# Plan for the Anoka Metro Regional Treatment Center

## Direct Care and Treatment and Chemical and Mental Health Services Administrations

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**Legislative Report**

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# AMRTC Plan: Report to the Legislature

# I. AMRTC Plan: Executive Summary

In a 2013 report from the Office of the Legislative Auditor, the Minnesota Department of Human Services (DHS) was directed to prepare a plan for the Anoka Metro Regional Treatment Center (AMRTC). This report responds to that recommendation. It provides historical context and current data to show that the patient flow problems at AMRTC are systemic problems resulting from gaps in Minnesota's service system for people with mental illnesses and substance use disorders.

Since its opening in 1899, AMRTC has continually adapted to meet the mental health needs of Minnesotans. Currently AMRTC is a psychiatric hospital serving a small target population: adults with serious and persistent mental illnesses and co-occurring conditions—including substance use disorders, intellectual disabilities, chronic physical illnesses, and aging-related dementia—that complicate their recoveries. Symptoms of some of these patients include aggressive and self-injurious behaviors that pose a risk to personal and public safety.

Minnesota's mental health service system is still in a de-institutionalization process that began in the 1950s. While Minnesota has made great strides in closing large mental institutions and shifting resources to community-based services, there are still gaps in the service system that compromise care for people in the target population. Key gaps include:

- A lack of adequate and coordinated community services to support individuals' recovery in their communities; and
- Inefficient administrative processes (especially in the commitment process, funding eligibility determinations, and community placements) that delay both treatment and recovery in community settings.

As a result of these gaps, AMRTC is experiencing severe patient flow problems: 1) a long waiting list for admission; 2) frequent treatment episodes for some patients; and 3) patients "stuck" at AMRTC after they no longer meet criteria for a hospital level of care because appropriate community settings and/or services are not available in their home communities. These patient flow problems reverberate throughout the service system, creating backups at community hospitals and preventing people from receiving the "right time, right place" care they need to successfully pursue recovery.

The gaps in the service system that result in patient flow problems are not solvable by AMRTC—or even DHS—alone. They require collaborative problem-solving by all stakeholders, including individuals and their families, providers, insurers, counties, tribes, policy makers, and advocacy groups. There are dozens of collaborative efforts already underway that address the gaps. These efforts are aligned with Minnesota's Olmstead Plan and with health care reform principles. The changes include:

- Adopting new decision-making and service-delivery processes at the state, regional, local, provider, and individual levels that are driven by the choices of people with disabilities.
- Increasing the recovery support services in communities so that people can get timely access to the services and supports they need in order to avoid inpatient psychiatric treatment whenever possible.
- Managing the service capacity to assure timely access to acute care (urgent care, crisis services, and inpatient care) when it is needed.
- Improving coordination and collaboration among service providers so that people in the target population are supported by recovery management partnerships with a common understanding of the individual's recovery goals, integrated or coordinated information and records, and regular communication and planning.

To alleviate the current pressures on AMRTC and other hospitals until the longer-term impacts of current efforts are felt, DHS is planning several immediate solutions, including opening a 16-bed transitional unit at Miller-North on the AMRTC campus; collaborating to open two new IRTS targeted to the population of people being discharged from AMRTC; and undertaking regional collaborative planning to build region-specific solutions.

Because stakeholders agree that AMRTC plays a crucial role in Minnesota's system of care, DHS will take steps to improve various processes but does not plan to make fundamental changes to AMRTC's role in the next five years. As Minnesota's Olmstead Plan and health care reform are implemented, DHS will continue to monitor AMRTC's role in the system and recommend changes as needed, following the DHS principle of providing services only when they are needed and other providers decline to provide them.

# II. Introduction

## A. The Legislative Auditor's Recommendation and Scope of this Report

In March 2012, the Legislative Audit Commission directed the Office of the Legislative Auditor (OLA) to evaluate the services provided by what was then called State Operated Services (SOS), a division of Minnesota's Department of Human Services. The evaluation focused on SOS's inpatient and residential services, looking at services provided, client flow through the programs, the availability of non-state alternatives, and the effectiveness of SOS's management of the services provided. The resulting report, "Office of the Legislative Auditor Evaluation Report: State-Operated Human Services," contained a list of 20 recommendations for addressing issues and improving the performance of SOS programs. One of those recommendations was the following:

> *The Department of Human Services should provide the 2014 Legislature with a substantive plan for the Anoka-Metro Regional Treatment Center.*[1]

This legislative report is DHS's response to that recommendation, one of many responses to the entire OLA report.[2] It addresses the issues raised about the Anoka Metro Regional Treatment Center (AMRTC) in the report, which included:

- Too many non-acute bed days (days that people spend in a hospital when they no longer meet the criteria for a hospital level of care)
- Long waiting lists for admission
- AMRTC's ineligibility for Medicaid reimbursements
- Question of the appropriate number of beds at AMRTC
- Possible need for additional legislative action to improve the community reintegration options for people served at AMRTC
- How AMRTC should collaborate with non-state hospitals (especially in the Twin Cities)

AMRTC, a state-run acute psychiatric hospital for people who have been committed to the Commissioner of DHS, plays a key role in the mental health and substance use disorder system of care in Minnesota. This system has become exceedingly complex, with clients moving among multiple levels of care that are provided by hundreds of public and private organizations and funded by sometimes-overlapping programs overseen by county, state, federal, and tribal agencies. In order to address the issues raised in the OLA report, this report takes a wide view, describing the mental health system transformation that is occurring in Minnesota and AMRTC's

[1] *State-Operated Human Services* (Saint Paul: Office of the Legislative Auditor, State of Minnesota, February 2013), 121.

[2] Another DHS response was the creation of a new Administration, Direct Care and Treatment, and the re-organization of State Operated Services. See Appendix A for a description of AMRTC's location in the current DHS organizational structure.

evolving role as the transition has progressed. It uses data and stakeholder input to describe AMRTC's operation, the challenges it faces, and the systemic problems that underlie those challenges. It then describes dozens of collaborative efforts that are underway across the mental health and substance use disorder service system to address those problems. These efforts are aligned with the state's health care reform activities and with Minnesota's Olmstead Plan to serve people with disabilities in the most integrated community settings of their choice.[3] Then the report focuses specifically on the changes that DHS is planning for AMRTC itself.

The domain of mental health and substance use disorder services is highly specialized, and there are many acronyms that have come into common usage in the field. DHS has tried to minimize the use of acronyms in this report, but some acronyms are so widespread that *not* using them can be confusing. To assist the reader who is new to the field, a key to the acronyms used in the report is included in Appendix B.

## B. The Process of Preparing this Report

The issues and problems identified in the OLA report are not new and DHS has been working with stakeholders for several years to address them. Positive steps have been taken in policy changes, system improvements, and gathering data to plan for the future. This report built upon those steps by adopting the following process:

1. Responsibility for this report was shared by the Chemical and Mental Health Services Administration (CMHSA), the mental health and substance use disorder policy administration of DHS, and Direct Care and Treatment (DCT), the division of DHS that provides the state-run mental health and substance use disorder treatment services. This collaboration fostered a system-level view of the problems at AMRTC and the need for changes throughout the system, not just at AMRTC.
2. DHS staff reviewed the volumes of input and ideas that DHS has received from stakeholders in the thousands of hours of meetings of task forces, committees, workgroups, and other collaborative activities that have occurred over the past five years.[4] This review, combined with interviews of stakeholders to pose specific questions,

[3] Minnesota recently released the Minnesota Olmstead Plan, a document that lays out Minnesota's strategy for complying with *Olmstead vs. L.C.*, a court case that guarantees people with disabilities the right to live in the most integrated community settings of their choice. *Putting the Promise of Olmstead into Practice: Minnesota's 2013 Olmstead Plan* (Saint Paul: State of Minnesota, November 1, 2013).

[4] *Road Map for Mental Health System Reform in Minnesota* (Saint Paul: Minnesota Mental Health Action Group, June 2005); *Mental Health Acute Care Needs Report* (Saint Paul: 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* (Saint Paul: Chemical and Mental Health Services Administration, March 2010); *Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services* (Saint Paul: Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, December 2010); *Report on the Utilization of the Community Behavioral Health Hospitals* (Saint Paul: Chemical and Mental

provided DHS staff with the background to write a description of the current system and the problems it faces. This description was circulated to stakeholders and revised based on their comments.

3. Staff collected and analyzed DCT and Medical Assistance reimbursement data to describe the people served by AMRTC and their movement through the system.
4. Based on stakeholder input and current DHS priorities, the report lays out a plan for AMRTC's role in the service system that responds to multiple (and often conflicting) stakeholder needs, market realities, and federal requirements. The report was delivered to the Commissioner in January 2014.
5. The mental health and substance use disorder service system is in flux due to health care reform and implementation of the Minnesota Olmstead Plan. Because the operation of AMRTC must constantly respond to changes in the entire service system, DHS intends to continue to revise this plan.

## C. Assumptions and Values Driving this Report

This report is based on the following assumptions and values:

- AMRTC is one provider in a complex and interconnected system that includes people with mental illnesses, their families and friends, public and private service providers, insurers, government agencies, tribes, advocacy groups, and others. Circumstances at AMRTC are affected by many factors outside AMRTC's direct control, and changes anywhere in the system can have intended and unintended effects elsewhere in the system. AMRTC's challenges are *system* challenges, and solving them will require system solutions.
- The health care system is in flux and is affected by many factors outside the control of AMRTC, DHS, or even the state as a whole. DHS needs to adopt a principled and flexible approach that allows Minnesota to take advantage of opportunities presented by health care reform to strengthen the state's care and treatment for people with mental illnesses and substance use disorders.
- The goal of mental health and substance use disorder services is recovery, which is defined by the Substance Abuse and Mental Health Services Administration (SAMSHA) as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[5]

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Health Services Administration, March 2012); DHS stakeholder meetings on Bloomington Site Planning, Elmer Anderson Bldg., St. Paul, MN on March 25, April 1, and April 8, 2011; Adult Mental Health Reform 2020 Steering Committee and Workgroups (IRTS, Early Onset of Psychosis, Behavioral Health Homes, and ARMHS/State Plan Option Workgroups), Elmer Anderson Bldg., St. Paul, MN, Fall 2012.

[5] "SAMHSA Announces a Working Definition of "Recover" From Mental Disorders and Substance Abuse Disorders," SAMHSA News Release accessed on December 22, 2013 at http://www.samhsa.gov/newsroom/

- The stigma surrounding mental illnesses and substance use disorders is a very powerful negative force that isolates people, supports discrimination, and dramatically complicates recovery. It is important to fight stereotypes and misleading information about mental illnesses and substance use disorders and to educate society about the reality of these illnesses.
- Recovery is best achieved by person-centered strategies and care, which means that each person should be in charge of his or her recovery to the greatest extent possible and that people should receive the right services at the right place and time to aid the recovery process. The approach is summed up in the "Nothing about me, without me" motto. While recovery is always the goal, it is important to recognize that some people in the target population have so many impairments that they are not capable of managing their own recoveries and they are likely to need intense support for the rest of their lives. For these people, family and friends can play an especially crucial role in helping assure that decision-making and care are driven by the preferences of the client as much as possible.
- Mental illnesses and substance use disorders are medical conditions that have physical, cognitive, psychological, behavioral, social, and spiritual dimensions. To support recovery, the health care service system as a whole should support people to address all of these dimensions.
- The Americans with Disabilities Act (ADA) defines certain mental health conditions as disabilities, thus giving protections to some people with mental illnesses who are served in the health care system.[6] The *Olmstead v. L.C.* court decision held that the ADA protects people with qualifying mental health conditions from services that have the effect of limiting their integration in their communities against their choice.
- Prevention is the key to promoting recovery and controlling costs: it is better to help someone avoid becoming more acutely ill than to wait until their condition has become more acute to provide services. Because this report focuses on a high-need population, it will emphasize secondary prevention (halting or slowing the progress of an illness that has already been diagnosed) and tertiary prevention (managing chronic diseases to prevent further deterioration and maximize quality of life).

## D. A Vision and Approach for the Future

DHS is committed to the development of a mental health and substance use disorder service system that aids the recovery of people in the target population so that they can live successfully in their chosen communities. In 2005 the Minnesota Mental Health Action Group (MHAG) outlined several guiding principles for Minnesota's mental health system, and those principles

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[6] The ADA includes people with behavioral health conditions who meet one of these three criteria: "1) a physical or mental impairment that substantially limits one or more major life activities of the individual; 2) a record of such an impairment; or 3) being regarded as having such an impairment." *Americans With Disabilities Act of 1990,* Title 42, Chapter 126, Section 12102. Accessed on October 18, 2013 at http://www.ada.gov/pubs/adastatute08.htm#12102

are still useful. Since 2005, the concept of person-centered care has gained more attention, as has the importance of assisting people to live in the most integrated community setting of their choice. Those two principles have been added to MHAG's original list of guiding principles to generate the following list of desirable characteristics of Minnesota's mental health and substance use disorder service system:[7]

- Person-centered, with individuals driving their own recovery journey as much as possible
- Flexible to meet the needs of different populations, ages and cultures
- Provides the right care and service at the right time
- Delivers care and services in the least intensive site possible
- Allows individuals to live in the most integrated community setting of their choice
- Uses a sustainable and affordable financial framework with rational incentives
- Easily navigated by consumers and providers because it operates in efficient, understandable pathways
- Uses evidence-based interventions and treatment to produce the desired outcomes
- Employs effective health promotion and prevention strategies
- Has appropriate providers and service capacity
- Clearly defines accountability among all parties

The Minnesota Olmstead Plan defines "person-centered awareness" as follows:[8]

> *"Person-centered awareness is an understanding of the core concepts and principles behind a process-oriented approach to assist a person in defining the life that person wants to lead, rooted in values, goals and outcomes important to that person and developing meaningful life goals based on the person's strengths and talents, utilizing individual, natural and creative supports and services. A person-centered approach puts the person in charge of defining the direction of their lives and leads to greater inclusion as a valued member of both community and society."*

Person-centered thinking involves a cultural change in how services are conceptualized and structured, how care is delivered, how staff are trained, and how outcomes are assessed. It requires changes not just in treatment environments, but in the organizational cultures of providers and policymakers. Some of the values of person-centered thinking include:

- Sharing ordinary places
- Making choices

[7] *Road Map for Mental Health System Reform in Minnesota* (Saint Paul: Mental Health Action Group, June 2005), 5.
[8] *Putting the Promise of* Olmstead *into Practice: Minnesota's 2013 Olmstead Plan* (Saint Paul: State of Minnesota, November 1, 2013), 80.

- Developing abilities
- Being treated with respect and having a valued social role
- Growing in relationships[9]

Implementing person-centered thinking is reflected in actions like seeing people first, rather than diagnostic labels; using ordinary language and images, rather than professional jargon; actively searching for a person's gifts and capacities in the context of community life; and strengthening the voice of the person—and those who know the person best—in accounting for their history, evaluating their present conditions, and defining desirable changes in their life.

[9] John O'Brien and Connie O'Brien, *Framework for Accomplishment* (Atlanta, GA: Responsive Systems Associates, 1989).

# III. Mental Health System Transformation in Minnesota

The problems that are identified in the Legislative Auditor's report have their roots in a transformation of the United States mental health system that began in the 1950s. This section describes that transformation in Minnesota, focusing on aspects that affect people in the target population.

## A. Deinstitutionalization in Minnesota

The first state hospital for mentally ill people opened in St. Peter, MN, in 1866, with similar institutions opening in the following decades.[10] These institutions were following the social reform movement of their time, which assumed that providing asylum—removing people from the community and serving them in peaceful, rural settings—would protect people with mental illnesses from exploitation and protect society from people with mental illnesses. The expectation for many residents was that they would live and work at the asylums for years or for the rest of their lives. Minnesota built eleven state hospitals, and by 1955, the system reached a peak size of 11,500 people with mental illnesses.[11]

By the late 1950s, however, serious questions were being raised about the quality of care in state hospitals. Social reformers called for the closing of these facilities because they believed that people could be better treated in more integrated community settings. New psychotropic drugs were expected to make it possible for institutional residents to return to their communities and lead integrated, productive lives. Driven by social and political movements to protect the rights and dignity of people with mental illnesses and by the promise of psychotropic drugs that provided new treatment options, President Kennedy signed the Community Mental Health Act of 1963, which promoted **deinstitutionalization** by funding community mental health centers aimed at delivering care for people with mental illnesses in integrated community settings. Table 1 shows that the population of Minnesota's state hospitals shrank rapidly through the latter half of the 20th century in response to this policy.

[10] *Deinstitutionalization of Mentally Ill People* (Saint Paul: Office of the Legislative Auditor, State of Minnesota, February 1986), 1.

[11] *Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill* (Saint Paul: Office of the Legislative Auditor, State of Minnesota, February 1981). The number provided is somewhat difficult to interpret, but it appears that this figure includes only people with mental illness, not the rapidly increasing number of people with developmental disabilities who were being served in state hospitals. This explains why the report called the 11,500 figure the "peak", while Table 1 (which includes all disability groups) shows a higher number of patients in 1960.

| State Hospitals | 1960 | 1970 | 1980 | Notes |
|---|---|---|---|---|
| Anoka | 1,085 | 476 | 362 | Became AMRTC in 1985 |
| Brainerd | 147 | 1,205 | 543 | Currently includes MinnesotaCare administrative program, MSHS-Brainerd, and C.A.R.E.-Brainerd. |
| Cambridge | 2,001 | 1,245 | 527 | Closed in 1999 |
| Faribault | 3,096 | 1,757 | 807 | Closed in 1998 |
| Fergus Falls | 1,852 | 594 | 550 | Closed in 2000 |
| Hastings | 940 | 381 | Closed in 1978 | |
| Moose Lake | 1,108 | 631 | 457 | Closed in 1995 |
| Rochester | 1,642 | 676 | 457 | Closed in 1982 |
| St. Peter | 2,111 | 634 | 368 | Closed in 2007 |
| MN Security Hosp. | 239 | 142 | 203 | Average population for FY2013 was 337.[12] |
| Willmar | 1,233 | 615 | 575 | Closed in 2007 |
| Total | 14,369 | 8,356 | 4,849 | |

**Table 1: Minnesota State Hospital Population, All Disability Groups**[13]

As the state hospitals closed, their funding was shifted to community-based residential and outpatient services. By the late 1960s, community mental health centers were diverting some people from the state hospitals and providing follow-up care for others. After the implementation of Medicare and Medicaid (called Medical Assistance in Minnesota) in the 1970s, community hospitals began increasing their psychiatric capacity to serve people whose care was reimbursable.[14] The state also began to shift some of its state-operated services to community-based models, including treatment for substance use disorders (the Community Addiction Recovery Enterprise—C.A.R.E.) and residential facilities for people with developmental disabilities (Minnesota State Operated Community Services—MSOCS).

Deinstitutionalization brought a new payment model to mental health services. Unlike the regional treatment centers, which relied on appropriated dollars to fund care, most community providers billed for their services. Medicare and Medicaid became key payers and the definition of services reimbursable under Medicare and Medicaid became important drivers of the types of services that would be provided. This increased the role of the federal government in shaping mental health services available within Minnesota.

Figure 1 shows that the deinstitutionalization trend has continued within state-operated services. It shows the average daily census (the average number of people served per day) in the three categories of DCT services between FY2002 and FY2012. The *Institution* category includes former regional treatment centers and nursing homes; *Community* includes substance use disorder treatment centers, residential rehabilitation and vocational support services, community

[12] Does not include patients served at DHS's Forensic Nursing Home or Young Adult/Adolescent Forensic Service.
[13] Figures for 1960-1980 are from *Deinstitutionalization of Mentally Ill People* (Saint Paul: Office of the Legislative Auditor, State of Minnesota, February 1986), 4.
[14] Ibid., 8.

hospitals, outpatient clinics, and community support services; *Forensic* includes services for people who have been civilly committed as Mentally Ill and Dangerous.

