' barriers within our area's county leadership, that making positive and lasting change has proven difficult.
	Therapeutic Services Agency	Therapeutic Services Agency	We no longer hold this certification with the state of MN. We opted not to renew the certification due to the inability to staff the program due to requirements of the program that caused an inability to have dedicated staff to this program. As such, we were unable to budget for this program. We attempted to hire for the program which did not yield any applicants.
Children's Intensive Bridging Service (CIBS - referenced as Bridging)	180 Degrees	180 Degrees	We have been in communication with Olmsted County to partner as a potential placement.
	Dakota County	Dakota	We have two dedicated clinicians to provide this service
	Greater Minnesota Family Services	Greater Minnesota Family Services	We currently have two full time clinical staff providing CIBHS. We are also recruiting for 2 more full time positions. Both of our colleagues average 6 clients and have wait lists.
	Nexus Family Services	Nexus East Bethel & Mille Lacs	We would be interested in pursuing this

	Nexus Family Services	Nexus Family Services	CIBS/SFT are services provided to families typically under a county contract. The counties maintain the waiting list and assign us cases as we have openings. We are still looking to fill FTE's in this program. We have about 9 therapists that are currently supporting this program.
	Nexus Family Services	Nexus Gerard	We do currently have this program with counties that drive it. We do not have a specific number of beds for any of our differing programs. Rather, our dorms have a certain capacity - but our programs (Residential, short term, CIBS, and 45 day assessment) do not have certain capacities. If a youth is referred to us under this program, they do get priority, but again - there is not a certain number of spots/beds available for those programs.
	VOA - Bar None	VOA - Bar None	Contracted for our BN Omegon program but has not yet been implemented.
Children's Therapeutic Services and Supports (CTSS) In-Home Care	Fernbrook	Fernbrook	Have a waitlist to provide CTSS skills (approximately 3-6 month wait) in the following counties: Blue Earth, Dodge, Rice, Mower, Steele. Unable to accept new referrals for CTSS skills in the following counties due to length of waitlist: Goodhue, Olmsted, Waseca. Have a waitlist to provide CTSS therapy (approximately 3-6 month wait): Waseca, Rice. Not accepting new referrals for CTSS therapy due to length of wait in the following counties: Blue Earth, Dodge, Goodhue, Mower, Olmsted, Steele. We also provide skills and therapy through SLMH programs- most of our school programs have a waitlist, but are accepting referrals. 8 schools are not accepting new referrals at this time.
	Greater Minnesota Family Services	Greater Minnesota Family Services	We have approximately 40 In-Home CTSS providers. The average case load size is 15 clients. All have wait lists.
	Lighthouse	Lighthouse	Yes, very minimal. We do this within other programs (outpatient, day treatment) when we see a need. We do not offer in home as a stand alone service. We closed our CTSS skills program several years ago due to low reimbursement rates which in turn result in low wages which in turn resulted in lack of quality candidates and high turn over.
	North Homes	North Homes	We currently provide CTSS. CTSS has transitioned to being provided as a 'school-based' service, this has helped in financially sustaining the services to some degree because of the incredibly low rates for CTSS. There has been a shift in that there is a reluctance to provide this service in the community or client's home due to perceived safety concerns. This is concerning in that family involvement has significantly decreased.

	Northland Counseling	Northland Counseling	We have done this in the past. We had to close services once another local agency went into contract with our School Districts. The school would allow ONLY members from the contracted agency to work with kids in the school setting. It is hard to find a dedicated, skills practitioner that wants to work only outside of school time hours (nights, weekends, Holidays, etc...). And the rates of reimbursement for such services was horrible.
	Northwood Children's Services	Northwood Children's Services	We have the capacity to provide CTSS services (Intensive Day Treatment) to children in their home schools with 4 programs serving up to 16 children per each program. We also have two on-site schools in which we offer Intensive Day Treatment with a total capacity of 96. We also have an Outpatient program in which we offer individual and family therapy, individual and group skills as well support the community with Diagnostic Assessments. The total Capacity at this time is 80 students.
	St. David's Center	St. David's Center	due to poor reimbursement St. David's Center had to reduce these in-home services to only clients also in our school linked mental health services or as a part of our day treatment programs
	Therapeutic Services Agency	Therapeutic Services Agency	due to poor reimbursement St. David's Center had to reduce these in-home services to only clients also in our school linked mental health services or as a part of our day treatment programs
	VOA	VOA	We provide CTSS to children with hearing loss. We currently have a waiting list due to capacity. The waiting list is short (1-2) but that is only because we have declined to add more to the waiting list.
	Nexus Family Services	Nexus Family Services	We have about five therapists (1 on leave, others are part-time) that equates to about 2.5FTE. One FTE is allocated to the juvenile justice center. We have about 21 clients on a waiting list for home-based services (median wait time of 96 days). We have 40 clients waiting for a DA or outpatient services.
Hi-Fidelity Wrap Around (can use Targeted Case Management partial reimbursement)	VOA	VOA	HFW and TCM
	VOA	VOA	We have high-fidelity wraparound services. As of June 3 we had 3 full time providers. 1 was full, 1 had capacity of 2-3 additional youth, and 1 was in their training/onboarding period. We have hired a fourth individual provider who will start mid-June and will be in their training/onboarding period. We anticipate being able to handle 40-44 families by the end of the year. Right now we are in need of more referrals for this program due to our recent expansion.

Intensive Rehabilitative Mental Health Services (IRMHS, also called Youth ACT)	n/a	n/a	
Other Services	Dakota County	Dakota County	We contract for pre-teaching foster parents on CIBHS to increase their likelihood of accepting teems with complex needs. n
	Dungarvin	Dungarvin	We provide IHS services, capacity is unable to be determined due to variables of location and staffing pool.
	Freeborn County	Freeborn County	Freeborn County provides Free in home family based therapy/counseling to all residents of our county on a voluntary bases. They present for an intake either at the agency or in their home and information is collected. The case is presented to the team and assigned according to area of specialty or open case toad.
	Greater Minnesota Family Services	Greater Minnesota Family Services	Family Group Decision Making.
	Nexus Family Services	Nexus Family Services	We also provide Family Response & Stabilization (FRSS) and Youth Care Transition program. FRSS provides immediate, in-person support and stabilization for youth ages 5-18 and their parents/caregivers in Hennepin County. Currently this is a contracted program through the county. YCT provides two tracks of coordinated services and transition support for youth with complex needs who need to transition to a more appropriate level of service. The team helps move youth move out of metro area emergency rooms and Psychiatric Residential Treatment Facilities in Minnesota.