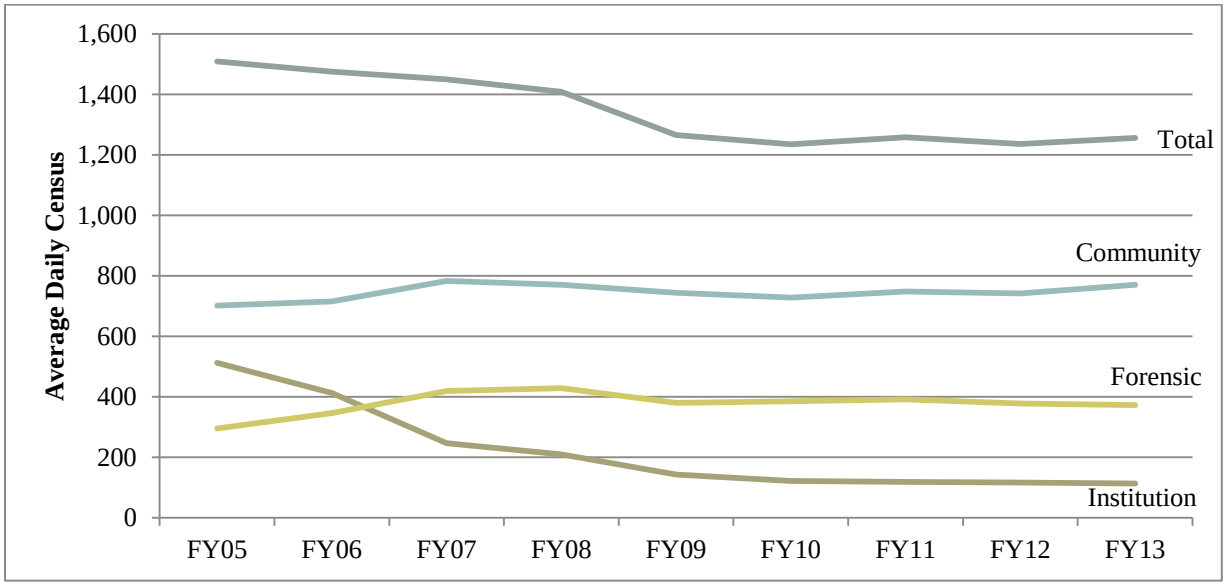
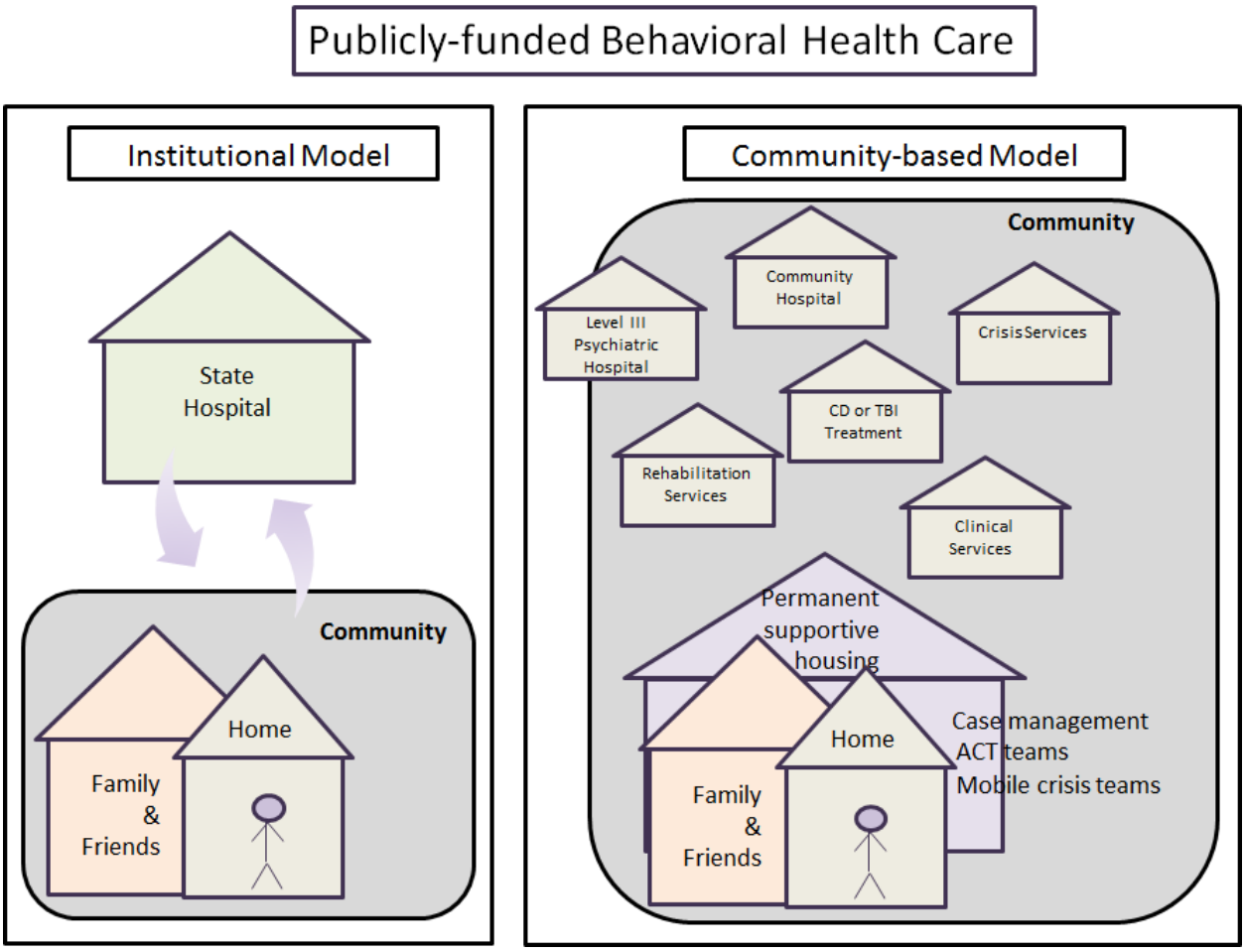



**Figure 1: Average Daily Census Trends for state-operated services (excludes Minnesota Sex Offender Program for all years)**[15]

## B. Deinstitutionalization and Access to Care

The deinstitutionalization of Minnesota's mental health care system has several inter-related dimensions. Structurally, deinstitutionalization refers to the closing of large state Regional Treatment Centers and replacing them with community-based services. This system-level change resulted in changes in how individuals gained access to care (see Figure 2).

[15] Short descriptions of the facilities in each of the community, forensic, and institutional categories are included in Appendix C.




| | **Key Characteristics of Institutional Model:** | **Key Characteristics of Community-Based Model:** |
|---|---|---|
| Location of Care | Person leaves family and community to access services. | Person receives services within home and community. |
| Community Integration | Assumes that separating people with mental illnesses from society is good for them and for society. | Assumes that integrating people with mental illnesses within society is good for them and for society. |
| Geographic Dispersion of Services | A wide range of general and specialized services is available in one location. | Ideally, a range of services is available locally. In fact, the range of services available varies from region to region. Expertise is often scattered and/or far away. |
| Care Coordination | Coordination of services occurs within the single institution. | Significant coordination of services among providers and levels of care is needed. |
| Funding Model | Funding goes directly to institution, which then provides the needed services. Access depends upon overall levels of appropriated funding. | Funding is program-based and consumer-directed. Access depends on qualifying for programs (decisions made mostly at county level) and documenting services provided (to seek reimbursement). |

**Figure 2: Comparison of Institutional and Community-Based Models of Care**

Figure 2 illustrates the increased complexity of today's mental health system for clients. Instead of leaving the community and receiving one-stop care at a state hospital, clients must now move

among providers and levels of care—some in the community and some far away. Most stakeholders, including clients themselves, say that this change has been positive, and that receiving services in the community is much more supportive of recovery than is treatment in a state hospital outside the community. However, the change has significantly increased the complexity of the mental health service system. This can make it more difficult to get access to care and adds a new requirement to coordinate among various providers and funders. This coordination is often unfunded or underfunded.

As the state has transitioned to the community-based model, one goal has been to create a *continuum* of care to replace the centralized institutional model. The concept of a continuum emphasizes the importance of integrating and coordinating care so that people can get the right care at the right time and place to meet their needs and that people can move among levels of care easily. It is important to note that the use of the term continuum is not meant to imply that a person on the road to recovery must always move sequentially from one service type to the next lower service type on a lock-step path of decreasing service intensity. In fact, people often skip quite successfully from one level of care (say, inpatient hospitalization) to a much less intensive level of care (say, living independently with periodic visits by support staff). For this reason, the term *comprehensive array of services* will be used in this report to highlight the need for a wide range of services that are well coordinated and easy to navigate.[16]

For the remainder of this document, the term *integration* will be used to refer to instances when services are bundled seamlessly by a provider, as when both mental health and substance use disorder treatments are provided to a client at the same time by an Integrated Dual Diagnosis Treatment provider. Integration can be achieved by having one provider with capacity to provide a range of services, or by collaborating providers who together can provide such integration. *Coordination* will refer to collaboration among providers in different locations or between levels of care (as a person transitions from inpatient to residential treatment, for example). In other words, not only should the new system include a comprehensive array of integrated health services**;** it should also include the coordinating mechanisms that help smooth an individual's recovery journey. Both together constitute a comprehensive array of services. Without this array, even effective treatment can be short-lived because gains made in one location are quickly lost when the person returns home without the transition planning and stabilizing supports needed to live successfully in the community.

[16] This excerpt from a leading textbook on psychiatric rehabilitation illustrates the shortcomings of the continuum concept, discussing one of the core principles of supported housing: "People have the opportunity to choose from an array of settings rather than a continuum. . . . A continuum of a step-wise series of settings with increasing demand and decreasing support does not allow the possibility of "non-stepwise" growth nor for choice. For example, some people like to live in groups. Some do not. Some people like to live alone. Some do not. Some people with few skills do better living alone where there is no pressure. Some people with very sophisticated interpersonal skills like and are able to live with a group of people." William Anthony, Mikal Cohen, Marianne Farkas, and Cheryl Gagne, *Psychiatric Rehabilitation (Second Edition)* (Boston: Center for Psychiatric Rehabilitation, Boston University, 2002), 243.

## C. Deinstitutionalization and the Acute Care Model

The federal government used Medicare and Medical Assistance programs as mechanisms to drive deinstitutionalization. These programs provided a new funding source for nursing homes and community inpatient treatment, with states sharing the cost with the federal government. Large state Regional Treatment Centers were classified by the federal government as "Institutes for Mental Disease" (IMDs) and were made ineligible for federal Medical Assistance reimbursements for people between 22 and 64 years of age.[17] States that hoped to improve care while controlling state budgets moved quickly to shift to services that could be reimbursed by Medicare and Medical Assistance, which shared costs between federal and state governments.

As the nation's largest health insurer, Medicare and Medical Assistance established utilization management requirements such that hospitals would not be reimbursed for care provided after a patient no longer met criteria for *medical necessity*, which basically required that a patient be in an acute, clinical crisis that presented a danger to self or others or an inability for self-care. The goal of hospital treatment focused on stabilization, not on long-term recovery. People were expected to continue their pursuit of recovery with support from other community-based providers, but lack of community services or coordination often meant that hospitals just discharged people once they were stabilized and did not play a collaborative role in their recovery. This acute care medical model was an important by-product of deinstitutionalization and the shift to Medicare and Medicaid funding for mental health.[18]

## D. Deinstitutionalization and the State Safety Net Role

Deinstitutionalization has meant that the state's safety net role has become increasingly shared with other public and private providers. Today, safety net providers care for people who are uninsured or under-insured so that their services are at least partially paid for by public payers; people who are committed to the Commissioner of DHS; and/or people whose health challenges are so complex that, even with insurance, community-based care cannot serve them adequately. As deinstitutionalization progressed, safety net providers have come to include:

- Direct Care and Treatment (the provider arm of DHS)
- Community hospitals
- Community health programs and clinics (including dental)

[17] The IMD policy was established to discourage states from "warehousing" people with mental illnesses in large institutions. For more information, see "Background Information on IMD Exclusion," National Alliance on Mental Illness, accessed on November 15, 2013 at http://www.nami.org/Content/ContentGroups/E-News/20073/March9/Background_Information_on_IMD_Exclusions.htm

[18] Steven Sharfstein and Faith Dickerson, "Hospital Psychiatry for the Twenty-First Century," *Health Affairs* 28 (2009), 685-688; David Cutler, *et. al*, "Public Mental Health in America: 'Enlightenment' to Accountable Care," in *Modern Community Mental Health*, ed. by Kenneth Yeager, David Cutler, Dale Svendsen, and Grayce Sills, (Oxford: Oxford University Press, 2013), 19; Jeffery Buck, "Medicaid Health Care Financing Trends and the Future of State-based Public Mental Health Services," *Psychiatric Services* 54 (2003), 969-975.

- Community mental health and substance use disorder programs
- Public health agencies
- Providers of mental health and substance use disorder services in jails and prisons
- Foster care and nursing homes

As will be seen in the following chapters, the fact that the safety net role is now being filled by a variety of public and private providers has led to significant conflict over who is to be served by whom. The state is no longer always the "go-to" provider of last resort, even for people committed to the Commissioner of DHS. The state's role in a community-based health service system is evolving.

## E. Deinstitutionalization and Trans-Institutionalization

As providers and policymakers have struggled to implement deinstitutionalization and address gaps in the mental health and substance use disorder service system, a narrative *of trans-institutionalization* has become so popular that it must be addressed in this report. The narrative suggests that as the regional treatment centers were closed, the people formerly treated in those centers were discharged to the streets where they were soon arrested, creating an explosion in the jail and prison population. This narrative is supported by graphs of the treatment center population superimposed on graphs of the homeless and incarcerated populations, showing a strong correlation between decreasing treatment center population and increasing prison population. It is also supported by estimates that about half of jail and prison inmates suffer from mental illnesses (the average for the entire adult population is estimated at about 20 percent in a given year).

While this narrative has been repeated so often that most people assume that it's true, academics have shown that reality is much more nuanced. Most people who were discharged from regional treatment centers were served by the many new community based services that received significant state and federal funding during the deinstitutionalization period. They did not end up on the street and they did not end up in jail or prison. A recent analysis found that between 1950 and 1980, there was virtually no trans-institutionalization for any demographic groups, while between 1980 and 2000, there was significant trans-institutionalization, especially for white men.[19] Still, the study estimated that only 4 to 7 percent of those incarcerated between 1980 and 2000 can be attributed to deinstitutionalization. Most of the increase in incarceration was due to changes in sentencing policies that occurred in most states. While 4 to 7 percent seems like a small number, it suggests that between 40,000 and 72,000 people incarcerated in 2000 (nationwide) would have been treated in treatment centers in years past.[20]

[19]Stephen Raphael and Michael Stoll, "Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate," *Journal of Legal Studies* 42 (2013), 187.
[20] Ibid., p. 187+.

Exploring the nuances of trans-institutionalization is important because it is often used as an argument to support the building of additional institutional capacity—residential treatment centers and/or inpatient hospital beds—to serve people with mental illnesses. In alignment with federal direction (from the Center for Medicare and Medicaid Services and SAMHSA) and Minnesota's Olmstead Plan, DHS plans to keep its emphasis on building community-based capacity instead. These trade-offs will be discussed further in section IX-B-4.

## F. The Changing Role of AMRTC during Deinstitutionalization

The Anoka State Hospital (now AMRTC) has been in constant evolution—in the types of clients served and the types of services provided—since the 1950s. This evolution has been in response to changing needs in the state's system of care. When deinstitutionalization began in the late 1950s, the Anoka State Hospital provided residential treatment for adults with mental illnesses, adults with substance use disorders, and children and adolescents with emotional disturbances. It also included geriatric, infirmary, and observation wards for people who were in the process of being transferred to other facilities. Table 2 summarizes some of the changes in the facility during the deinstitutionalization period.[21] These changes were responses to identified needs within Minnesota and demonstrate that AMRTC's mission and services have continued to evolve since the 1950s.

| Year | Change in Facility |
|---|---|
| 1950 | Designated as state's tuberculosis center for people with mental illnesses |
| 1965 | Adult Psychiatric Center opened |
| 1969 | Tuberculosis center closed |
| 1970 | Chemical dependency treatment program opened |
| 1971 | General surgery program closed |
| 1972 | Program for children with emotional disturbances aged 5-12 closed |
| 1973 | Program for adolescents closed |
| 1985 | Name changed to AMRTC |
| 1999 | New facility opened as a regional psychiatric hospital. |
| 2010 | Designation of units specialized for treatment of: acute mental illnesses and co-occurring intellectual disabilities; acute mental illnesses and medical comorbidities (especially aging population with dementia); and acute mental illnesses and intensive behavioral symptoms. |

**Table 2: Changes in the Anoka State Hospital/AMRTC, 1950-2013**

The hospital's population peaked at about 1,500 people in 1954, two-thirds of whom were women.[22] The Anoka State Hospital was re-named the Anoka Metro Regional Treatment Center in 1985. Oddly, this renaming occurred just as the facility was transitioning from a residential

[21] Table 2 begins in the 1950s for brevity; the services at the Anoka State Hospital changed periodically since its opening.
[22] *1973 State Institutions Informational Brochure* (Saint Paul: Department of Public Welfare, State of Minnesota, 1973), 4.

treatment facility to a hospital (in our modern sense of an accredited acute care setting with strict criteria for admission and discharge). This transition is apparent in the program descriptions provided in the annual Minnesota State Institutions Informational Brochures, which later became the annual Fact Books (see Table 3). The excerpts from the 1973 Brochure suggest a residential facility with a psycho-social focus, while the excerpts from 1985 and 1993 illustrate an increasing medical focus with an emphasis on diagnoses of acute psychiatric illnesses. The 1993 description also shows the increasing focus on serving people whose symptoms included aggressive behaviors and who had been committed to the Commissioner, and the difficulties of discharging people after treatment was complete.

As AMRTC evolved, its certification and licensing also changed. AMRTC was approved by the American Hospital Association in 1940. It was licensed as a specialized hospital by the Minnesota Department of Health in 1944. During the mid-1980s, AMRTC was also licensed as a Rule 36 facility. AMRTC was first accredited as a hospital by The Joint Commission on April 4, 1989.

| Excerpts from the 1973 Informational Brochure[23] | Excerpts from the 1985 Fact Book[24] | Excerpts from the 1993 Fact Book[25] |
|---|---|---|
| Unit One, 162 beds: "All staff members participate in a daily activity program designed to activate and remotivate every resident of the building."<br><br>Unit Two, 84 beds: Similar program, "involving the entire staff, and especially concentrating on the overly-dependent patients."<br><br>Fairweather Lodge Program, 42 beds. "Places responsibility for making decisions and planning future action on the resident, with the entire staff acting as consultants and motivators."<br><br>Chemical Dependency: One unit deals with the chronic alcoholic, involving 6 month to 2 years of treatment. Two units provide 6 months of treatment for the "chronic, committed male alcoholic who has repeatedly been through the 'revolving door' of detoxification, workhouse, short-term treatment, and back to the streets." | "Anoka State Hospital provides inpatient mental illness and chemical dependency treatment services to severely disabled persons from the Metro Region, most of whom have exhausted community hospital and outpatient program alternatives and are medically indigent. The hospital has a total of 347 licensed beds."<br><br>"All patients admitted with a mental illness diagnosis are placed on one of the admission units for initial assessment, evaluation, and treatment planning followed by transfer to the treatment unit which is determined to most effectively meet their treatment needs."<br><br>Chemical Dependency Primary Treatment Unit: Program is of 4-6 weeks duration.<br><br>Chemical Dependency Extended Treatment Unit: Program is of 3-4 months duration. | "At present, 98 percent of the patients are admitted to the program following court orders, mostly civil commitments. Almost all of the patients are admitted directly from community hospital mental health units where they have received acute care prior to court commitment."<br><br>"AMRTC maintains a 23-bed secure, intensive care unit which provides assessment and treatment to persons with mental illness who persistently demonstrate assaultive behaviors and are considered to pose serious danger to others."<br><br>"In July 1990 the State Legislature allocated a one-time fund of $500,000 to provide special services to 'difficult to place' patients currently residing at the AMRTC. . . A number of patients have been placed following intensive collaborative review, individualized coordination, and planning efforts by AMRTC social workers, county mental health staff, contracted mental health providers and the Mental Health Division of DHS." |

**Table 3: Excerpts Illustrating AMRTC's Evolving Service Niche**

By 1993, AMRTC was operating as a regional specialized acute psychiatric hospital serving predominantly the seven-county metro area (since then, it has gradually become a statewide hospital). Almost all people treated at AMRTC were committed to the Commissioner of DHS, and specialized services were offered for people whose symptoms included aggressive behaviors, people with serious mental illnesses and co-occurring medical conditions, and people with both

[23] *1973 State Institutions Informational Brochure* (Saint Paul: Department of Public Welfare, State of Minnesota, 1973), 4-5.
[24] *Fact Book: State Hospitals and Nursing Homes* (Saint Paul: Department of Human Services, State of Minnesota, January 1985), 20-22.
[25] *Fact Book: Minnesota State Operated Residential Programs* (Saint Paul: Department of Human Services, State of Minnesota, January 1993), 39-40.

mental illnesses and substance use disorders. In 1992, it had an average daily census of 266, 35 of whom were in the chemical dependency treatment program.

Table 4 shows the number of licensed beds, budgeted average daily census, actual average daily census, annual admissions, and average length of stay for people at AMRTC since 2008. It shows that AMRTC's capacity has continued to shrink both because the number of budgeted beds has decreased and because the average length of stay has increased.

| Capacity Indicators | FY2008 | FY2009 | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|---|---|
| Number of licensed beds | 193 | 175 | 175 | 175 | 175 | 175 |
| Budgeted average daily census | 186 | 168 | 129 | 110 | 110 | 110 |
| Actual average daily census | 170 | 131 | 113 | 110 | 108 | 106 |
| Average occupancy[26] | 91% | 78% | 88% | 100% | 98% | 96% |
| Annual admissions | 754 | 529 | 503 | 477 | 425 | 359 |
| Average length of stay (in days) | 75.5 | 93.5 | 82.2 | 83.8 | 93.8 | 105.4 |

**Table 4: AMRTC Capacity, FY2008 - FY2013**

This brief review of changes at AMRTC during the period of deinstitutionalization reveals three important points:

- Service needs in the public mental health system of care and legislative responses to those needs have driven AMRTC's constant evolution since the 1950s. Its "transformation" has not been a singular event, but an ongoing process that continues today.
- Even though the Anoka facility's name changed from the Anoka State Hospital to the Anoka Regional Treatment Center (AMRTC) in 1985, functionally the facility actually underwent transition *from* a regional treatment center (based on a residential model) *to* a hospital (based on an acute care medical model). Today, AMRTC is a specialized psychiatric *hospital*.
- AMRTC's capacity has continued to decrease since deinstitutionalization began over a half-century ago, both in licensed beds and in average daily census.

[26] Average occupancy equals the average daily census divided by the budgeted average daily census.

# IV. The Target Population

This report focuses on a very small, highly complex sub-population of Minnesotans, the characteristics and needs of whom are described in this section.

## A. Defining the Target Population

The target population of people served at AMRTC is a very small subset of the general subpopulation of Minnesotans who are diagnosed with mental illnesses. Minnesota statute defines "mental illness" as follows:

> *"Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.*[27]

The DHS Chemical and Mental Health Services Administration (CMHSA) estimates that about 20 percent of the adult population experiences a mental illness in a given year. This translates to more than 800,000 adults in Minnesota each year, and includes a very wide range of people, illnesses, and contextual circumstances. Many of these people do not seek professional help for their illnesses, and most who do are served in public and private out-patient settings and recover fully within a relatively short period of time. Most never require inpatient psychiatric services or experience a civil commitment to the Commissioner of DHS.

The federal Substance Abuse and Mental Health Administration (SAMHSA) estimates that approximately 5.4 percent, or 221,000 of adults in Minnesota, have a serious mental illness. The federal definition of adults with a serious mental illness are adults who currently have, or at any time during the past year had a diagnosable mental illness that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.[28]

Unlike many other states and SAMHSA, Minnesota statute has defined a sub-category of people with serious mental illnesses: people with *serious and persistent* mental illnesses (SPMI). The definition of this category was created in order to establish eligibility for certain case management services. It is based on repeated use of mental health services (see Appendix D). CMHSA estimates that about 2.6 percent of Minnesota adults have serious and persistent mental illnesses in a given year.

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[27] Minnesota Statutes, section 245.462, Subd. 20 (a).

[28] Joan Epstein, Peggy Barker, Michael Vorburger, and Christine Murtha, *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders* (Washington, D.C.: Department of Health and Human Services, SAMHSA Office of Applied Statistics, 2002). Accessed on October 3, 2013 at http://www.oas.samhsa.gov/CoD/CoD.htm#ch3

Within the category of people with serious and persistent mental illness is a much smaller sub-population of adults that constitute the target population of people who are served at AMRTC or at risk for needing services like those provided at AMRTC. The people in the target population have serious and persistent mental illnesses and co-occurring conditions that complicate their recovery and pose a risk to personal and/or public safety. Co-occurring conditions include: substance use disorders, traumatic brain injuries, developmental disabilities, chronic physical illnesses, and aging-related dementias.

Aggressive behaviors are one symptom of some mental illnesses. Intermittent explosive disorder, for example, is characterized by poor impulse control that can lead an individual to be aggressive in response to authoritarian behavior. Schizophrenia can involve hallucinations that lead an individual to be aggressive in order to appease the voices they are hearing. Because some people in the target population exhibit aggressive behaviors in addition to their other symptoms, some have had contact with law enforcement and the criminal justice system.

The definition of the target population of people who might need the services provided at AMRTC can be summarized as:

> **Target population**: Adults with serious and persistent mental illness and co-occurring conditions—including substance use disorders, intellectual disabilities, chronic physical illnesses, and aging-related dementia—that complicate their recovery. Symptoms of some of these patients include aggressive and self-injurious behaviors that pose a risk to personal and public safety. This is the population currently served at AMRTC and at several other psychiatric hospitals in Minnesota.

## B. Estimating the Size of the Target Population

It is difficult to determine the number of people in the target population because the definition is somewhat inexact, people in the population are served in a number of different settings, and no single agency is responsible for their care. The following data can help inform such an estimate:

- About 1,100 adults were referred to AMRTC in 2012. Less than half of these were actually served at AMRTC, but this number provides a lower limit estimate for the size of the target population because all of these people were reviewed and their needs were deemed appropriate for AMRTC's services.
- Table 5 shows that about 6,600 court cases were filed in 2012 for civil commitments for mental illness. Not all of these cases resulted in civil commitment, but this number gives a sense of the total number of people considered at risk for needing services at the level of those provided at AMRTC. More than a third of the 6,600 individuals were committed for both mental illnesses and chemical dependency, which puts them more squarely in the

target population of people with severe and persistent mental illnesses and co-occurring conditions.

- The 2012 Minnesota Homelessness Study found that 55 percent of homeless adults reported a significant mental illness, which included being told by a doctor or nurse that they had at least one diagnosis including major depression (38 percent), bipolar disorder (21 percent), personality disorder such as antisocial or obsessive-compulsive disorders (16 percent), schizophrenia (6 percent), or other paranoid or delusional disorders (7 percent). Based on the 7,915 adults whom the study estimates are homeless in Minnesota on a given day, this indicates that about 4,500 homeless adults could possibly be included in the target population.[29] Some of these people are likely counted in the above two categories, but some are almost surely not counted because their homelessness has made it difficult or impossible to access the public social services system.

| Commitment Case Filing Type | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|
| Commitment - Mentally Ill | 3,917 | 3,697 | 3,715 | 3,931 | 4,155 |
| Commitment - Mentally Ill & Chemically Dependent | 1,740 | 1,712 | 2,113 | 2,240 | 2,367 |
| Commitment - Mentally Ill & Developmentally Disabled | 81 | 49 | 90 | 85 | 80 |
| Commitment - Mentally Ill, Developmentally Disabled & Chemically Dependent | 3 | 26 | 36 | 23 | 10 |
| Total | 5,741 | 5,484 | 5,954 | 6,279 | 6,612 |

**Table 5: Minnesota Mental Illness Civil Commitment Case Filings by Year and Type[30]**

With these figures as background, DHS estimates that somewhere around 5,000 adults could be in the target population in a given year in Minnesota. To get a more accurate number, a point-in-time study, similar in method to the Minnesota Homeless Study, would be needed.

[29] *Homelessness in Minnesota: Findings from the 2012 Statewide Homeless Study* (Saint Paul: Wilder Research, September, 2013), 34.
[30] Data provided by the Court Information Office, State Court Administrator's Office, Minnesota Judicial Branch, October 1, 2013.

| Population Category | Description | % Estimate | # of Adults Estimate |
|---|---|---|---|
| No mental illness | Adults with no diagnosable mental illness during the year | 80.0% | 3,283,000 |
| Mild mental illness | Adults with a diagnosable mental illness during the year. | 14.6% | 598,000 |
| Serious mental illness | Adults who had a diagnosable mental illness in the past year that resulted in functional impairment and that substantially interfered with or limited one or more major life activity | 2.8% | 115,000 |
| Serious and persistent mental illness (SPMI) | Adults with schizophrenia, bipolar disorder, severe forms of depression, panic disorder, and obsessive compulsive disorder who make repeated use of mental health treatment | 2.5% | 103,000 |
| SPMI & complex co-occurring conditions-target population | Adults with serious and persistent mental illnesses who also have complex co-occurring conditions and legal and law enforcement involvement. | 0.1% | 5,000 |
| | Total adult Minnesota population in 2012 | 100.0% | 4,104,000 |

**Table 6: DHS's Estimates of Minnesota's Mental Health Population**[31]

Table 6 highlights the fact that while the number of people in the target population is relatively small, their service needs are high. Even within this very small target population are sub-populations that are important to understand. Recovery for people with severe and persistent mental illnesses and traumatic brain injuries, for example, can look quite different from recovery for people with severe and persistent mental illnesses and developmental disabilities. Chronic medical conditions can also shape one's recovery, as can a history of aggressive behaviors accompanying one's mental illnesses. The defining characteristic of people in the target population is that the combination of their conditions is unique and that the support they need to pursue and manage their recovery is also unique.

## C. Recovery for People in the Target Population

Empirical evidence demonstrates that people with serious mental illnesses can lead meaningful, satisfying lives in their communities. The Substance Abuse and Mental Health Services Administration (SAMSHA), the federal agency in charge of U.S. mental health and substance use disorder policy, defines recovery as "a process of change through which individuals improve

[31] The population estimates in this table are based on state Census Bureau population estimates for 2012, which estimated Minnesota's adult population at 4,104,283. The percentage estimates for Serious Mental Illness and Serious and Persistent Mental Illness categories are based on the SAMHSA estimation method described in "Estimation Methodology for Adults with Serious Mental Illness (SMI)," *U.S. Federal Register* 64 (June 24, 1999), 33890. The estimate for the prevalence of any diagnosable mental disorder is from *Mental Health: A Report of the Surgeon General* (Washington, D.C.: Department of Health and Human Services, U.S. Public Health Service, 1999), 15. The estimate of the target population is an educated guess based on the estimates presented in the preceding paragraph.

their health and wellness, live a self-directed life, and strive to reach their full potential."[32] Recovery does not always involve a total cure of one's mental illness; for some people with serious mental illness it involves the successful management of one's illness so that one can lead a self-directed life and strive to reach his or her full potential.[33] In recent years, the concept of recovery has become an increasingly frequent topic of discussion in both the professional literature and in consumer-driven policy meetings.[34]

For people in the target population, mental illness is usually longstanding and somewhat unpredictable. The interactions among each person's mental illnesses and possible substance use disorders or chronic physical illnesses, combined with their unique personal and cultural histories and present circumstances, create a biological, psychological, social, and behavioral system that that is complex and often difficult for the individual to manage.

### 1. Stigma: A Barrier to Recovery

It is important to remember that the barrier to recovery for people in the target population is not that they have complex conditions; it's that the system of care has not responded effectively to their needs. The biggest barrier to recovery is the overwhelming stigma attached to mental illnesses and substance use disorders and our society's inability to understand and support recovery. Stigma can lead to a very narrow definition of "normal" or "healthy" and fear of being stigmatized can leave people struggling to hide their difficulties and thus forego access to support and treatment. Stigma can also discourage family and friends from offering support and it can encourage unhelpful responses when help is needed most.

Stigma and the lack of understanding of recovery have resulted in discrimination in public policy regarding mental illnesses and substance use disorders. Until very recently, federal policy did not require that health insurers cover mental health services or that those services be covered at parity with other medical conditions (and parity still does not require coverage for mental illnesses). This discrimination has forced some people with mental illnesses to rely on the public mental health service system that has itself been under-funded in relation to physical medicine. And funding is only part of the problem. Some public service programs were designed for people with physical illnesses, intellectual disabilities, and physical disabilities, and thus are not always well suited to people with mental illnesses, especially people in the target population. DHS reforms have tried to assure that services are flexible enough to meet the unique needs of

[32] "SAMHSA Announces a Working Definition of "Recover" From Mental Disorders and Substance Abuse Disorders," SAMHSA News Release accessed on December 22, 2013 at http://www.samhsa.gov/newsroom/advisories/1112223420.aspx

[33] Martina Rogers, Diane Norell, John Roll, Dennis Dyck, "An Overview of Mental Health Recovery," *Primary Psychiatry* 14 (December), 76-85, access on August 14, 2013 at http://primarypsychiatry.com/an-overview-of-mental-health-recovery/

[34] For example, see: Larry Davidson, Maria O'Connell, Janis Tondora, Thomas Styron, and Karen Kangas, "The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation," *Psychiatric Services* 57 (2006), accessed on October 14, 2013 at http://journals.psychiatryonline.org/article.aspx?articleid=96652

each person and that there is integration or coordination among the multiple services that a person might need. Integrated needs assessments, treatment plans, and community-support plans can help prevent people in the target population from "falling through the cracks" in the service delivery system.

### 2. Aggressive Symptoms and Recovery

While holding on to the centrality of recovery as a goal for everyone in the target population, it is also critical that we acknowledge the challenges involved for the small number of people in the target population whose symptoms include aggressive behaviors, self-injury, and sexual acting out. One director of a community hospital's psychiatric unit wrote the following in response to an earlier draft of this document:

> *"I strongly endorse a recovery model, protection of the rights of the disabled, and stigma reduction. However, your draft only touches on the extreme behavioral issues that accompany some conditions, some of the time. . . The system does not have [a solution] for the group I am focusing on and that drives highest costs, has the poorest chance of recovery and often hurts caregivers and family members along the way. It is one thing to fight stigma and quite another to bury the potential for violence so far under the carpet that it can barely be seen. . . Yes, many mentally ill people are more likely to be victims than to victimize—but certainly not all. Violence against caregivers is epidemic."*

People who have mental illnesses and as a result have caused or intended to cause serious physical harm to another, and who are deemed likely to take such action again in the future can be committed to the Commissioner of DHS as Mentally Ill and Dangerous; they are sent to the Minnesota Security Hospital for treatment. They are not considered part of the target population for purposes of this report, which focuses on AMRTC and the other facilities that provide care for people who would otherwise be served by AMRTC. However, as this hospital administrator points out, some people in the target population do have symptoms that include aggressive behaviors, and the system is not yet set up well to handle those behaviors.

### 3. Recovery Management

For people in the target population, recovery is likely to be a long-term process of working with a variety of supports (including natural supports) to manage one's mental illnesses and other co-occurring conditions in order to lead a satisfying, meaningful, and successful life in the community. Some people in the target population may never achieve self-managed recovery, but will rely on others to chart a course that best fits with the individual's wishes. In either case, the recovery process requires a system of care that is fundamentally oriented toward recovery and person-centered illness management, replacing the older concept of episodic acute care with the newer and more appropriate concept of *recovery management*.

The concept of recovery management is adapted from substance use disorder treatment expert William White, who used it to describe the most suitable model of care for people with chronic

addiction.[35] It is somewhat analogous to *disease management*, used by physicians to describe appropriate care for people with persistent conditions like Type 2 diabetes, hypertension, and asthma. The key distinction captured by the term is between a system set up to provide episodic acute care and a system set up to prevent disease or impaired functioning in the first place. Recovery management, as the term will be used in this report, means the coordination and provision of ongoing care and support to minimize or prevent the need for acute care.

The U.S. health care system is currently transitioning from an acute care model to a disease management model for the care of chronic diseases. Table 7 articulates the analogous model in mental health care, summarizing some major differences between an acute care model and a recovery management model.

| | Acute Care Model | Recovery Management Model |
|---|---|---|
| Duration of care | Short | Long-term |
| System focus | Focus on responding quickly and effectively when a person gets sick | Focus on keeping people as healthy as possible |
| Goal | Organized to cure illness and/or relieve symptoms | Organized to prevent and relieve symptoms |
| Who's involved | Psychiatric specialists, physicians, case managers | Psychiatric specialists, physicians, peer specialists, client, client's family & friends, case managers, care coordinators, community providers, other community supports |
| Patient/client role | Comply with treatment plan | Self-manage planning, treatments, medications, and life decisions as much as possible |
| Psychiatric professional role | Direct and provide care | Provide care and prepare patient/client to self-manage; collaborate with multi-disciplinary teams and client |
| Care coordinator role | Assists in gaining access to services and coordinates public funding for care | Coordinates among multiple providers and assists client in managing recovery as much as possible |
| Site of care | Hospitals, clinics | Comprehensive array of services: hospitals and clinics, residential treatment, crisis services, community services, client's home |
| Outcomes measures | Length of stay, readmissions | Days stable in community, length of stay, readmissions, client satisfaction, and client-defined quality of life measures |

**Table 7: Comparison of Acute Care Model and Recovery Management Model in Mental Health Care**

[35] William White, *Recovery Management and Recovery-Oriented System of Care: Scientific Rationale and Promising Practice* (Northeast Addiction Technology Transfer Center and the Great Lakes Addiction Technology Transfer Center, April 2008).

There is wide agreement that the acute care model is not adequate for promoting recovery of people in the target population.[36] In recent years, Minnesota has made significant progress toward a more recovery-oriented system of care, including these major developments:

- Medicaid reimbursement for adult rehabilitative mental health services, assertive community treatment, intensive residential treatment services, community-based crisis services (mobile response services and residential stabilization), targeted case management, and a variety of clinical services for mental health conditions.
- Statewide dissemination of several nationally recognized evidence-based practices, including illness management and recovery, integrated dual diagnosis treatment, supported employment using the individual placement and support model, dialectical behavior therapy, and permanent supportive housing.
- State funding for a housing subsidy program called Bridges, which provides modified, temporary rental assistance to people with serious mental illnesses who are waiting for permanent federal housing subsidies.
- Certified peer specialist support and other services provided on a peer-to-peer basis by people in recovery.
- Requirements that substance use disorder screening be a routine component of Medicaid-reimbursed mental health diagnostic assessments, in order to encourage an integrated treatment approach for co-occurring disorders.
- Pilots of innovative recovery management approaches for whole populations, such as Hennepin Health and the Dakota Wellness Preferred Integrated Network.
- Receiving permission from the federal government to develop Behavioral Health Homes.

Despite these many positive steps, a number of unresolved problems remain. For one thing, there is still a great deal of geographical disparity in the mental health service system. Because much of the system is county-administered, the list of services available in one county can be quite different from those available in another county, especially if one is urban and the other is rural. Adults living with mental illnesses in rural areas of Minnesota are all too familiar with the special problems they face when attempting to access the full array of necessary and appropriate services. Some of these services are extremely difficult to adapt to settings with low population density, chronic professional workforce shortages, and long driving distances.

Another issue has to do with the fact that innovative approaches are most often introduced gradually, through systematically evaluated pilot or demonstration projects, and not rolled out

[36]See, for example, *Mental Health Acute Care Needs Report* (Saint Paul: Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, March 2009), 18; *2013 County Long-Term Services and Supports Gaps Analysis Survey: Adult Mental Health, Full Report* (Saint Paul: Adult Mental Health Division, Chemical and Mental Health Services Administration, Department of Human Services, August 2013), especially pages 31-33.

everywhere at once. It may be years before an evidence-based practice or a promising new service model can be spread throughout the state, even if it appears to be potentially beneficial and cost-effective. The associated program design, funding, staff training, and county/state oversight issues all take time to resolve.

Perhaps most importantly, Minnesota is only now beginning to implement truly prevention-oriented approaches to mental illnesses. More attention is being paid to prenatal and infant health, parent training, and connections with needed social services and supports (primary prevention). New programs based on recent research on the impacts of early trauma are attempting to assist children to build resiliency and recover from trauma in order to prevent mental illnesses that could otherwise result from that trauma (secondary prevention).[37] In the long term, these approaches should help to reduce the number of people who fall into the high-need target population, but the positive effects will not be immediate.

## D. Risk Management and the Target Population

Risk is an important dimension of serious mental illnesses. For people in the target population, stigma and the threat of loss of self-control or independence make it very risky to show one's symptoms and ask for help. There is also a serious risk in not seeking assistance, as people with serious mental illnesses face a significant risk for self-harm, substance use disorders, and co-occurring physical illnesses. In treatment facilities the risks include the possibility that clients will hurt themselves, hurt other clients in the facility, or hurt staff. There is also a risk of staff hurting clients. There is also a risk that property will be damaged or destroyed. In addition to those risks, there are liability risks involved in decisions around who gets care and when, and around when a person is safe to be discharged to a lower level of care. There are also financial risks involved when providers accept a client into a treatment facility, from property damage or because providers might end up having to provide uncompensated or under-compensated care.

Attempts by all parties in the health system to manage risk are at the heart of the challenges the system presents for people in the target population. It is important to acknowledge that both providers and consumers face risks, and that the risks are physical, psychological, social, professional, legal, and financial. The atmosphere of risk can make it difficult to develop the trust, cooperation, and collaboration that are necessary for effective treatment and long-term recovery. As one consumer advocate put it,

> *"Everybody is afraid of everybody. The people who rotate through state services have already figured out that it's not working, that there is no hope for them.*

[37] For example, the MFIP partnership with the Minnesota Department of Health Home Visiting program for teen parents that aims to create safer and more consistent relationships with their children; CHMSA's Child and Adult Mental Health Integration project, which supports adult mental health providers to build clients' awareness of child development processes and to teach parenting skills; and Mower Refreshed, a citizen-driven partnership of community providers that is designed to support resilience among youth.

> *These are hope-less services. We've only begun to talk about recovery and wellness. That will be a game-changer. Care managers aren't asking people, 'What are your goals and dreams?' Every crisis plan includes going to a treatment facility, but being in a facility is not on most people's true, personal plan. Human connection and hope are what's missing in our system; they are the real risk management strategy."*

## E. Service Needs of People in the Target Population

People in the target population want the same things that most adults want: a safe place to live, a good education, a satisfying job, and strong relationships with family and friends. The Minnesota Olmstead Plan identified goals in each of these areas in order to achieve the vision of people with disabilities "living, learning, working, and enjoying life in the most integrated setting:"[38]

- Employment
- Housing
- Transportation
- Supports and services
- Lifelong learning and education
- Healthcare and healthy living
- Community engagement

Because of the bio-psycho-social nature of mental illnesses, people in the target population may need assistance in any or all of the above categories in order to pursue recovery in their homes and communities. Having a job, for example, can promote financial independence, interpersonal connections, and stability, all of which can aid recovery. However, a job can also be a source of unmanageable stress that overwhelms someone who is struggling with a mental illness. Due to the uniqueness and complexity of their mental illnesses and co-occurring conditions, what people in the target population need most is a support system that is *flexible*. It should be set up to help the individual recognize and communicate his or her needs—which may change rapidly—and to access individually-customized solutions to meet those evolving needs.[39]

Another issue of critical importance is the national finding that people with serious mental illnesses are dying 25 years earlier than the general population, most often from disorders that are inherently preventable or treatable: diabetes, heart and lung diseases, and other common

[38] *Putting the Promise of Olmstead into Practice: Minnesota's 2013 Olmstead Plan* (Saint Paul: State of Minnesota, November 1, 2013), 9.
[39] *Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services* (Saint Paul: Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, December 2010),139.

medical conditions.[40] A study co-sponsored by the DHS Adult Mental Health Division (AMHD) found an almost identical premature death rate for Minnesotans with serious mental illnesses.[41] Symptoms of mental illnesses can make it difficult to seek out medical treatment, and few medical practitioners are trained to customize their medical provision to the range of unique needs of people with mental illnesses. Moreover, some psychiatric medications have complicated and challenging physical side effects that can further compromise health if not well-managed.

While members of the target population may benefit from services in all of the categories listed on the previous page, this report was requested to focus specifically on health services provided by AMRTC. For this reason, Chapter IV will focus on the services most directly targeted to people who live with serious mental illnesses and complex co-occurring conditions:

- Recovery management
- Recovery supports (including housing, transportation, education, employment, etc.)
- Rehabilitation services
- Clinical services
- Crisis response services
- Residential treatment
- Inpatient psychiatric services

Each person in the target population needs a unique complement of services in these categories, and their needs will change over time. One person may be able to live independently in the community with support from family, peers, and an employment specialist; another person might be more likely to succeed in a building that has 24-hour staff support available on site. The service system needs to be flexible enough to meet each individual's needs, as well as to respond quickly when those needs change.

While the costs associated with these services may at first seem high, providing them will promote recovery and give people in the target population the opportunity to live satisfying, meaningful, and successful lives in the community. Moreover, providing these services can also significantly decrease overall system costs by helping to prevent avoidable hospitalizations, unnecessary emergency room visits, homelessness, incarceration, and other negative outcomes. Some people in the target population also return to work, achieving their personal goals, contributing to the economy, and paying taxes.

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[40] Joe Parks, David Pollack, Stephen Bartels, and Barbara Mauer, *Integrating behavioral health and primary care services: Opportunities and challenges for state mental health authorities* (Alexandria, VA: National Association of State Mental Health Program Directors, 2005).

[41] Michael Trangle, Gary Mager, Paul Goering, and Rodney Christensen, "Minnesota 10 by 10: Reducing morbidity and mortality in people with serious mental illnesses," *Minnesota Medicine* (June 2010), 38-41.

# V. Minnesota's Current System of Mental Health and Substance Use Disorder Services

Minnesota has made great strides in deinstitutionalizing the care of people with mental illnesses, substance use disorders, and intellectual disabilities. Public and private providers have built an array of community-based services designed to support resilience and recovery by ensuring that people receive the appropriate services at the right time and in the right place. Minnesota's state-provided services have changed significantly during the past two decades, with the closing of large institutions, the re-deployment of institutional staff, and the creation of state-run community-based services to eliminate or reduce significant gaps in the service system. This section describes the public-private service system as it exists today, using the service categories introduced in the previous section.

## A. Mental Health and Substance Use Disorder Service Providers in Minnesota

The health care delivery system is exceedingly complex and includes: providers, funders, insurers and payers, suppliers, education/research institutions, and government. All of these play roles in the care of people in the target population.

### 1. Providers

The mental health Minnesota has hundreds of public and providers of mental health and substance use disorder services:[42]

- **Specialty mental health and substance use disorder services providers**: Psychiatrists, psychiatric nurse practitioners, psychologists, and social workers in public and private practice; community mental health centers and outpatient clinics; residential treatment and rehabilitation centers; psychiatric hospitals; and psychiatric units of general hospitals.
- **General medical and primary care providers:** Primary care doctors, nurse practitioners, and nurses often provide mental health services as part of their physical medicine practices in private clinics, community health centers, and hospitals.
- **Human services providers**: Minnesota has a huge network of social service providers who assist clients with direct mental health services as well as support services including housing, education, employment, food supports, family counseling, etc. Mental health and substance use disorder services are also sometimes provided in schools, community centers, spiritual centers, jails, and prisons.

[42] These categories are borrowed from *Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, 1999), accessed on December 2, 2013 at http://mentalhealth.about.com/cs/comprehensivesites/l/blsgc6s1.htm.

- **Voluntary and community networks**: Minnesota has an especially vibrant network of volunteer- and peer-run organizations that support people with mental illnesses and substance use disorders.

In addition to these providers of mental health and substance use disorder services are other providers of preventive and auxiliary services, including: public health departments, dental clinics, surgery centers, pharmacies, and hospices.

### 2. Funders/Insurers/Payers

Mental health and substance use disorder services are paid for by employers (through employee health insurance plans), state and federal agencies, and individuals who directly purchase such services or purchase their own health insurance. A little over half (54 percent) of Minnesota's health care spending in 2011 was through private health insurance, out-of-pocket, and other private spending; the other half was through government-supported health insurance plans—Medicare, Medical Assistance and MinnesotaCare, and Veterans Affairs.[43] Several other non-profit health insurance plans also serve people in the target population, including Blue Cross Blue Shield/Blue Plus of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, Sanford Health Plan, and UCare.

### 3. Suppliers

The health care industry is supported by a wide variety of suppliers of goods and services used in health care, including equipment, information technology software and hardware, consulting services, and pharmaceuticals. For mental health and substance use disorder services, pharmaceutical companies are significant suppliers.

### 4. Research/Education

Research and education organizations not only supply information and guidance on treatment approaches, they also help train the professionals that staff Minnesota's mental health and substance use disorder treatment providers. These include medical and dental schools, nursing and physical therapy programs, professional certification programs, and schools of public health. There are also national/federal organizations with education and research roles, most importantly the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services.

### 5. Professional Associations and Advocacy Groups

Minnesota has a robust advocacy community that represents consumers, providers, insurers, and government agencies active in the mental health and substance use disorder service system.

[43] *Minnesota Health Care Spending and Projections, 2011* (Saint Paul: Minnesota Department of Health, December, 2013), 5.

Table 8 lists some of the organizations most active in the policy issues raised in this report. Many of these have national counterparts.

| Government | Consumer Advocates | Provider Associations |
|---|---|---|
| Association of Minnesota Counties | American Indian Mental Health Advisory Council | Minnesota Association of Community Mental Health Programs |
| Minnesota Association of County Administrators | Governor's Council on Disabilities | Minnesota Association of Treatment Directors |
| Minnesota Association of County Social Services Administrators | Mental Health Association of Minnesota | Minnesota Hospital Association |
| Minnesota County Attorney's Association | Mental Health Consumer/Survivor Network | Minnesota Psychiatric Society |
| Minnesota Inter-County Association | Minnesota Association for Children's Mental Health | Mental Health Providers Association of Minnesota |
| Minnesota Police Chief's Association | Minnesota Association for the Treatment of Sexual Abusers | |
| Minnesota Sheriff's Association | Minnesota Association of Resources for Recovery and Mental Health | |
| | Minnesota Brain Injury Alliance | |
| | Minnesota Disability Law Center | |
| | Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities | |
| | Minnesota Sex Offender Re-entry Project | |
| | Minnesota State Advisory Council on Mental Health | |
| | National Alliance on Mental Illness - MN | |
| | The ARC of Minnesota | |

**Table 8: Associations and Advocacy Organizations Active in the Mental Health and Substance Use Disorder System**

### 6. Government

There are at least one hundred federal, state, regional, county, and tribal agencies that play a role in shaping the mental health and substance use disorder services in Minnesota. At the federal level, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) leads public health efforts to reduce the impact of mental health and substance use disorders in communities. State agencies include the Department of Human Services, the Department of Health, the Department of Education, and the Department of Public Safety.

Unlike other states that have assigned responsibility for mental health to regional entities or centralized it at the state level, Minnesota has designated each county of the state as a local mental health authority that plans, develops policy, and allocates resources for mental health services. This state-supervised, county-administered structure affords the opportunity for significant local input into policies and service provision, including through local advisory councils facilitated by counties. The state's counties are coordinated regionally through sixteen Adult Mental Health Initiatives, each of which receives funding from the state to assess needs, facilitate cooperation among policy-makers and providers, and undertake projects to improve the regional service system.

Minnesota's American Indian tribes also play a role in the mental health and substance use disorder services for their members. Tribes are developing extensive culturally-specific services; the Leech Lake Band of Ojibwe, for example, has increased its staff from less than 5 mental health and substance use disorder workers in 2011 to more than 35 staff today (including practitioners and clinicians). Tribal providers are able to bill Medical Assistance for 100 percent federal reimbursement of costs (with no state match), which is supporting an expansion of services on several reservations in Minnesota. In addition to service provision, the Red Lake Band of Chippewa Indians and the White Earth Band of Ojibwe have the legal authority to make civil commitments to the Commissioner of DHS (in addition to counties' authority), another important role.

## B. A Comprehensive Array of Services for People in the Target Population

The service array for the target population includes both community-based and institutional services. Community-based services include permanent housing with supports, employment and education services, clinical services, rehabilitation services, case management, care coordination, and crisis services. Residential services provide an intensive level of treatment and rehabilitation, and acute care is provided in specialized psychiatric hospitals, the psychiatric units of community hospitals, and sometimes in general medical units of community hospitals.

The array of adult mental health and substance use disorder services in Minnesota is provided by a wide range of providers, both public and private. While state-operated facilities still play a significant role in this service system, their role has shrunk as more services are provided by counties or county-contracted provider organizations, tribal authorities and their provider networks, and other private providers.

### 1. Recovery Management

Recovery management seeks to integrate all of the mental health and substance use disorder services, physical health and wellness, financial security, housing, transportation, education, employment, family and social relationship, and other supports necessary for successful community living. This category includes care coordination and case management approaches designed to carry out these tasks by focusing first and foremost on the individual's own personally chosen recovery goals:

- **Integrated recovery management models:** There are some local public-private experiments underway in Minnesota that integrate an individual's physical health, mental health, and substance use disorder services care into comprehensive recovery management models. These projects use payment mechanisms that reward health systems for containing costs and achieving good health outcomes and high customer ratings. One example of this integrated approach is Hennepin Health, a demonstration project involving Hennepin County, Metropolitan Health Plan, and other partners. Another example is the Dakota Wellness Preferred Integrated Network (PIN), a public-

private partnership involving Dakota County, Medica, and Medica Behavioral Health. Both of these projects were recognized as recipients of the 2012 DHS Commissioner's Circle of Excellence Awards.

- **Targeted case management (TCM)** is a Medical Assistance-reimbursed service that helps adults with serious and persistent mental illness to gain access to medical, social, educational, vocational, and other necessary services related to the person's mental health needs. The case manager carries out a functional assessment, assists the person in preparing a community support plan, and helps the person to carry out the plan. Typical case management activities may include planning the discharge process for people leaving inpatient hospitals or residential treatment facilities, helping to obtain health care coverage and needed services, arranging for transportation to services, and tracking progress. The number of individuals who must be served by each case manager—30 adults is the legal maximum although some case managers have more—makes it difficult to find enough time to assist people with the most complex needs (the target population for this report).
- **Liaison case managers:** One solution to the problem of county case managers having inadequate time and/or experience to assist clients with the most complex mental health needs is the *liaison case manager*, a specialized case management role that is being used in all seven metro counties and in two rural Adult Mental Health regions, the Southwest 18 and CREST.[44] Liaison case managers are specially trained and highly experienced case managers who work as liaisons with people served at AMRTC, county case managers, AMRTC social workers, and other relevant parties to coordinate the planning for people during their stay at AMRTC and their transition back to their communities. The liaison case manager role was designed to help assure that people can make timely and smooth transitions back to the community once they no longer require the acute inpatient psychiatric care provided at AMRTC.

### 2. Recovery Support

This category includes a broad range of professional support services, peer-to-peer and family support activities, and dedicated funds that facilitate the community recovery process for Minnesotans living with serious mental illnesses. There are several sources of funding for these services, including private health insurance, Medicare, and Medical Assistance. To help people with disabilities to remain in their homes and communities rather than moving into nursing facilities, Minnesota has several waiver programs that provide funding for home and community-based services: Community Alternatives for Disabled Individuals (CADI) waiver, Brain Injury waiver, Developmental Disability waiver, and Elderly waiver.

[44] See Appendix E for the counties included in the Southwest 18 and CREST regions.

- **In-home supports** include a wide range of services to assist people to live independently in their homes: companion service, day care, 24-hour emergency assistance, chore services, home-delivered meals, home adaptations, and other services. These services can be flexible to meet the unique needs of each individual and his or her family circumstances.
- **Housing:** Permanent supportive housing is an evidence-based practice recognized by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and identified as a priority for statewide dissemination by DHS. This best-practice approach to housing has the following core characteristics: tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent; tenants have access to the support services they need and want in order to retain the housing; and tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities. Minnesota has several federal and state housing support programs. The Bridges program is a state-funded housing subsidy program that provides modified, temporary rental assistance to people with serious mental illnesses who are waiting for permanent federal housing subsidies, such as Section 8. The Bridges program is administered by the Minnesota Housing Finance Agency in partnership with DHS.
- **Transportation** services have been identified as a key recovery support. These include medical crisis transportation as well as everyday transportation within the community (to work, stores, social engagements, healthcare appointments, support groups, etc.).
- **Employment**: Minnesota supports the employment of people with serious mental illnesses with the Extended Employment-SMI and Individual Placement and Support (supported employment) programs, which assist people in gaining and keeping employment. These programs improve client's employment stability and help prevent the need for alternative services including day programming, crisis services, and inpatient hospital stays. A 2012 report estimated that 26 percent of Minnesota counties do not have access to an Extended Employment-SMI or Individual Placement and Support provider, and warned that capacity is not sufficient even in those counties that do have providers.[45]
- **Projects for Assistance in Transition from Homelessness (PATH)** services are funded by SAMHSA to serve people with serious mental illnesses, including those with co-occurring substance use disorders, who are experiencing homelessness or at risk of becoming homeless. PATH services include community-based outreach, mental health, substance use disorder, case management and other support services, as well as a limited set of housing services.

[45] *Status and Evaluation of Employment Support Services for Persons with Mental Illness*: *Report to the Legislature* (Satin Paul: Department of Employment and Economic Development, December, 2012), 5.

- **Consumer-run services** are mental health programs or services that are provided directly by current or former mental health consumers. This category includes Wellness Recovery Action Plan (WRAP) training programs, support groups, warm lines for support and encouragement, social clubs, advocacy and support organizations, and other activities led by peers.[46] Certified Peer Specialist services are described below in the section describing rehabilitation services.
- **Family support and education** services assist the family and friends of individuals diagnosed with mental illnesses, including respite care, family counseling, and training. These services are offered by several advocacy organizations in Minnesota.
- **Drop-in centers** are social programs or clubs that provide a friendly atmosphere, a supportive environment, and a flexible schedule of activities for individuals living with mental illnesses. In many cases, the operating budgets of these programs are supported in whole or in part by grants from DHS.
- **Mental health services for veterans** are programs and interventions specifically targeted to service members, veterans, and their families by community mental health providers and by units of local, state, tribal, and federal government, including the Department of Veterans Affairs and TRICARE health systems.

### 3. Rehabilitation Services

This category includes a variety of interventions designed to restore people's community functioning. While some of the services in this category may be provided at mental health centers or other facilities, more typically they are provided in the community rather than in a center. Rehabilitation services are often, but not always, reimbursed by Medical Assistance under the Rehabilitation Option. Services in this category include the following:

- **Adult rehabilitative mental health services (ARMHS)** is a Medical Assistance-reimbursed rehabilitation service designed to bring recovery-oriented interventions directly to individuals in their own homes or elsewhere in the community. The goal of the service is to help individuals acquire, practice, and enhance skills that have been lost or diminished due to the symptoms of mental illness. ARMHS is defined in Minnesota Statutes 256B.0623 and has five billable service components: basic living and social skills, certified peer specialist services, community intervention, medication education, and transition to community living.
- **Assertive community treatment (ACT)**, an evidence-based practice, is an intensive, comprehensive, nonresidential team model reimbursed by Medical Assistance. The services provided are consistent with ARMHS except that ACT services (a) are provided by multidisciplinary, qualified staff who have the capacity to provide most mental health

[46] For information on WRAP, see: http://www.mentalhealthrecovery.com/. For other consumer-provided services, see the Mental Health Consumer/Survivor Network website: http://www.mhcsn.org/ and the National Alliance on Mental Illness-Minnesota website: http://www.namihelps.org/support.html

services necessary to meet the person's needs, using a total team approach; (b) are directed to individuals diagnosed with serious mental illnesses who require an intensive level of service; and (c) are offered on a time-unlimited basis, with staff available, if necessary, 24 hours a day and 365 days a year. There are 26 ACT teams for adults in Minnesota, 14 in the metro area and 12 in other regions of the state, with a total capacity of just under 2,000 participants. Most of the programs are privately operated, although several are operated directly by a county or joint powers board.

- **Intensive residential treatment services (IRTS)**, an intensive, Medical Assistance-reimbursed rehabilitation service, is described below in the "Residential Treatment" section.
- **Certified peer specialist services** are rehabilitative services provided by a current or former consumer of mental health services who has successfully completed a DHS-approved training program and certification exam. Certified Peer Specialist services emphasize the acquisition, development, and enhancement of skills needed by an individual with a mental illness to pursue recovery. The services are self-directed, person-centered, and characterized by a partnering approach between the certified peer specialist and the individual served.
- **Illness management and recovery** is an evidence-based practice whose aim is to empower consumers to manage their illnesses, find their own goals for recovery, and make informed decisions about treatment by teaching them the necessary knowledge and skills through a range of individual and group interventions.
- **Integrated dual diagnosis treatment** is an evidence-based practice providing integrated treatment for co-occurring mental illnesses and substance use disorders at the same time and in one setting.
- **Supported Employment using the Individual Placement and Support model** is a vocational rehabilitation approach for people with serious mental illnesses that helps them to obtain competitive work in the community and provides the necessary supports to ensure their success in the workplace. The Individual Placement and Support model of supported employment is an evidence-based practice defined by eight core principles and a 25-item fidelity scale.
- **Adult day treatment** or intensive outpatient treatment are intensive psychotherapeutic treatments whose goal is to reduce or relieve the effects of mental illness and substance use disorders and to provide rehabilitative training that enables the person to live in the community. The program may be provided by a licensed outpatient hospital with Joint Commission accreditation, a Minnesota Health Care Programs-enrolled community mental health center, or an entity under contract with a county to operate a day treatment program.

### 4. Clinical Services

This category includes a variety of services whose primary focus is to reduce symptoms and ameliorate disease or illness. The goal is to treat a condition (or a set of co-occurring conditions) which, if left untreated, could result in mental or physical deterioration. Some of the major clinical services in Minnesota's publicly supported mental health system include the following:

- **Medical management** services are specialized evaluation and management services provided by a psychiatrist or other qualified psychiatric care provider. As used here, the term includes the concept of "medication management" as described currently in the Minnesota Health Care Programs Provider Manual. This follows the American Medical Association's Current Procedural Terminology guidelines for evaluation and management (E/M) services, including diagnosis, risk assessment, counseling about prognosis, course of illness, review of treatment alternatives (including risks and benefits of complex treatments), ordering and interpretation of laboratory tests, and coordination of care with primary care providers, other medical specialists, and community providers.
- **Psychotherapy** is a planned and structured, face-to-face treatment of a person's mental illness that is provided (a) using the psychological, psychiatric, or interpersonal method most appropriate to the needs of the person; (b) according to current community standards of mental health practice; (c) to accomplish measurable goals and objectives specified in the person's individual treatment plan.
- **Dialectical behavior therapy** is a treatment approach provided in an intensive outpatient treatment program that uses a combination of individualized rehabilitative and psychotherapeutic interventions. Such a program involves individual therapy, group skills training, telephone coaching, and consultation team meetings.
- **Partial hospitalization** is a time limited, structured program of multiple and intensive psychotherapy and other therapeutic services provided by a multidisciplinary team, as defined by Medicare, and provided in an outpatient hospital facility or community mental health center that meets Medicare requirements. The goal of the program is to resolve or stabilize an acute episode of mental illness.

### 5. Residential Care

Some people in the target population reside in residential care facilities that provide a variety of services on the premises. These congregate living arrangements, which range in size from very small to quite large, include the following major types:

- **Foster care** is a home that provides sleeping accommodations and services for one to five adults and is licensed by DHS. The rooms may be private or shared, and the dining areas, bathrooms, and other spaces are shared family-style. Foster care homes can offer a wide array of services. There are two types of foster care: family foster care and corporate foster care. In family foster care, the license holder lives in the home and is the

primary caregiver. In corporate foster care, the license holder does not live in the home and is not the primary caregiver; trained staff provide the services.

- **Assisted living residences** generally combine housing, support services, and some kind of health care. Individuals who choose assisted living can customize the services they receive to meet their individual needs. To be considered an assisted living residence, the facility must provide or make available, at a minimum, specified health-related and supportive services. Examples include: assistance with self-administration of medication or administration of medication, supervised by a registered nurse; two meals daily; daily check system; weekly housekeeping and laundry services; assistance with three or more activities of daily living (dressing, grooming, bathing, eating, transferring, continence care, and toileting); and assistance in arranging transportation and accessing community and social resources. Every assisted living facility must have a license from the Minnesota Department of Health in order to operate.
- **Boarding care** facilities are licensed by the Minnesota Department of Health and are homes for people needing minimal nursing care. They provide personal or custodial care and related services for five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are common areas for dining and for other activities.
- **Board and lodge** facilities vary greatly in size, some resembling small homes and others more like apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with a private or attached bathroom. There are common areas for dining and other activities. Many offer a variety of supportive services (such as housekeeping or laundry) or home care services (such as assistance with bathing or medication administration) to residents.

### 6. Residential Treatment

When people with serious mental illnesses need 24-hour care, there are several types of residential services available in Minnesota:

- **Intensive residential treatment services (IRTS)** is a time-limited, Medical Assistance-reimbursed service provided on a 24-hour basis in a supervised residential setting to individuals in need of an intensive rehabilitative service and at risk for significant functional deterioration if they do not receive it. The service is typically provided for fewer than 90 days, although the actual duration depends on each person's individually determined medical necessity. IRTS programs are designed to develop and enhance the individual's psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills needed for living in a more integrated setting chosen by the individual. IRTS services can be used to divert people from unnecessary inpatient care and to provide intensive services to those who no longer need acute inpatient care but do need a 24-hour

supervised setting. In order to qualify for Medicaid reimbursement under federal regulations, IRTS settings are limited in size to 16 beds. While most of the programs are privately operated, four are operated by the DHS through Direct Care and Treatment.

- **Residential substance use disorder treatment**: There are about 95 residential substance use disorder services providers in Minnesota. Several of these providers work with clients who have serious mental illnesses in addition to their substance use disorders. Residential program staff conduct ongoing comprehensive mental health and substance use assessments, provide group and individual therapy, and facilitate support groups. They also provide psycho-education on topics such as the interactions between mental illnesses and substance use disorders and the development of new coping mechanisms that promote recovery. They also routinely provide medication assessment and monitoring, and facilitate family involvement in the treatment process. Residential treatment can last anywhere from a few days to a number of months, depending on individual client need.
- **Nursing homes** are long-term care facilities that offer a full array of personal, dietary, therapeutic, social, spiritual, recreational, and nursing services to residents. These facilities provide nursing care to people who are not sick enough to need hospital care but who are not able to remain at home. Every nursing home and assisted living facility must have a license from the Minnesota Department of Health in order to operate. In order to make sure that people with mental illnesses are not inappropriately admitted to nursing homes, federal law requires pre-admission screening to identify people with a history of mental illness or developmental disabilities; should such a history be found, federal law requires an additional review to determine if special services are needed within the nursing home.

### 7. Crisis Response Services

This category includes mobile crisis response services, residential crisis stabilization services, crisis intervention team training for first responders, and a state-supported crisis housing fund. The types and availability of these crisis services vary considerably among geographic regions of the state. The major crisis response service types are as follows:

- **Mobile crisis response services** currently serve 49 Minnesota counties, including the 7-county Metro Area. The service generally starts with a telephone call from the person experiencing a crisis or a member of the public. Mobile staff go to wherever the person in crisis may be, accompanied by law enforcement if necessary. The mobile response team provides a crisis assessment and a face-to-face, short-term, intensive intervention to help the person cope with immediate stressors, identify strengths and available resources and begin to use them, and begin to return to his/her level of functioning that existed before the crisis or emergency. The team's initial work is followed by crisis stabilization services if necessary, which may include further assessment and referrals, preparing the

crisis stabilization treatment plan, supportive counseling, skills training, residential crisis stabilization, and collaboration with other providers in the community.

- **Residential crisis stabilization** is a mental health service that follows crisis assessment and intervention services. It is provided in a short-term, supervised, and licensed residential program. A program of this type is usually licensed as a Rule 36 facility with a crisis stabilization variance or as an adult foster home.
- **Crisis intervention team training** for law enforcement personnel uses a nationally known best practice called the Memphis Model, in which first responders learn safer, more effective crisis intervention techniques to facilitate pre-arrest jail diversion for people in mental health crisis situations. DHS has supported crisis intervention team training conducted by the Minnesota Crisis Intervention Team Officers Association and the Barbara Schneider Foundation.
- **A state-supported crisis housing fund**, administered by the Minnesota Housing Partnership, covers housing expenses that a person was previously paying but is no longer able to pay because their income is being used to pay for treatment. Referral for assistance must be made by the person's adult mental health targeted case manager.

#### 8. Inpatient Psychiatric Services

Inpatient psychiatric services treat the most acute mental illnesses and substance use disorders. The treatment usually takes place in psychiatric hospitals and in psychiatric units of general hospitals. Individuals are assessed upon arrival and are admitted if they meet criteria for a hospital level of care, which include presenting a risk of harm to self or others or an inability to care for self that creates a risk of physical harm or illness. In addition to providing psychiatric treatment to stabilize the patient's symptoms, hospitals assist the individual with planning the transition back to the community and locating appropriate community services, if needed.

## C. Client/Patient Flow

One of the defining characteristics of a community-based model of care is that the individual receiving care has to move around to access services because the services are not all provided in one place. From the individual perspective, this is described as "getting the right services at the right time and place," and it can be extremely challenging to gain access to these services. An individual must be able to identify the appropriate services, qualify for funding for those services, and receive and manage a variety of services (as each service provides support for different aspects of an individual's recovery needs). From the system perspective, this requires smooth and efficient client flow through the system.

As Section V-B of this report has shown Minnesota has developed many community-based services that help clients remain stable in their communities and institutional options if higher levels of care are needed. Unfortunately, many people in the target population make journeys through the service system over and over, cycling from hospital to residential placement to home

to hospital. This disrupts their lives and the lives of their families and friends. A major goal of community-based care systems is to prevent the need for people to move to higher levels of care whenever possible and to help people move back to lower levels of care, and/or to their homes, as soon as that is appropriate.

The Legislative Auditor requested this report primarily because of the patient flow problems at AMRTC. These problems (discussed in detail below) are evidence of wider system-level problems that can be summarized briefly here. A lack of adequate community support services results in people in the target population too frequently needing a hospital level of psychiatric care. Once admitted and treated, individuals in the target population often occupy inpatient hospital beds (at AMRTC and community hospitals) even after they no longer meet the criteria for a hospital level of care because an appropriate community-based setting for them is not currently available. As a result, they remain in inpatient beds that are needed by others who *do* meet the criteria for a hospital level of care. Those people wait in inappropriate settings (jails, emergency rooms, and community hospital units) for beds to become available, often for days or weeks.

The factors that force people to wait for access to inpatient psychiatric beds are called *front door* issues, and the factors that prevent a patient from leaving AMRTC or a community hospital at the appropriate time are called *back door* issues. Both front door and back door problems prevent people from making smooth transitions to the right care in the right place at the right time. The lack of community services underlies the failure to prevent people from needing a hospital level of care and too much demand forces people to wait (front door). The (back door) problem of people "stuck" at AMRTC and other hospitals exacerbates the front door problems and forms a serious barrier to recovery. Both problems waste scarce resources that could be better spent on appropriate care and prevention programs. Both problems are further exacerbated by inefficient legal processes, complicated eligibility and funding processes, and inadequate coordination among agencies.

## D. Gaps in the Service System for People in the Target Population

The underlying causes of the patient flow problems are gaps in the service system that are especially problematic for people in the target population. Several recent legislative reports and planning projects have identified such gaps, and the Adult Mental Health Policy Division's 2013 Gaps Analysis Survey of counties, mandated by the Minnesota Legislature, reaffirmed the existence of these gaps (see Appendix F).[47] The gaps in the service system for the target population can be summarized as follows:

[47] *2013 County Long-Term Services and Supports Gaps Analysis Survey: Adult Mental Health, Full Report* (Saint Paul: Adult Mental Health Division, Chemical and Mental Health Services Administration, Department of Human Services, August 2013).

### 1. Community recovery supports are inadequate

As emphasized in Minnesota's Olmstead Plan, the fundamental requirements for maintaining a satisfying, productive life in the community of one's choice include employment, housing, supports and services, life-long learning and education, healthcare and healthy living, transportation, and community engagement.[48] This is as true for people in the target population as it is for all other adults in Minnesota. While it can be tempting to focus on gaps specifically related to mental health services, it is actually crucial to recognize that recovery support services—including housing, daily living supports, employment, education, transportation, and child care—are the core supports that allow people in the target population to maintain stability in their community.

- Housing: Across the state there is a shortage of quality affordable housing with consumer-chosen supports. People in the target population often have problematic rental histories, making it difficult to find willing landlords (especially when community-wide vacancy rates are in the low single digits). It is also difficult to assemble a flexible array of services to go along with the housing, especially if the individual lives in a rural area. While the Bridges RTC funds (rental assistance) have helped some clients, some counties have not been able to use these funds to help their clients because there is inadequate funding for the other support services the individual would need to remain stable while living independently.
- Living supports: Some people in the target population need assistance with daily living, including help with personal care, meal preparation, and housekeeping. Minnesota pays for these home and community-based services through the Personal Care Assistance (PCA) and Community Alternatives for Disabled Individuals (CADI) waivers. These programs have been helpful in allowing some people in the target population to move out of institutions and into the community. There have been reports of shortages of CADI resources in some counties, in part due to legislative limits on the growth in the waiver program, that have caused delays in access to CADI services for some people in the target population. The 2013 legislature authorized changes in the management of CADI resources, including increases that are dedicated to supporting people leaving AMRTC.
- Corporate Foster Care: The moratorium on Corporate Foster Care beds was instituted to reduce reliance on more intensive services for those who can move to their own homes with supportive services, while targeting this resource to those who need it the most. While stakeholders agree that the moratorium has ended the practice of referring people to foster care who could have lived more independently elsewhere, they report that the moratorium is now creating a shortage of beds for a few people who truly need that level

[48] *Putting the Promise of Olmstead into Practice: Minnesota's 2013 Olmstead Plan* (Saint Paul: State of Minnesota, November 1, 2013), 9.

of care. Stakeholders have also criticized the nature of care provided in Corporate Foster Care, saying that it lacks adequate programmatic requirements or training for care staff.

- Long-term care rates: Concerns have been raised that the rates that the state pays for long-term care and/or nursing facilities may not adequately cover the cost of providing services for people in the target population. DHS has studies underway to address this situation: a study of critical access to services, another service gaps analysis, and a study of the longitudinal impact of rates on access to services.
- Employment: Minnesota has a robust system of vocational rehabilitation programs, but they are not optimum for people's whose symptoms of mental illness are their primary barrier to employment. The Individual Placement and Support (IPS) model of employment has proven to be an effective approach, emphasizing competitive employment of the client's choice and focusing on job searching, employee advocacy, and ongoing support when needed to help the employee maintain employment. This approach is aligned with the Minnesota Olmstead Plan, which identifies several needed improvements in the system including: more person-centered planning, better training and technical assistance for staff of employment programs, and better communication and coordination with employers.[49] The IPS model has not yet been widely implemented in Minnesota.
- Transportation: Transportation presents a key barrier to recovery for people in the target population. Even in metro counties, it can be difficult for people to find rides to work, social activities, psychiatric treatment, medical care, and other supports; in rural areas, it can be almost impossible. In some cases, individuals must choose between living in their (rural) home communities and getting the services they need; transportation challenges just compound whatever service shortages a rural community might face. While individuals can use Non-Emergency Medical Transportation (paid by Medical Assistance) for some trips to treatment, consumers report that this service barely begins to address their transportation needs. An additional transportation gap is the lack of humane and respectful psychiatric crisis transport, which can force people into traumatic and stigmatizing ambulance or law enforcement transportation, exacerbating stress at the worst possible time.

The inadequacy of recovery supports is making it difficult for people in the target population to attain long-term recovery in their communities of choice. Without these supports, individuals' symptoms can become so unmanageable that they are forced to seek residential or inpatient treatment. Once discharged from residential treatment settings or acute care facilities, they can cycle quickly back into those settings because they have not been able to manage their illness

[49] *Putting the Promise of Olmstead into Practice: Minnesota's 2013 Olmstead Plan* (Saint Paul: State of Minnesota, November 1, 2013), 33-36.

while also trying to negotiate their family and social relationships and find and maintain housing, transportation, employment, and education.

### 2. Psychiatric services are inadequate to meet the need

Minnesota has used payment reforms and policy development to encourage community providers to offer acute, residential, and crisis psychiatric treatment services. However, gaps in the community-based service system remain, especially for people in the target population:

- Mental health and substance use disorder professionals are in short supply across the state. A shortage of psychiatrists is problematic for people in the target population, who can wait for weeks (or months) to get an appointment with a psychiatrist or psychiatric nurse practitioner when they need care or after they are discharged from an inpatient or residential facility. According to the Gap Analysis report, "The shortage of psychiatrists and advanced practice nurses with mental health expertise limits consumer choice and creates long waits for essential appointments, not only in Greater Minnesota but in the metro area as well."[50] Other mental health professionals are also in short supply.
- Most communities lack adequate crisis response capacity. This can include psychiatric urgent care, mobile crisis teams, outpatient and residential crisis services, and law enforcement and emergency medical staff who are trained to recognize and respond to people experiencing a mental health crisis.
- It is often difficult to access acute psychiatric beds when they are needed, especially for people in the target population who require specialized care and/or whose symptoms include aggressive behaviors. This gap will be discussed in detail below.
- AMRTC and other acute care hospitals are set up to discharge people when they no longer meet medical criteria for a hospital level of care. While their psychiatric symptoms might be stabilized, many people are not ready to manage their own recovery. There is a need for residential psychiatric treatment for people with complex medical needs and/or aggressive behaviors that goes beyond what is currently offered at most IRTS providers. Stakeholders have called for "specialized" IRTS or a new transition service that would extend the existing IRTS level of care and enable longer stays, more specialization around aggressive behaviors, and more capacity to assist clients with complex physical medicine needs in addition to their mental illnesses.[51]
- Though this is controversial given the Minnesota Olmstead Plan's goal of community integration, there are many county, provider, and consumer representatives who say there is a need for medically-monitored, long-term residential settings to help people in the

[50] *2013 County Long-Term Services and Supports Gaps Analysis Survey: Adult Mental Health, Full Report* (Saint Paul: Adult Mental Health Division, Chemical and Mental Health Services Administration, Department of Human Services, August 2013), 9.

[51] It is important to note that although IRTS services commonly last 90 days, they can last longer if the need for continued treatment is documented. The fact that IRTS services are not limited to 90 days is often misunderstood.

target population remain stable in the community and avoid hospitalization. These stakeholders have told DHS that there are a small number of people with very complex needs who require long term housing that incorporates 24-hour mental health supports on-site and that the level of supports needed are only financially feasible if the site can serve 10-20 people in one location.

- There are not enough providers offering long-term care for people in the target population experiencing dementia, especially those whose symptoms also include aggressive behaviors. This is likely to be a growing need as the baby-boomer generation moves through the service system.
- Some offenders in the criminal justice system are deemed incompetent to stand trial because of their mental illnesses. Under Rule 20.02, these individuals are sent to AMRTC or the Minnesota Security Hospital for *competency restoration*, treatment that stabilizes the symptoms of their mental illnesses so that they can understand and participate in their legal process. Stakeholders have called for new options to providing competency restoration so that AMRTC beds could be used for people needing acute psychiatric care.

### 3. There is inadequate capacity to serve people whose symptoms include aggressive behaviors

People in the target population have complex co-occurring conditions in addition to their mental illnesses, and all of those conditions create challenges for both the individuals and the providers who serve them. People whose symptoms include aggressive behaviors, however, are particularly under-served in Minnesota's current mental health system.

There is currently no system for tracking the number of aggressive or violent acts committed against or by people with serious and persistent mental illnesses in Minnesota, but data from outside of Minnesota can provide some context:

- People with mental illnesses are more likely to be victims of violence than to perpetrate violence.[52] One study of the relationship between mental illness and violence concluded that "The challenge for medical practitioners is to remain aware that some of their psychiatric patients do, in fact, pose a small risk of violence, while not losing sight of the larger perspective—that most people who are violent are not mentally ill and that most people who are mentally ill are not violent."[53]

[52] Louis Appleby, Preben Mortensen, Graham Dunn, and Urara Hiroeh, "Death by Homicide, Suicide, and Other Unnatural Causes in People with Mental Illness: A Population-based Study," *The Lancet* 358 (2001), 2110-2112; Virginia Hiday, et. al., "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50 (1999), 62-68.

[53] Richard Friedman, "Violence and Mental Illness: How Strong is the Link?" *New England Journal of Medicine* 355(2006), 2064–2066. See also Jennifer Skeem, Sarah Manchak, and Jillian Peterson, "Correctional Policy for

- One 1990 report summarizing interviews with 10,000 subjects conducted for the National Institute of Mental Health's Epidemiological Catchment Area Survey found that 2.1 percent of those who did not meet DSM-III criteria for a mental disorder reported committing a violent act in the previous year. This compared with 12.7 percent for those who met criteria for schizophrenia, 11.7 percent for major depression, 11 percent for mania or bipolar disorder, 24.6 percent for alcohol abuse/dependence and 34.7 percent for drug abuse/dependence.[54] Another researcher found that the rate of violence among people treated at psychiatric hospitals peaked at the time of admission to a hospital, remained higher than the average for a 10-week period after discharge, but was no higher than average within 50 weeks of discharge.[55] These studies indicate that acute treatment providers (e.g., crisis services, emergency departments, inpatient hospitals, and IRTS) are likely to work with some people whose symptoms include aggressive or violent behaviors.

There are systems and techniques that have been developed that offer person-centered strategies for treating and supporting people whose symptoms include aggressive behaviors, but most psychiatric professionals and other provider staff have not been trained on those techniques.[56] Moreover, most treatment settings are not staffed or architecturally designed to implement such techniques easily. Insurance and legal liability pose further challenges. Some efforts have been undertaken to address this gap in Minnesota's service system, including treatment innovations, architectural modifications, staffing changes, and trainings and conferences.[57] However, a more systematic effort is needed.

#### 4. Psychiatric services are not available in all locations

While providers have stepped in to provide many of the services listed above in some regions, the gaps in services are particularly challenging in rural Minnesota. People in the target population need specialized services, and there are often not enough providers in small or remote communities to support such specialization. Providers rely on a wide range of mental health

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Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction," *Law and Human Behavior* 35 (2011), 110-126.

[54]Jeffrey Swanson, Charles Holzer III, Vijay Ganju, and Robert. Jono, "Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys," *Hospital Community Psychiatry* 41 (1990), 761-770.

[55] Henry Steadman, Edward Mulvey, and John Monahan J, et al., "Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods, *Archives of General Psychiatry* 55 (1998), 393-401.

[56] Marie Rueve, MD and Randon Welton, MD, "Violence and Mental Illness," *Psychiatry* 5 (2008), 34-48; Ashleigh Anderson and Sara West, MD, "Violence Against Mental Health Professionals: When the Treater Becomes the Victim," *Innovations in Clinical Neuroscience* 8 (2011), 34-39.

[57] For example, "Danger to Self—Danger to Others: A One Day Conference Exploring Mental Illness, Aggression and Violence," held by the South Central Community-Based Initiative, October 15, 2013, Mankato, MN; "Working Together for Better Mental and Behavioral Health Care: Ways to Improve Patient and Staff Safety," Minnesota Hospital Association Conference, November 8, 2013, Plymouth, MN.

professionals: psychiatrists, nurses, physician assistants, psychologists, clinical social workers, marriage and family therapists, licensed professional clinical counselors, and mental health workers that require the supervision of a licensed mental health professional. There are shortages of these skills across Minnesota. For example, there are only 13 counties in all of Minnesota that have *not* been federally designated as a Mental Health Professional Shortage Area because of a lack of mental health professionals.[58] The shortage that has received the most attention is the lack of psychiatrists. In 2011, there were 643 licensed psychiatrists practicing in Minnesota, or about 1 for every 8,200 people.[59] Psychiatry is one of the few physician categories that has actually shrunk in the past five years, with the number of practicing psychiatrists in the United States dropping .7 percent between 2005 and 2010.[60] This drop is likely to continue because practicing psychiatrists tend to be older than most other categories of physicians, with 57 percent of practicing psychiatrists in 2010 being aged 55 and older (average for all categories is 40 percent).[61] These shortages are mirrored in other categories of clinicians and practitioners.

Without these professionals, some necessary services just can't be offered. This has resulted in gaps in the service system and people ending up in inappropriate levels of care, having to travel long distances to receive care, or not receiving needed services at all, thereby exacerbating symptoms and/or creating backlogs that reverberate throughout the entire system of care. Finding culturally appropriate specialty services in rural Minnesota is even more difficult.

It is likely that tele-health outreach services could help address these shortages by bringing some consultation and direct services to people in areas that do not have easy face-to-face access. Such services are already being used in some areas. Other solutions include greater use of Physician Assistants and Nurse Practitioners in treatment teams and better collaboration with primary care teams.

**5. Integration, care coordination, and transition planning are inadequate**

A comprehensive array of services requires integration and/or coordination to smooth transitions among providers and levels of care and to manage ongoing support and treatment in the community. Such coordination is often inadequate to meet the unique and specialized needs of the target population. Stakeholders report that clients face a number of coordination gaps:

[58] Health Professional Shortage Areas Data Warehouse, Health Resources and Services Administration, U.S. Dept. of Health and Human Services, accessed on December 10, 2013 at http://hpsafind.hrsa.gov/HPSASearch.aspx. The counties that were not designated as shortage areas were: Anoka, Carver, Dakota, Dodge, Hennepin, Houston, Mower, Olmsted, Ramsey, Scott, Steele, Wabasha, Waseca, Washington, and Winona.
[59] *The Geographic Distribution of Minnesota Physicians, by Specialty* (Saint Paul: Office of Rural Health and Primary Care, Minnesota Department of Health, January 2013), 2.
[60] *2012 Physician Specialty Data Book* (Washington, D.C.: Association of American Medical Colleges, Center for Workforce Studies, November 2012), 25.
[61] Ibid., 15.

- Ineffective communication strategies and collaboration among providers, for example between a local community's hospitals and its crisis team, or between inpatient psychiatric units and residential facilities. In another example, tribes are often left out of the decision-making around services provided to their members, even though they play a significant role in supporting the recovery of people living on reservations. This can lead to ill-informed decisions around civil commitment and to poor discharge planning.
- Lack of shared data and interoperable health information systems to adequately track clients and coordinate solutions.
- Disparate, inadequate, disconnected and/or overlapping funding streams.
- Over-worked case managers and care coordinators due to strained social services budgets.
- Lack of recovery management that incorporates psychiatric and medical specialists, social services, peer supports, spiritual communities, families and friends in support of the person's recovery plan. Some of this lack is due to resource shortages, but some is due to lack of awareness and training. As one county administrator described it, *"We need technical assistance to learn how to do a better job of individual transition planning. Our staff don't know how to do this, and they are not ready for some of the clients they get. We need individualized training to prepare county and provider staff for the complex and unique needs of each client."*

While case managers and care coordinators do their best to provide continuity and coordination, Minnesota's service system is somewhat fractured and it can be difficult for people in the target population to gain access to the services they need. Health care reform's use of managed care models should improve coordination and/or integration, but the fuzzy line between medical care and social services will need to be constantly negotiated in order to support recovery for people in the target population. There are technical/policy obstacles as well, including the complexity of eligibility requirements and the difficulty of sharing patient records.

### 6. Integration of mental health, substance use disorder, and physical health services is needed

About two-thirds (62 percent) of the people discharged from AMRTC over the past four fiscal years have had a substance use disorder diagnosis in addition to their serious mental illnesses. Historically, Minnesota's treatment system for substance use disorders has been separated from that for mental illnesses; people would be treated for one disease and then move to a new location to address the other. Outcomes are improved, however, when both sets of illnesses are treated at the same time.[62] Minnesota has adopted the evidence-based practice of Integrated Dual Diagnosis Treatment, but it has not yet been widely implemented.

[62] *Integrated Treatment for Co-Occurring Disorders Evidence-Based Practices (EBP) Kit*, (Washington, D.C.: SAMHSA, 2010, accessed on December 10, 2013 at http://store.samhsa.gov/product/SMA08-4367.

As more data is reported about the relationships between mental health and other physical illnesses, the importance of integrating mental health, substance use disorder, and physical health services is almost universally recognized. National studies have shown that people with serious mental illnesses are dying 25 years earlier than the general population, often from disorders that are inherently preventable or treatable.[63] The recognition of this public health crisis has pushed the integration of mental health and primary medical care into the top tier of policy issues nation-wide. In Minnesota, DHS is acutely aware of the problem and has made its resolution a high priority, through a public-private campaign called the *10 x 10 Initiative*—whose name encapsulates the ambitious goal of extending the average lifespan of people with serious mental illnesses by 10 years within the next 10 years.

### 7. Culturally-sensitive services are inadequate

Bio-psycho-social treatment approaches are by definition reflective of particular cultural values. Research shows that treatment is more successful when it aligns with the cultural values of the person undergoing treatment. For many ethnic subpopulations of Minnesotans, culturally specific treatment programs are either very far from their home communities or they don't exist at all. DHS has adopted a goal of reducing the gaps in access and outcomes for health care in cultural and ethnic communities, and has a variety of programs to encourage the development of more culturally-sensitive and culturally-specific programs, but much remains to be done. In the Gap Analysis survey, less than one-fifth of the county respondents reported that their providers were "very prepared" to deliver culturally competent services to their minority clients.

| Respondents were asked to rate their local providers' degree of preparation for delivering culturally competent care for each of these communities: | "Local providers are VERY PREPARED to deliver culturally competent care" | "Local providers are SOMEWHAT PREPARED to deliver culturally competent care" | "Local providers are NOT AT ALL PREPARED to deliver culturally competent care" |
|---|---|---|---|
| Racial/ethnic minority communities | 14% | 83% | 3% |
| New American/immigrant/ refugee communities | 6% | 69% | 24% |
| Gay, lesbian, bisexual, transgender, queer, and/or intersex communities | 18% | 79% | 3% |
| Other cultural communities | 15% | 80% | 5% |

**Table 9: Cultural Competence Assessed by County Respondents to Gap Survey[64]**

American Indian tribes in Minnesota have made significant progress in the past five years in the development of culturally-specific services for their members living on reservations. These services are based on trauma-informed care models and consider the impact of historical trauma

[63] Joe Parks, Dale Svendsen, Patricia Singer, and Mary Ellen Foti, *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors, October 2006).
[64] *2013 County Long-Term Services and Supports Gaps Analysis Survey: Adult Mental Health, Full Report* (Saint Paul: Adult Mental Health Division, Chemical and Mental Health Services Administration, Department of Human Services, August 2013), 15. County respondents were asked how prepared, in general, local mental health services providers are to deliver care that is culturally competent to members of these cultural communities.

as well as individuals' personal experiences of trauma. Most tribes operate tribal mental health and substance use disorder programs, and the White Earth Band of Ojibwe is in the process of becoming legally responsible for all of the human services to their tribal members and their families. Outside the reservations, however, there is much less understanding of the specialized needs of American Indians, as Table 9 shows. This has resulted in significant disparities in health outcomes for American Indians, including higher rates of suicide than other sub-populations of Minnesotans.

**8. The Civil Commitment process is problematic**

Because most people served at AMRTC are committed to the Commissioner for mental illnesses and some are committed for chemical dependency (12 percent) and/or developmentally disability (1.6 percent), as well, the civil commitment process plays an important role in the access to care (see Table 12). Many stakeholders have identified the civil commitment process as a barrier to "right place, right time" services. According to a report from DHS's Ombudsman for mental health,

> *"The commitment process is filled with inconsistencies, inaccuracies, ignorance of the law, and confusion that is inherent with 87 different counties directing the process as well as many medical professionals in many different hospitals who may not have complete or adequate legal knowledge or context given different procedures in different counties. It can be frightening and abusive for the person proposed to be committed. In addition it creates inefficiencies for providers that can lead to delays in providing needed treatment and expensive extended hospital stays using scarce mental health bed capacity."*[65]

It is beyond the scope of this report to delve in detail into Minnesota's commitment process, but many stakeholders have identified aspects of the commitment process that compromise care for the target population:

- Varying interpretations of commitment statute among counties: There are reports that the commitment process is being used inappropriately by some counties and hospitals as a way to manage their risk in caring for people in the target population (by seeking commitment to AMRTC or the CBHHs for some individuals who could be served without resorting to commitment). On the other hand, stakeholders have also described cases in which an individual met the criteria for commitment, but the process was never initiated or the criteria were applied inappropriately so that the commitment did not occur. A survey completed by the Mayo/Blue Earth County Collaborative found widely varying understandings of the commitment process among its county and hospital staff,

[65] *Civil Commitment Court Related Issues and Discussion of a Consolidated Metro Area Mental Health: Court Ombudsman Discussion Paper* (Saint Paul: DHS Office of the Ombudsman for Mental Health, 2002), 1.

which led to development of a training effort to improve understanding of the process. It is likely that this variation exists in other counties as well.

- Opportunity to avoid some commitments: Is it possible to use continuances more frequently so that, with professional consultation (with crisis providers and/or specialized psychiatric staff, for example), some commitments could be avoided?
- Inefficient process: Lack of staffing in counties and courts has led to significant delays in getting services for people in the commitment process, many of whom sit in jails or hospitals while they wait for their cases to wind through the courts. There is also a need for better coordination of the commitment process so that the multiple players (including the individual, attorneys, courts, case managers, crisis services providers, social workers, and health providers) could improve decisions and minimize undue delays that compromise care.
- Commitment process and Jarvis hearings: There are sometimes delays when a patient who has completed the commitment process continues to wait an additional period (e.g., two weeks) for a Jarvis hearing (which considers whether medications can be administered without the patient's consent). Some clinicians have recommended that the two processes be coterminous to decrease the delays.
- Community commitments: Community commitments were intended to reduce the need for institutional care, but they are rarely used. Can community commitments be utilized to be more effective at ensuring that individuals can receive the community supports they need?
- Responsibility for people civilly committed to the Commissioner: As health care reform is implemented, who will be financially responsible for people committed to the Commissioner? Will insurers and/or health systems be responsible for the major decisions about the treatment and discharge of people under commitment? Who will be responsible for finding long-term placements and community recovery supports? What role will counties and DHS play in this process?
- Commitment of people with primary personality disorders: Except for borderline personality disorder, psychiatrists recognize that the effective treatment options for personality disorders are quite limited. Yet the legal definition for committing someone as mentally ill is so broad and behavior-based (as opposed to diagnosis-based) that it includes many people with primary personality disorders, not mental illnesses. This places people in the treatment system for illnesses for which there is no agreed-upon and proven course of treatment. Policymakers need to clarify the process and identify appropriate pathways for people with primary personality disorders.
- Holding people for pending Rule 20.01 reviews (which assess an individual's competence to participate in the legal process): It is standard practice to move people from jail to AMRTC pending a Rule 20.01 review, but this may not always be warranted. If a person in jail is mentally stable, does it make more sense to provide support to the jail to assist the client rather than to transfer the person to an inpatient facility?

- Remote provisional discharges: Sometimes a community hospital must wait to provisionally discharge a committed patient because only a few DCT staff are authorized to handle those discharges remotely (i.e., go to the community hospital, assess the patient, and provide authorization for the provisional discharge). In the worst cases, the patient is actually transferred to AMRTC just to be assessed and discharged. This process needs to be streamlined.

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In conclusion, Minnesota is still transitioning to an integrated community-based care system and there are many unanswered questions. How can the system implement a recovery management approach to care for people in the target population? What will mental health and substance use disorder services look like in a comprehensive, continuous, integrated health care system? How will health care payment reform affect delivery of safety net services? Are there new roles for DCT that will emerge as the state learns more about the demands of a community-based model of care? As the transition proceeds, DCT will continue to look for ways to fulfill its shared public safety net role while using public resources efficiently to optimize care for the people it serves.

# VI. The Role of AMRTC in the Current System of Care

## A. Overview of AMRTC

AMRTC is a tertiary psychiatric hospital that serves people who are civilly committed as mentally ill in a large campus-based setting. The facility has six treatment units with a total of 175 licensed beds, 110 of which are currently funded by the legislature. The units include:

- **Intensive Behavioral** units specialized for individuals whose mental illness symptoms include aggressive or disruptive behaviors (2 units, total of 36 funded beds)
- **Medical-Psychiatric** unit specialized for individuals with acute mental illnesses and major medical diagnoses requiring additional nursing care (1 unit, 22 funded beds)
- **Neuropsychiatry** unit specialized for individuals with acute mental illnesses and cognitive disorders (1 unit, 14 funded beds)
- **Complex Co-Occurring** units specialized for individuals with acute mental illnesses and substance use disorders or personality disorders (2 units, total of 42 funded beds).

AMRTC had 359 inpatient admissions in FY 2013 and 366 discharges.[66] Staffed 24 hours a day, the hospital employs about 400 people, including professionals specializing in chaplaincy, dental, primary health care, nursing, nutrition and diet, occupational therapy, physical therapy, pharmacy, psychiatry, psychology and neuropsychology, social work, and therapeutic recreation.

[66] These figures include all the episodes of care during FY2013 (i.e., a patient who had two episodes of care was counted twice in these totals).

AMRTC employs evidence-based practices, which are methods of treatment that researchers have demonstrated are effective in supporting people with mental illness in their recovery. Intensive, multidisciplinary services provided by the hospital include:

- Assessment of mental, social, and physical health by psychiatrists, clinical nurse specialists, advanced practice nurses, psychologists, clinical social workers, medical physicians and other rehabilitation therapists, as appropriate.
- Development of a person-centered treatment plan.
- Comprehensive mental health treatment including the Illness Management and Recovery model of care. This model is an individualized, person-centered approach that includes the family and community in treatment planning and implementation.
- Individualized discharge planning and collaboration with people served at AMRTC, family members, significant others as well as county and tribal social services and mental health case managers for transitioning back to an appropriate setting in the community.

In addition to its extensive professional staff, AMRTC also takes advantage of the unique contribution that peers can make in the recovery of people served at AMRTC. About five years ago, AMRTC implemented Integrated Dual Diagnosis Treatment, an evidence-based practice that addresses mental illnesses and substance use disorders at the same time and with the same treatment professionals. Peer supports are a key dimension of the approach at AMRTC. The following peer support groups currently meet at AMRTC: Alcoholics Anonymous, Artists and Musicians AA Squad of NE Minneapolis, Dual Recovery Anonymous, Narcotics Anonymous, Overeaters Anonymous, Hearing Voices Network Peer Support Group, and Seven Feathers Warrior Healing Group.

The use of peer supports has been a tremendous complement to AMRTC's treatment modalities. It is inspiring for clients at AMRTC to experience the support of others who have "walked in similar shoes," and peer support groups can provide motivation, fellowship, and healthy social network for clients after they are discharged to the community. DCT is considering the expansion of peer supports to include hiring Certified Peer Specialists at AMRTC, which would allow for more peers to work individually with clients, augmenting the group peer opportunities that already exist.

## B. Data on the People Served by AMRTC[67]

This section describes all of the episodes of care of people discharged between July 1, 2009 and June 30, 2012 (four fiscal years). There were a total of 1,806 episodes during this period.

[67] Unless stated otherwise, all of the data presented in this section represent the episodes of care of patients discharged from AMRTC in FY 2013. This means that if a patient had two episodes of care in FY2013, he or she is counted twice in this data.

### 1. Demographics

Table 10 provides demographic information about the people served at AMRTC.

| Demographic Category | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|
| Gender | | | | |
| Female | 41% | 36% | 33% | 37% |
| Male | 59% | 64% | 67% | 63% |
| Race Categories | | | | |
| American Indian/Native Alaskan | 3% | 1% | 3% | 5% |
| Asian | 4% | 4% | 2% | 3% |
| Black/African-American | 17% | 19% | 17% | 22% |
| Latino/Hispanic | 3% | 2% | 2% | 5% |
| Pacific Island/Native Hawaii | 0% | 0% | 0% | 0% |
| White/Caucasian | 71% | 70% | 73% | 63% |
| No Entry | 0% | 0% | 0% | 0% |
| Other | 2% | 3% | 2% | 2% |
| Age Categories | | | | |
| 18-21 years | 12% | 9% | 11% | 11% |
| 22-44 years | 47% | 50% | 53% | 55% |
| 45-64 years | 33% | 34% | 28% | 27% |
| 65+ years | 8% | 6% | 9% | 6% |
| Total episodes | 538 | 480 | 422 | 366 |

**Table 10: Demographics of People Served at AMRTC for All AMRTC Episodes Discharged in FY2010-FY2013**

### 2. Region of origin

AMRTC tracks the county that is financially responsible for each admitted patient. While this is not a perfect indicator of a client's home community, it is the best measure available to indicate where clients come from. Because the numbers of people from rural counties is so small, the data for Greater Minnesota counties are presented in Adult Mental Health Initiative Regions. These regions were formed by legislation in 1995 to fund and promote collaboration among counties in planning regional mental health and substance use disorder services. Appendix E includes a list of the counties in each of the regions.

| County/Region | FY2010 | % FY2010 | FY2010 | % FY2011 | FY2012 | % FY2012 | FY2013 | % FY2013 | 4-year ave. % | % State Pop.[68] |
|---|---|---|---|---|---|---|---|---|---|---|
| Metro Counties | 418 | 77.7% | 351 | 73.1% | 282 | 66.8% | 247 | 67.5% | 71.3% | 54.0% |
| Anoka | 50 | 9.3% | 47 | 9.8% | 35 | 8.3% | 26 | 7.1% | 8.6% | 6.2% |
| Carver | 7 | 1.3% | 6 | 1.3% | 4 | 0.9% | 5 | 1.4% | 1.2% | 1.7% |
| Dakota | 33 | 6.1% | 33 | 6.9% | 15 | 3.6% | 21 | 5.7% | 5.6% | 7.5% |
| Hennepin | 189 | 35.1% | 154 | 32.1% | 137 | 32.5% | 130 | 35.5% | 33.8% | 21.9% |
| Ramsey | 118 | 21.9% | 88 | 18.3% | 79 | 18.7% | 53 | 14.5% | 18.4% | 9.6% |
| Scott | 6 | 1.1% | 6 | 1.3% | 6 | 1.4% | 1 | 0.3% | 1.0% | 2.5% |
| Washington | 15 | 2.8% | 17 | 3.5% | 6 | 1.4% | 11 | 3.0% | 2.7% | 4.5% |
| Greater MN AMHI Regions | 118 | 22.3% | 120 | 26.9% | 134 | 33.2% | 117 | 32.0% | 28.6% | 45.6% |
| BCOW | 5 | 0.9% | 14 | 2.9% | 6 | 1.4% | 11 | 3.0% | 2.1% | 2.9% |
| CommUNITY | 15 | 2.8% | 19 | 4.0% | 21 | 5.0% | 14 | 3.8% | 3.9% | 7.5% |
| CREST | 16 | 3.0% | 24 | 5.0% | 23 | 5.5% | 19 | 5.2% | 4.7% | 7.8% |
| Northwest MN 8 | 6 | 1.1% | 4 | 0.8% | 7 | 1.7% | 8 | 2.2% | 1.4% | 1.7% |
| Region 2 | 4 | 0.7% | 3 | 0.6% | 5 | 1.2% | 3 | 0.8% | .8% | 1.4% |
| Region 3 North | 18 | 3.3% | 13 | 2.7% | 18 | 4.3% | 16 | 4.4% | 3.7% | 5.7% |
| Region 4 South | 3 | 0.6% | 2 | 0.4% | 5 | 1.2% | 1 | 0.3% | .6% | 1.3% |
| Region 5 + | 14 | 2.6% | 10 | 2.1% | 12 | 2.8% | 6 | 1.6% | 2.3% | 3.3% |
| Region 7 East | 10 | 1.9% | 3 | 0.6% | 9 | 2.1% | 7 | 1.9% | 1.6% | 3.0% |
| SCCBI | 10 | 1.9% | 16 | 3.3% | 14 | 3.3% | 17 | 4.6% | 3.3% | 5.7% |
| Southwest 18 | 17 | 3.2% | 12 | 2.5% | 14 | 3.3% | 15 | 4.1% | 3.3% | 5.3% |
| Unknown | 2 | 0.4% | 9 | 1.9% | 6 | 1.4% | 2 | 0.5% | 1.1% | |
| Total Episodes | 538 | | 480 | | 422 | | 366 | | | |

**Table 11: Region/County of Origin of People Served in all Episodes of Care Discharged from AMRTC in FY2010-FY2013**

Table 11 indicates that Greater Minnesota represented an increasing percentage of people served at AMRTC between FY2010 and 2012, but that this leveled off in FY2013. A disproportionately high number of people served at AMRTC continue to come from Hennepin County, relative to the county's percentage of the state's population.

### 3. Diagnosis

People admitted to AMRTC are given a primary psychiatric diagnosis, and almost all have co-occurring diagnoses (mental illnesses, substance use disorders, intellectual disabilities, and physical illnesses). Table 12 shows the percentage of episodes that had a diagnosis in each of the categories listed for all the episodes of care at AMRTC during FY2010-FY2013. For more information about the categorization of diagnoses, see Appendix G.

[68] U.S. Bureau of the Census, population estimates for July, 2011 (the latest available).

| Diagnosis Category | FY2010 | FY2011 | FY2012 | FY2013 | Average |
|---|---|---|---|---|---|
| Schizophrenia | 59% | 58% | 51% | 58% | 56% |
| Major Depression and Affective Conditions | 26% | 25% | 31% | 29% | 28% |
| Other Psychoses | 8% | 10% | 14% | 16% | 12% |
| Neurotic and Other Depressive Conditions | 10% | 7% | 8% | 11% | 9% |
| Personality Conditions | 26% | 29% | 24% | 25% | 26% |
| Drug Abuse | 25% | 24% | 24% | 28% | 25% |
| Alcohol Abuse | 51% | 58% | 60% | 58% | 57% |
| Intellectual Disabilities | 4% | 6% | 9% | 7% | 6% |
| Physical Illness | 10% | 9% | 14% | 13% | 11% |
| Total episodes | 538 | 480 | 422 | 366 | 1,806 |

**Table 12: Categories of Diagnoses in Episodes of Care Discharged from AMRTC in FY2010-FY2013**

Table 12 shows that in about 57 percent of AMRTC episodes of care the person had a diagnosis of alcohol abuse and in about 25 percent he or she had a diagnosis of drug abuse. Because many individuals had both, the percentage of episodes in which the person had some diagnosis of substance use disorder was 62 percent.

### 4. Legal status at admission

Almost every patient at AMRTC is committed to the Commissioner of DHS or is in the process of commitment. Minnesota statute allows for six types of commitment as Mentally Ill, Developmentally Disabled, Chemically Dependent, Mentally Ill and Dangerous, Sexual Psychopathic Personality, and Sexually Dangerous Person. People committed as Sexual Psychopathic Personalities or Sexually Dangerous Persons are treated in the Minnesota Sex Offender Program. People who are committed as Mentally Ill and Dangerous are transferred to the Minnesota Security Hospital. There are also a few people at AMRTC for *competency restoration*, a type of treatment that prepares people who have been accused of crimes to understand and participate in their legal process.

| Legal Status Category | FY 2010 | % | FY 2011 | % | FY 2012 | % | FY 2013 | % | 4-Yr Total | Total % |
|---|---|---|---|---|---|---|---|---|---|---|
| Voluntary | 2 | 0.4% | 5 | 1.0% | 0 | 0.0% | 0 | 0.0% | 7 | 0.4% |
| Emergency & Judicial Holds | 24 | 4.5% | 33 | 6.9% | 19 | 4.5% | 19 | 5.2% | 95 | 5.3% |
| Commitment-Mental Illness (MI) | 405 | 75.3% | 348 | 72.5% | 300 | 71.1% | 273 | 74.6% | 1,326 | 73.4% |
| Commitment-Developmental Disability (DD) | 3 | 0.6% | 4 | 0.8% | 8 | 1.9% | 2 | 0.5% | 17 | 0.9% |
| Commitment-Chemical Dependency (CD) | 2 | 0.4% | 4 | 0.8% | 2 | 0.5% | | 0.0% | 8 | 0.4% |
| Commitment-MI/CD | 57 | 10.6% | 48 | 10.0% | 61 | 14.5% | 45 | 12.3% | 211 | 11.7% |
| Commitment-MI/DD | 2 | 0.4% | 5 | 1.0% | 13 | 3.1% | 6 | 1.6% | 26 | 1.4% |
| Commitment-MI/DD/CD | | 0.0% | 1 | 0.2% | | 0.0% | | 0.0% | 1 | 0.1% |
| Commitment-MI & D Initial | 1 | 0.2% | 1 | 0.2% | 1 | 0.2% | 1 | 0.3% | 4 | 0.2% |
| Treat to Competency-Rule 20.01 | 11 | 2.0% | 7 | 1.5% | 11 | 2.6% | 13 | 3.6% | 42 | 2.3% |
| Court Authorized Neuroleptics | 31 | 5.8% | 24 | 5.0% | 7 | 1.7% | 7 | 1.9% | 69 | 3.8% |
| Total | 538 | | 480 | | 422 | | 366 | | 1,806 | |

**Table 13: Legal Status at Admission of Episodes Discharged from AMRTC in FY2010-FY2013**

### 5. Living arrangements prior to admission

When people are admitted to AMRTC, intake staff members attempt to identify the type of living arrangements they came from. In many cases, staff do not have the information to answer this question and thus list either the hospital the patient was referred from (which is not really a living arrangement) or enter "unknown" or "other." DCT is working to improve the reliability of this coding, but the data is included here because it offers a sense of some people' circumstances before admission. About a third of people served at AMRTC were living at home before they were admitted, about ten percent were in assisted permanent housing, and small but growing percentages were in Intensive Residential Treatment Services or correctional facilities.[69]

| Living Arrangement Category | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|
| Assisted Permanent Housing | 11% | 11% | 10% | 10% |
| Home | 36% | 32% | 34% | 30% |
| Hospital | 27% | 29% | 20% | 21% |
| Intensive Residential Treatment Services (IRTS) | 4% | 3% | 6% | 9% |
| Jails/Corrections | 2% | 3% | 3% | 6% |
| MN Security Hospital | 1% | 1% | 1% | 2% |
| No Permanent Address | 11% | 7% | 8% | 5% |
| Other or Unknown | 8% | 14% | 18% | 17% |
| Total episodes | 538 | 480 | 422 | 366 |

**Table 14: Living Arrangements Prior to Admission for People Discharged from AMRTC in FY2010-FY2013**

[69] "Assisted permanent housing" includes assisted living facility, foster care, nursing home, board and care, and board and lodge. "Home" includes the patient's own home or the home of friends or family. "Jail/Corrections" includes local, county, or state jails and prisons.

### 6. Discharge living arrangements

Many people discharged from AMRTC continue to need assistance after they leave. While some can pursue recovery in their homes with the help of community support services, others need residential placements as a transition back to the community. The living arrangements to which people are discharged can have a big impact on whether they are able to successfully pursue recovery in their communities and avoid readmission to a psychiatric hospital. Table 15 shows that most people served at AMRTC are discharged to various forms of assisted permanent housing (foster care, board and lodge, assisted living, or nursing home).

| Living Arrangement Category | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|
| Foster Care | 19% | 18% | 17% | 25% |
| Intensive Residential Treatment Services (IRTS) | 27% | 21% | 31% | 21% |
| Home | 21% | 20% | 17% | 18% |
| Board & Lodge / Board & Care | 5% | 10% | 7% | 9% |
| Assisted Living Facility | 4% | 7% | 6% | 6% |
| MN Security Hospital | 7% | 4% | 6% | 4% |
| Community Addiction Recovery Enterprise (C.A.R.E.) | 0% | 3% | 2% | 4% |
| Nursing Home | 5% | 4% | 4% | 3% |
| Jails/Corrections | 3% | 2% | 3% | 2% |
| Another Hospital | 4% | 6% | 1% | 1% |
| Other & Unknown | 7% | 6% | 7% | 7% |
| Total episodes | 538 | 480 | 422 | 366 |

**Table 15: Discharge Living Arrangements of People Discharged from AMRTC in FY2010-FY2013**

As Minnesota has closed regional treatment centers and transferred their funding to community-based services, AMRTC has taken on an increasingly crucial role in serving the target population. While several larger community hospitals also operate psychiatric units that serve people with serious mental illnesses and complex co-occurring conditions, AMRTC is the safety net hospital for the most psychiatrically complex people in the state (except those who have committed violent crimes and been deemed by a court to be Mentally Ill and Dangerous and sent to the Minnesota Security Hospital). Every person served at AMRTC has been determined by a court to be a threat to public or personal safety, and while some community hospitals also serve some people committed to the Commissioner, community hospitals refer the most challenging and clinically complex people to AMRTC.[70]

Providing acute care for this population is expensive and challenging. Very specialized psychiatric staffing is required, and there is a high risk of staff and patient injuries. Most community hospitals (including DCT's Community Behavioral Health Hospitals) are not structured to provide the levels of psychiatric specialization, physical medicine, and security

[70] These referrals are partly due to the treatment and security needs that these patients present for community hospitals; they are also due to complex financial arrangements that can leave hospitals responsible for weeks or months of expensive and uncompensated care.

needed to serve these people well while also assuring the safety of their staff and other patients. They rely on the availability of beds at AMRTC so that they can quickly move people in the target population from their emergency rooms to AMRTC. Jails also count on AMRTC to take people whose criminal behavior is determined to be the result of mental illness (a new law requires that AMRTC accept referrals from jails within 48 hours of referral). Because of insufficient capacity in the service system, there are lengthy waiting lists for AMRTC beds.

## C. Overview of Patient Flow Challenges

The gaps in Minnesota's service system for the target population cause several problems related to patient flow at AMRTC (and community hospitals):

- **Wait lists**: The waiting list at AMRTC fluctuated between 60 and 100 people between October and December of 2013. Long waiting lists for admission to AMRTC cause people to wait for a bed, forego services, or to receive services in sub-optimal settings, including emergency rooms and jails. Hospitals use the term "psychiatric boarding" to describe this problem.
- **Cycling**: A small number of people with complex needs are frequent users of AMRTC (and community providers). They cycle in and out of emergency rooms, acute care hospitals, and crisis services and do not attain the community stability that would support their recovery.
- **People "stuck" at AMRTC**: People discharged from AMRTC in FY2013 spent about 13,800 days during their treatment episodes at AMRTC when they did not meet criteria for a hospital level of care.[71] This impedes recovery and wastes public and private funds. Assuming an average length of stay of 99 days, these bed days could have allowed an additional 140 people to be treated at AMRTC if people had been discharged as soon as their treatment was completed. Common discharge barriers include a lack of appropriate community services, supports, and housing, as well as inefficient legal and funding processes and inadequate care coordination. Less common barriers include problematic immigration status, lack of highly specialized medical services, and the unique financial situations of some clients.

These three challenges will be examined in detail in the next chapter. The challenges are all *systemic* issues: they are the result of many weaknesses across the service system. Figure 3 depicts the barriers that can prevent people in the target population from receiving the right care at the right place and time. It illustrates the systemic nature of Minnesota's patient flow challenges: barriers in one part of the system reinforce barriers in other parts of the system. Lack of adequate community services can prevent people from timely discharges from inpatient hospitals. These "stuck" people remain in beds that are thus unavailable for other individuals

[71] These days are called "non-acute bed days." This measure is explained in more detail in Section VII-C-1.

who need them. When rapid access to specialized psychiatric hospitals (especially AMRTC and the Community Behavioral Health Hospitals) is not available, people needing inpatient care often wait in inappropriate settings, including jails, emergency rooms, and community providers.

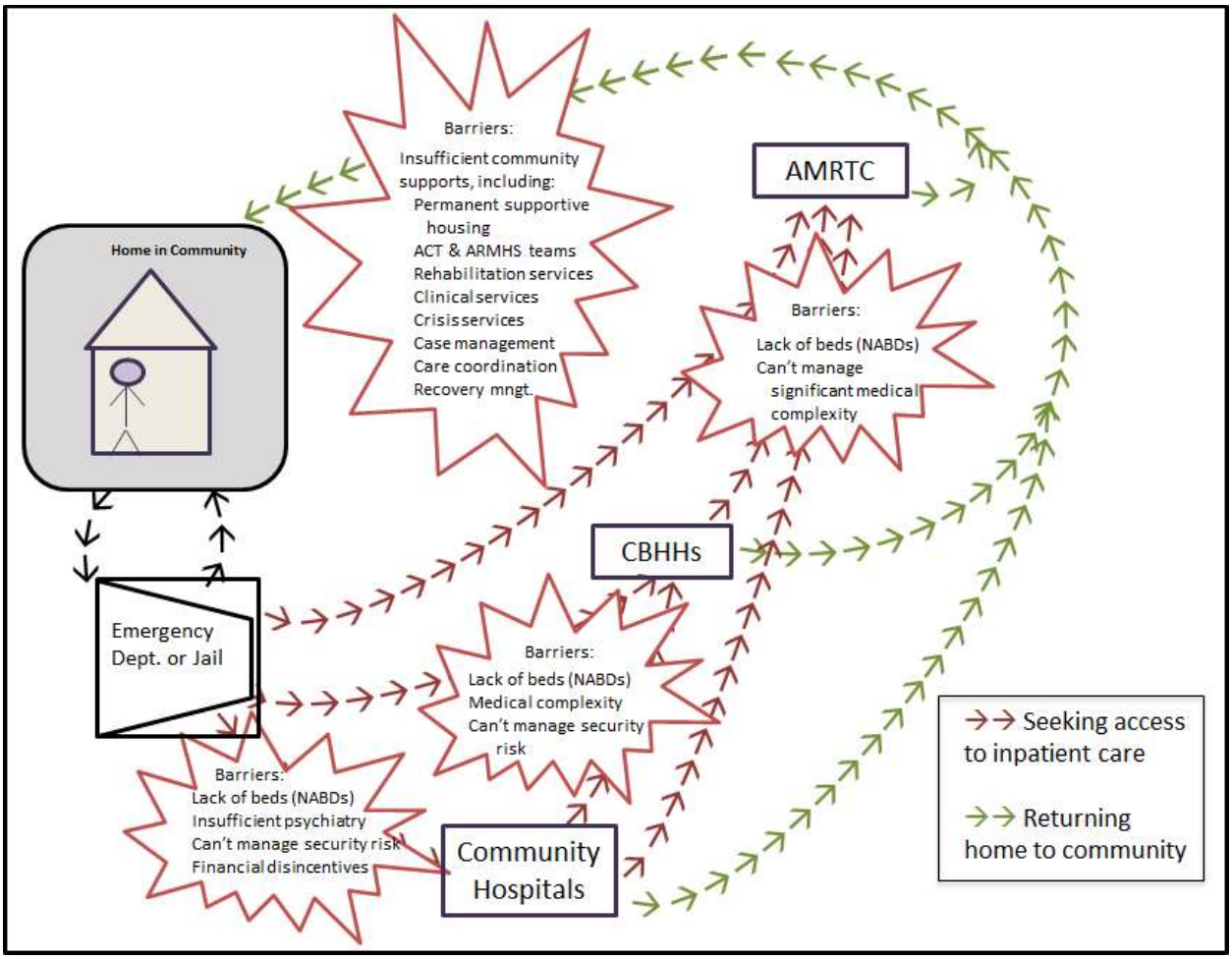



**Figure 3: Barriers in the Inpatient Care Path for People in the Target Population (NABD = Non-Acute Bed Day)**

## VII. Analysis of Patient Flow Challenges

This chapter looks in more detail at the three patient flow challenges identified in the previous chapter: AMRTC's long waiting list, people who cycle repeatedly through inpatient hospitals and people who get "stuck" in inpatient hospitals even after they no longer need a hospital level of care.

### A. People on the Waiting List

In the spring of 2012, the list of people waiting for beds at AMRTC topped 100 people for the first time. It declined to as low as 60 people during the rest of 2012, but topped 100 in October 2013 before falling below 80 in December 2013. Table 16 shows that the amount of time that people wait for a bed at AMRTC has increased significantly since FY2010. To identify

appropriate solutions to the long waiting list and achieve a service system that can provide the right services at the right place and time for people in the target population, it is important to understand the complexity behind AMRTC's waiting list.

| | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|
| Average of Days from Referral to Admission to AMRTC | 19.2 | 20.7 | 23.9 | 30.1 |

**Table 16: Average Days from Referral to Admission for People Discharged from AMRTC in FY2010-FY2013**[72]

### 1. How the waiting list works

#### *a. Referral to AMRTC*

When an individual in the target population enters an emergency room or jail and an initial assessment indicates that they need acute psychiatric treatment, a decision must be made as to whether the individual poses such a threat to self or others that her or she should be committed to the Commissioner of DHS (thus losing the right to decline care). County social workers can, and usually do, refer people to AMRTC as soon as the commitment process has begun, but those people do not receive admission priority until they are actually committed to the Commissioner.

There are implicit financial, legal, and risk-related incentives for county and tribal social services, courts, and community hospitals to seek commitment and referral to AMRTC for some individuals. These include:

- **Safety risk:** If case managers, court officials, law enforcement personnel, or hospital staff are concerned that an individual is at risk of hurting himself or herself, hurting someone else, or damaging property, one way to mitigate that risk is to encourage referral of the person to AMRTC so that the state will then assume and manage that risk. Some consider the state to be much more capable of taking on such risk than a small county or community hospital. In a rural county that has very few community-based services, decision-makers sometimes feel that it is safer for the individual to go to, or remain at, AMRTC than being served locally, even if the patient does not meet criteria for the level of services provided at AMRTC. A few decision-makers still operate within the mind-set of the old Regional Treatment Center model, assuming that individuals in the target population belong at AMRTC even though AMRTC has long since shed its old RTC institutional role.
- **Financial risk**: Counties, tribes, and hospitals have limited budgets, and individuals in the target population sometimes need services that can be complex and costly to provide. These can require increased staffing ratios, specialized staff, specialized equipment, and physical plant changes, as well as posing the possibility of having to provide uncompensated care. For small counties, tribes, or hospitals, these costs for just one or

[72] The date that the patient is first referred to AMRTC until the date the patient is admitted to AMRTC.

two individuals can be higher than the entire annual budget for such arrangements. Some clients' circumstances pose even more financial risk for providers and counties. Clients who have dementia but lack legal guardians; people with very complex medical challenges (e.g., cancer); people with complex situations that complicate eligibility for MA and waiver funds; and undocumented workers are examples of categories of people who pose high financial risk of protracted legal processes and uncompensated care.

- **Legal risk**: In an increasingly litigious society, the risks described above can have legal consequences that only compound the costs for counties, tribes, courts, and hospitals. While the Americans with Disabilities Act and Minnesota's Olmstead Plan now present legal risks in the other direction—by making it illegal to commit someone unnecessarily or serve someone in an unnecessarily restrictive setting—there have been very few such cases in Minnesota so far.
- **Public opinion risk**: There is a great deal of stigma surrounding mental illnesses, and county or tribal officials and community hospitals can be especially hesitant to serve a high profile client with a violent or sexual predator history without state involvement for fear of the public response. A county attorney, for example, might have to risk negative public opinion that could affect his or her career when deciding to place a client whose symptoms include aggressive behaviors in a local hospital.

### *b. Managing the waiting list*

Once people are referred to ARMTC, DCT's Central Preadmission unit gathers medical and related information to create a referral record. Referrals are prioritized based on several factors, with people under civil commitment who are waiting in jail having the highest priority and people on revoked provisional discharges having second priority.[73] The lowest priority are people on the waiting list whose whereabouts are unknown by their social worker (usually less than 5 percent of the names on the list).

| | Admitted | Deferred | Denied | Deferred & Denied | Not a Referral | Referral Hand Off | Status TBD | Total |
|---|---|---|---|---|---|---|---|---|
| Number | 350 | 797 | 17 | 814 | 11 | 6 | 50 | 1,231 |
| Percent | 28% | 64% | 1% | 65% | 0% | 0% | 4% | |

**Table 17: AMRTC Waiting List in CY2013**

Table 17 shows that AMRTC opened 1,231 referral records in CY2013. Eleven of these turned out to be informational calls and not real referrals ("not a referral"). Six were handed off to DCT's IRTS program ("referral hand off") and 17 were denied because the patient did not meet the criteria for admission to AMRTC. The status of 50 of the records was not yet determined on

[73] Revoked provisional discharges are cases in which a civilly-committed person has been discharged with requirements set by the court (for example, that the person will attend substance use disorder outpatient treatment) and the person has not fulfilled the requirements so the provisional discharged has been revoked, sending the person back to the hospital.

December 31st, 2013. Of the remaining referrals, 350 were admitted to AMRTC, and 797 were deferred to other locations. This means that about two-thirds (64 percent) of the people on the AMRTC waiting list were deferred to other locations before they could be admitted. Most were stabilized in the hospital where they were waiting and were discharged to less-acute settings.

There are conflicting perspectives on AMRTC's high percentage of deferrals. Some see this as a sign that the deferred referrals did not truly require AMRTC's level of service and were thus sent to other more appropriate community facilities.[74] Others say that most deferred people *were* appropriate for AMRTC, and that they were sent to other, less-appropriate facilities because this solution was better than forcing them to continue to wait for a bed at AMRTC. What cannot be denied is that truly patient-centered care would not entail long waits for a bed in an appropriate facility, and that Minnesota's service system for the target population is currently forcing people to wait.

How long people wait depends upon many factors: where they are waiting, the severity of their symptoms, and the availability of beds in the particular unit they are waiting to get into. Table 18 shows that the average wait times (from date of first referral call to Central Preadmission to date of admission to AMRTC) varies by what unit the patient is waiting for. While the wait times for all units have been increasing, the Medical/Psychiatric unit and the Complex Co-Occurring units have much longer wait times than the other two units. The Medical/Psychiatric unit's average wait times had a huge increase from FY2012 to FY2013, from 26 days to 47 days. The increase mirrors significant increases in both the average length of stay and the average number of non-acute bed days in that unit from FY2012 to FY2013.

| Units at AMRTC | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|
| Unit B: Medical-Psychiatric | 19 | 23 | 26 | 47 |
| Units C & E: Complex Co-Occurring | 21 | 25 | 32 | 33 |
| Units D: Neurocognitive | 21 | 22 | 22 | 23 |
| Units G & H: Intensive Behavioral | 19 | 12 | 15 | 19 |

**Table 18: Wait Times (in days) for Units at AMRTC**

### 2. What happens when people wait for beds at AMRTC

Individuals waiting for beds at AMRTC wait in emergency departments, community hospitals, DCT's own Community Behavioral Health Hospitals, IRTS, jails, and their own homes. Several problems can arise during these waits. According to one psychiatrist from a community hospital in rural Minnesota,

[74] For example, patients referred to AMRTC from community hospitals because the patient's care was not reimbursable may have been receiving appropriate care; the deferral created a financial burden for the hospital, but not inadequate treatment for the patient.

> *". . . [W]e must focus on the elephant in the room and talk about the biggest problem for the entire system: Insufficient capacity for the State to provide care for the highest utilizers and most severely mentally ill patients (i.e., those with longer-term symptom severity and / or violent-aggressive patients). The State is and should be the provider of last resort and when they shirk their responsibility, the entire system gets jammed up. When patients cannot go to a State facility due to insufficient capacity, they remain in our community hospital unit, taking up a bed and consuming resources at a higher rate than they would in a State facility. When those beds are taken up (and those resources used up) by community hospitals providing care of the State-responsible patients, then that leaves fewer psychiatric resources and beds to provide preventative care to those patients who are less severe and acute – thus increasing their potential to escalate and move into the SPMI group themselves.*
>
> *Having patients spend 30+ days in a community hospital before they can get into the State system is one example of the state having insufficient capacity to fulfill their mandate. Having 60 percent of patients in a community hospital who are in the commitment process is an example of the state having insufficient capacity to fulfill their mandate. Those figures are based upon our current actual experience. Community hospitals do not get reimbursed for the vast portion of these lengthy stays while these patients are awaiting adjudication; this occurs regardless of whether the patient is in a prolonged, severely acute (read: violent / aggressive) condition, or has clinically stabilized and no longer meets acute inpatient psychiatric hospitalization criteria, but is court-ordered to be held on the community hospital unit through – and sometimes beyond – commitment adjudication."*

The following sections explore some of the impacts described by this community hospital psychiatrist.

### *a. Psychiatric boarding*

When individuals are brought to an emergency room and a mental illness is suspected, the individual usually waits in the emergency department for an initial assessment. Some individuals return home after a few hours, and others are admitted to the hospital for treatment. But if the local hospital cannot serve the individual, he or she can enter a frustrating limbo of waiting for a bed at another facility, including AMRTC. "Psychiatric boarding" is the practice of holding admitted patients in emergency department (ED) areas, including hallways, until an inpatient psychiatric bed becomes available.[75] A nationwide 2008 survey of emergency department physicians reported that 79 percent believed their hospitals "boarded" psychiatric patients in their emergency department, and community hospitals in Minnesota have complained

[75] David Bender, Nalini Pande, and Michael Ludwig, *A Literature Review: Psychiatric Boarding* (Washington, D.C.: U.S. Department of Health and Human Services, October 29, 2008), 1.

bitterly about the lack of state facilities that forces them to board people in psychiatric crisis.[76] Many smaller hospitals do not have psychiatric units and their emergency departments are not designed or staffed to care for patients with acute psychiatric symptoms.

When county or tribal case managers and hospital staff are not able to find an appropriate inpatient setting for an individual waiting in an emergency department, the hospital is forced to either board the individual in the emergency department or admit them to one of their physical medicine units. Both of these options can lead to severe disruptions and security risks for the individual, staff, and other people being served at the hospital, as well as financial difficulties:

- Emergency rooms are stressful and noisy; this difficult environment can exacerbate the symptoms of the person with mental illness, the very opposite of recovery-oriented care.
- The person with mental illness can cause disruptions that hinder operation of the ED, which threatens the health and safety of everyone in the ED.
- If an individual with mental illness is exhibiting symptoms of self-harming or aggressive behaviors, these can threaten the care and safety of the individual, staff, and other patients. In some cases, hospitals are forced to hire a security guard for round-the-clock observation, which is expensive, intimidating, and does not contribute to the recovery of the patient or others on the unit.

#### *b. People served in community hospitals*

Most people admitted to AMRTC have been waiting for that bed while being treated in a community hospital. As Table 17 showed, almost two-thirds of the people on the AMRTC waiting list are deferred to other locations; many of those are treated at a community hospital and discharged before a bed at AMRTC becomes available. Community hospitals often resent having to serve people who have been referred to AMRTC; they believe that it is the state's role to take people once they have been committed to the Commissioner. Treating people under commitment poses these difficulties for community hospitals:

- Lack of specialized staff: Some community hospitals lack staff with the specialized psychiatric training that is needed to successfully treat people with complex, acute needs.
- Capacity constraints: Waiting people take up beds that would otherwise be available for the hospital's other patients.
- Security risks: People with symptoms of self-harm or aggressive behaviors pose a security risk that many community hospitals are unprepared to handle. Responding to these risks pulls staff away from their other patients. Because staff are not always trained—and their units were not designed—to serve people whose symptoms include aggressive behaviors, damage to property and physical injuries can result.

[76] *ACEP Psychiatric and Substance Abuse Survey* (Irving, TX: American College of Emergency Physicians, 2008), 1.

- Hospitals are reimbursed by Medical Assistance according to "diagnosis-related groups" or DRGs. The DRG system establishes criteria for the reimbursement that a hospital receives based upon characteristics of the patient, diagnoses, and comorbidities. Often patients in psychiatric boarding stay much longer and are much more expensive than the DRG-based reimbursement that the hospital receives. This uncompensated care is very financially challenging for hospitals.
- Uncompensated care: Community hospitals get caught in the same bind as other hospitals when they have a patient for whom no community placement can be found after treatment is complete. Once the patient no longer meets criteria for a hospital level of care, the hospital can no longer seek reimbursement from Medical Assistance for their care. For small hospitals, this can be a significant financial burden. There is a process for "remote provisional discharge," in which AMRTC (which is legally responsible for the committed patient's care) can give permission for the patient to be provisionally discharged, but this process can take time to complete.

### *c. Individuals in jail*

A great deal of media attention has been given to the growing number of adults in Minnesota jails and prisons who have severe mental illnesses.[77] Jails and prisons are legally responsible for the medical care of all inmates under their jurisdiction, which includes mental health and substance use disorder services. Even though they are legislatively mandated to provide mental health services for inmates who need them, county jails across the state sometimes fail to provide adequate mental health services.

For inmates who have been arrested, tried, and convicted of a serious crime, their treatment for mental illnesses and substance use disorders is usually provided through the corrections system. However, when law enforcement officers first encounter an individual, there are a few decision points that determine whether the individual will be taken into the criminal justice system or into the mental health system. The first is when law enforcement responds to a call. They assess the situation and decide whether the individual should be taken to jail, an emergency room, or a mental health crisis center (if there is one locally). The latter two locations lead directly to the mental health system.

If an individual is taken to jail, however, it is still possible that the person will be diverted to the mental health system. This can occur when law enforcement, corrections, or court personnel witness behavior that leads them to believe that mental health issues might be contributing to the individual's alleged criminal behavior. They can request a psychological evaluation, the results

[77] Paul McEnroe and Glenn Howatt, "Left in Limbo, Hundreds of Minnesotans with Mental Illness Languish in Jail," *Star Tribune*, September 8, 2013, accessed on December 20, 2013 at http://www.startribune.com/lifestyle/health/222828641.html; Paul McEnroe and Glenn Howatt, "Minnesota Jails Fail Inmates with Mental Illness, with Deadly Consequences," *Star Tribune*, November 23, 2013, accessed on December 20, 2013 at http://www.startribune.com/local/minneapolis/233106911.html

of which can lead them to drop charges against the individual and refer him or her to the mental health system, and/or begin the commitment process. If this happens, individuals can end up waiting in a jail for a psychiatric bed at AMRTC or a community hospital. This whole process (from initial contact with law enforcement until admission to a hospital) can take two months or more.[78] Meanwhile the individual waits in jail, hopefully (but not always) receiving psychiatric treatment as mandated by law. Legislation passed in 2013 requires that people referred to AMRTC from jail be admitted within 48 hours, but this 48-hour clock often starts ticking only after the individual has been waiting for weeks or months. This has negative impacts:

- The individual may not receive adequate psychiatric care while in jail. In the worst cases, this can lead to self-harm, assaults by other patients, or assaults on other patients or staff.
- Inadequate psychiatric care presents a significant liability risk if inmates or staff are injured while someone waits to receive appropriate services.

### 3. The appropriate number of acute psychiatric beds

Long waits for acute care beds would seem to indicate that the state does not have enough beds to serve all the people who need care. Determining the appropriate number of acute psychiatric beds is difficult because the need for beds is affected by so many factors and the beds are provided by public and private providers who do not collaborate to determine total capacity or need. The factors affecting availability include:

- The number of beds currently licensed, funded, and staffed in both community hospitals and state-operated hospitals.
- The availability of housing and support services in the community that allows people to be discharged when they no longer meet criteria for a hospital level of care.
- The effectiveness of community services and supports in helping clients to remain stable in the community so that they do not need psychiatric hospital care.
- The effectiveness of crisis services that can help people resolve situations that would otherwise have led to a need for hospitalization.

In 2012, a report from the Treatment Advocacy Center brought national attention to the psychiatric bed capacity issue, claiming that states had cut the number of residential treatment centers so drastically that people could not gain access to acute psychiatric care and were being left untreated on the streets, in their own homes, in jails, and other inappropriate community

[78] According to a *Start Tribune* analysis of the experience of nearly 100 inmates jailed in Hennepin County and subsequently evaluated for commitment, the inmates waited, on average, more than a month to receive a psychiatric evaluation and another 36 days for the examiner to submit the findings of the evaluation. Then they waited a week for the court to open the commitment case, and an additional 30 days for the judge to decide whether to commit the inmate to the Commissioner. "Left in Limbo, Hundreds of Minnesotans with Mental Illness Languish in Jail," ibid., 1.

settings.[79] This report provided very misleading information about the situation in Minnesota because it under-represented the number of psychiatric beds in Minnesota (by not counting the beds in private hospitals) and the community services (including ACT teams and IRTS) that have been created in Minnesota to decrease the need for acute psychiatric care in hospitals. As a result, the report listed Minnesota near the bottom in the number of available psychiatric beds per capita, failing to acknowledge that counting psychiatric beds is a very poor indicator for the availability and quality of services. Because Minnesota has moved quicker than many other states to close its institutions and embrace community integration, its reliance on community settings means that it should need a smaller number of acute beds.

While most stakeholders agree with Minnesota's embrace of community integration in general, almost everyone agrees that there is a current problem with a shortage of psychiatric beds for the target population in Minnesota. Table 19 indicates that Minnesota's acute psychiatric beds were 93-95 percent full in FY2013. Most hospital administrators would consider this too full because there needs to be some slack in the system in order for admissions and discharges to flow smoothly even at peak times. Assistant Commissioner Dave Hartford suggests that between 85 percent and 90 percent of capacity would provide substantially improved access to community psychiatric beds.

The long waiting list at AMRTC indicates that the shortage is especially problematic for people in the target population. One community hospital administrator responded to an early draft of this report with this comment:

> *"Based on the analysis of the 'target population,' does AMRTC have enough beds to accommodate these admissions, based on their average length of stay? I agree with many who believe that we have enough inpatient hospital bed capacity between the CBHHs and private/county hospitals, but I am less sure about the capacity for the target complex patients, who are the ones who truly tax our resources."*

While the solution may look obvious—staff and fund more beds—it is not that simple. The following two sections describe two intervening problems, both of which cause inappropriate over-use of the available beds. Many stakeholders believe that the best solution for Minnesota is not to build more beds, but to use the ones that are already available more appropriately.

[79] *No Room at the Inn: Trends and Consequences of Closing Public Psychiatric Hospitals, 2005-2010* (Arlington, VA: Treatment Advocacy Center, July 19, 2012).

| Hospitals | Average Psychiatric Beds Available in FY2013 | Average Utilization in FY2013 |
|---|---|---|
| Community Psychiatric Hospital Beds[80] | 680 | 93.6% |
| State-operated Community Behavioral Health Hospitals | 98 | 93% |
| AMRTC | 110 | 96% |
| Total | 892 | |

**Table 19: Acute Psychiatric Hospital Beds in Minnesota**

## B. People with Frequent Episodes of Care

A second problem related to patient flow at AMRTC is that some people cycle through AMRTC and community hospitals over and over. They receive treatment and are discharged, but they do not remain stable in the community and are soon back in the hospital. For all but the most psychiatrically complex people, frequent inpatient hospital stays are an indication that the person's recovery is not being adequately supported. Frequent inpatient episodes are disruptive and difficult for the people being treated and their families, they are costly, and they tie up inpatient beds.

From FY2010 through FY2013, there were 1,806 episodes of care discharged from AMRTC. They were spent by 1,392 different people, which means that the average person had about 1.3 episodes at AMRTC over the four years, or .32 episodes at AMRTC per year. Table 20 shows how the episodes were distributed. The vast majority of people had just one episode of care. About 80 people had three or more episodes of care at AMRTC during the four-year period. These figures understate the actual number of times that people served at AMRTC were in an out of psychiatric hospitals, however, because they do not show their episodes at private community hospitals or the state-operated Community Behavioral Health Hospitals (CBHHs) during the same time period.

| # of Episodes during FY2010-FY2013 (four years) | # of People Who Had That Many Episodes |
|---|---|
| 12 | 1 |
| 11 | 1 |
| 5 | 1 |
| 4 | 31 |
| 3 | 46 |
| 2 | 207 |
| 1 | 1,102 |

**Table 20: Episodes of Care at AMRTC during FY2010-FY2013**

[80] Data was obtained from the Minnesota Mental Health Access database (commonly referred to as the "bed tracker" system) which is monitored and maintained by the Minnesota Hospital Association (MHA). Hospitals and bed numbers represent 32 hospitals, and include all beds for adults 18+, including those indicated for geriatric only. The utilization estimate is from weekly compilations of MHA data. Utilization data is created when hospital staff update the bed tracker system by entering the number of beds that are currently available and filled. Hospitals are supposed to update per shift, but MHA reports that not all hospitals are following that rule.

Hospitals count readmissions as a way of monitoring and assessing effective discharge planning and adequate community supports. Readmissions can be defined in a variety of ways, but they are often defined as people returning to the hospital within 30, 60, or 90 days following discharge. Measuring readmissions to AMRTC is a problematic exercise because AMRTC's long waiting list makes it very difficult to get readmitted, meaning that people would usually end up being readmitted to another hospital, not to AMRTC. To find out more about readmissions of people discharged from AMRTC in CY2011, DHS staff reviewed Medical Assistance claims data that captures inpatient visits reimbursed by Medical Assistance.

There were 456 episodes of care that were discharged from AMRTC during CY 2011. These episodes were spent by 417 different people. Using identification numbers and matching on first and last names, DHS staff were able to identify 397 people (from the group of 417) who were enrolled in MA for at least some time during CY2010, CY2011, and CY2012. Of these, 392 had at least one MA claim (for any type of healthcare service) during CY2010-2012. The analysis that follows is based upon the inpatient hospital stays at either DCT facilities or community hospitals for those 392 people during the 3-year period. Thus this data only includes inpatient stays of the 392 people that were provided at AMRTC or one of the CBHHs (regardless of payment) or that were billed to MA by any community hospital. During the 3-year period, the 392 people had a total of 2,175 inpatient hospital stays at any hospital (including AMRTC). This means that the average person had 5.5 inpatient episodes over the three years or about 1.8 episodes per year. This means that in this sample of people, for every inpatient hospitalization the average person had at AMRTC, he or she had about 5 hospitalizations somewhere else.

| **Characteristics of Inpatient Episodes** | | |
|---|---|---|
| Total number of inpatient hospital episodes during 3-year period for the 392 people | | 2,175 |
| Average number of inpatient episodes over the 3-year period for the 392 people | | 5.5 |
| Average number of inpatient episodes per year for the 392 people | | 1.8 |
| Primary Diagnosis Type[81] of the episodes | # | % |
| Developmental Disability | 9 | .4% |
| Physical medicine | 424 | 19% |
| Mental Illness | 1,676 | 77% |
| Substance Use Disorder | 53 | 2% |
| NA | 13 | 1% |

**Table 21: Overview of Inpatient Episodes (at any hospital) of 392 People Who had at Least One AMRTC Episode of Care in CY2011 and at Least One MA Claim in CY2010-2012**

For each of the 2,175 inpatient stays, the number of days since the discharge date of the previous inpatient stay was calculated. Having zero days between episodes was considered a transfer, not a readmission. Stays that were embedded in another stay (for example, when a patient at AMRTC was briefly treated at a community hospital for a physical illness and then returned to AMRTC) were considered embedded stays, not readmissions. If the person's last episode was

[81] When a person is admitted to the hospital, they are assigned a primary diagnosis for that admission. See Appendix G for more explanation of these categories.

less than 90 days before the end of the data set period (12/31/12), the duration of readmission was coded as unknown.

Table 22 shows that 38 percent of the inpatient episodes ended in a readmission within 90 days. It is important to note that this analysis does not determine whether the readmission was preventable or not. It is likely that some of these readmissions were for illnesses unrelated to the diagnosis of the previous stay. For example, among the 652 episodes with a primary diagnosis of mental illness that resulted in a readmission within 90 days, 83 percent of the readmissions were also for mental illnesses. Only 14 percent of the readmissions were for physical illnesses, and 2 percent were for substance use diagnoses.

| **Readmission Categories** | **#** | **%** |
|---|---|---|
| Readmissions | 1,527 | |
| Following stay occurred between 1-6 days | 187 | 9% |
| Following stay occurred between 7-13 days | 141 | 6% |
| Following stay occurred between 14-29 days | 180 | 8% |
| Following stay occurred between 30-90 days | 324 | 15% |
| Following stay occurred after more than 90 days | 695 | 32% |
| Not Readmissions | 563 | |
| Transfer | 502 | 23% |
| Embedded Stay | 61 | 3% |
| Unknown | 85 | 4% |
| Total | 2,175 | |

**Table 22: Readmission Duration for 2,175 Episodes of Care**

Table 23 shows that the readmission duration of the episodes was virtually identical, whether the patient's primary diagnosis was for a physical illness or a mental illness/ substance use disorder/ intellectual disability.

| **Readmissions** | **Physical Medicine Primary Diagnosis** | | **MI, SUD or ID Primary Diagnosis** | |
|---|---|---|---|---|
| Following stay occurred between 1-6 days | 32 | 11.5% | 152 | 12.3% |
| Following stay occurred between 7-13 days | 26 | 9.4% | 114 | 9.2% |
| Following stay occurred between 14-29 days | 32 | 11.5% | 147 | 11.9% |
| Following stay occurred between 30-90 days | 59 | 21.2% | 264 | 21.3% |
| Following stay occurred after more than 90 days | 129 | 46.4% | 563 | 45.4% |
| Total | 278 | | 1,240 | |

**Table 23: Readmission Duration by Episode's Primary Diagnosis**

Table 24 shows that when people were readmitted to a hospital within 90 days of their previous episode, they went back to the same hospital only 44 percent of the time. They went back to a

hospital in the same system only 53 percent of the time.[82] The high number of readmissions and the fact that people were often readmitted to a different hospital or hospital system both highlight the need for collaboration among the various providers of inpatient care in order to prevent people from cycling in and out of inpatient facilities.

| Episodes in which Patient was Readmitted within 90 Days | Readmitted to the same hospital? | % | Readmitted to a hospital in the same system? | % |
|---|---|---|---|---|
| Yes | 365 | 44% | 445 | 53% |
| No | 467 | 56% | 387 | 47% |
| Total | 832 | | 832 | |

**Table 24: Location of Readmission for Episodes that Ended in Readmission within 90 days,**

## C. People with High Non-Acute Bed Days

A key to patient-centered care is assuring that people can move smoothly from acute care settings to less-intensive treatment settings—including their own homes—once they no longer need a hospital level of care. Determining the appropriate setting for each individual is a complex decision that incorporates many factors, including the acuity of their symptoms, the amount of support they have from family and friends, their ability to manage their symptoms, the types of treatment settings that are currently available, the level of recovery supports available, etc. This complexity is compounded by the fact that mental symptoms can vary even during the course of a single day: an individual's symptoms at 10 a.m. might be very different from those displayed at 9 p.m.

### 1. Non-Acute Bed Days as a measure of transition timeliness

Lacking better measures, analysts have focused on the measure of *non-acute bed days* (NABDs) to help understand this problem. Non-acute bed days are days that people spend in a hospital when they do not meet the criteria for a hospital level of care. This measure was not designed to determine the appropriate setting for a patient; it was designed as part of a funding audit process, to assure payers that the inpatient stays they are funding are actually medically necessary. All hospitals are thus required to continually audit the treatment progress of people being treated at the hospital to make sure that they continue to need a hospital level of care as defined by the Centers for Medicare and Medicaid Services (CMS).

At AMRTC, the determination of whether a patient needs a hospital level of care is made by the treating provider through a process of consultation with the Utilization Management (UM) team and the Chief Medical Officer. This process is initiated when staff in the UM team review the charts of patients (approximately every 2 weeks). The first step of the UM review does not

[82] Many hospitals are part of a provider system that can include other hospitals, outpatient clinics, rehabilitation facilities, etc. Larger systems in Minnesota include Allina, Avera, Essentia, Fairview, Healtheast, HealthPartners, Mayo, Sanford, and DHS's Direct Care and Treatment. For purposes of this study, hospitals were determined to be members of a healthcare system if their public website indicated an affiliation with a larger system.

involve contact with the patient by the UM reviewer, but rather is a review of the current clinical documentation in the medical record. This assessment by UM staff is then reviewed by the licensed psychiatrist who is responsible for the patient. If the psychiatrist concurs with a UM assessment that the patient no longer meets criteria for a hospital level of care, then notification is sent to the patient and the county financially responsible for the patient's care. If there are questions, a more thorough consultation and/or a second review is conducted to make the final determination.

While most people agree that the NABD measure has several flaws as an indicator of patient flow in a system, it is the best number available. It is somewhat uniformly operationalized across hospitals and has been collected in a similar way for many years, and is thus a useful indicator for identifying when people are stuck.

### 2. Non-Acute Bed Days at AMRTC

Table 25 indicates that the average length of stay at AMRTC is increasing, and stood at 99 days in FY2013. The average number of NABDs per episode has also increased, to 37.8.

| | FY2010 | FY2011 | FY2012 | FY2013 |
|---|---|---|---|---|
| Total Patient Days | 49,925 | 42,018 | 38,180 | 36,391 |
| Total Episodes | 538 | 480 | 422 | 366 |
| Average LOS | 93 | 88 | 90 | 99 |
| Total NABDs | 17,902 | 10,995 | 10,641 | 13,833 |
| NABDs per Episode | 33.3 | 22.9 | 25.2 | 37.8 |
| NABDs as a percentage of all bed days | 36% | 26% | 28% | 38% |

**Table 25: Patient Days, Episodes, Length of Stay, and Non-Acute Bed Days at AMRTC, FY2009 - FY2013**

Table 26 shows that patient destination is correlated with how long a patient waits for a placement after he or she no longer needs a hospital level of care. People moved fairly quickly into another hospital, the C.A.R.E. program, their own homes, an IRTS, or a Board & Lodge. However, people transferring into foster care, assisted living, nursing homes, and the Minnesota Security Hospital experienced significant delays. This simplistic analysis assumes that the place a patient ended up was the *appropriate* place for the patient (instead of just a place that was available), which is not always a safe assumption.

| Living Location After Discharge from AMRTC | Number of 2013 Discharges | % of Discharges | Number of 2013 NABDs | % of NABDs | NABDs per Episode |
|---|---|---|---|---|---|
| Foster Care | 92 | 25% | 4,470 | 32% | 49 |
| IRTS | 78 | 21% | 2,338 | 17% | 30 |
| Home | 66 | 18% | 1,845 | 13% | 28 |
| Board & Lodge / B&C | 34 | 9% | 1,092 | 8% | 32 |
| Assisted Living Facility | 23 | 6% | 1,222 | 9% | 53 |
| Other | 22 | 6% | 625 | 5% | 28 |
| MN Security Hospital | 15 | 4% | 1,168 | 8% | 78 |
| C.A.R.E. | 14 | 4% | 174 | 1% | 12 |
| Nursing Home | 10 | 3% | 551 | 4% | 55 |
| Jail/Corrections | 8 | 2% | 302 | 2% | 38 |
| Another Hospital | 2 | 1% | 24 | 0% | 12 |
| Unknown | 2 | 1% | 22 | 0% | 11 |
| Total | 366 | 100% | 13,833 | 100% | 38 |

**Table 26: Non-Acute Bed Days and AMRTC Living Arrangements After Discharge, FY2013. There were 366 episodes of care discharged from AMRTC in FY2013. Those episodes included 13,833 non-acute bed days (NABDs) days.**

Table 27 shows that the number of NABDs also varies depending on what county has financial responsibility for the person being served. The table shows all of the counties with more than 2 percent of Minnesota's population separately, and combines all of the smaller counties in rural Minnesota. A three-year index was created by dividing the county's percentage of NABDs to the county's percentage of the state's population. A score less than 1 indicates that the county had fewer NABDs than its population would predict; a score more than 1 indicates that the county had more NABDs than its population would predict. Hennepin County has a disproportionate share of the NABDs at AMRTC in comparison to the county population. Table 27 also shows how the distribution of NABDs is shifting. Smaller, rural counties had an increasing percentage of the NABDs until 2012, but their percentage dropped significantly in 2013.[83] Overall, less-populated counties had significantly fewer NABDs.

[83] This analysis is based on data of episodes discharged in each of the fiscal years. This has been a useful way to show longer-term trends in non-acute bed days, but the data can be misleadingly pessimistic when counties are working successfully to find placements for people who have been "stuck" at AMRTC for a long time. When they are discharged, their (high) number of NABDs is included in that county's annual total, which drives up the county's percentage of NABDs for the year even though a successful (and long overdue) discharge has occurred. This statistical effect is most marked in small counties with few people at AMRTC. See Section VII-C-1 for more information about measures of NABDs.

| | FY 2011 NABDs | % of total NABDs | FY2012 NABDs | % of total NABDs | FY2013 NABDs | % of total NABDs | % of state population | 3-year Index [84] |
|---|---|---|---|---|---|---|---|---|
| Hennepin | 3,983 | 36.2% | 4,137 | 38.9% | 5,509 | 39.8% | 21.9% | 1.8 |
| Ramsey | 1,519 | 13.8% | 1,147 | 10.8% | 1,299 | 9.4% | 9.6% | 1.0 |
| Dakota | 407 | 3.7% | 162 | 1.5% | 718 | 5.2% | 7.5% | 0.7 |
| Anoka | 891 | 8.1% | 573 | 5.4% | 1,258 | 9.1% | 6.2% | 1.5 |
| Washington | 155 | 1.4% | 72 | 0.7% | 319 | 2.3% | 4.5% | 0.5 |
| St. Louis | 167 | 1.5% | 759 | 7.1% | 631 | 4.6% | 3.7% | 1.2 |
| Stearns | 477 | 4.3% | 306 | 2.9% | 479 | 3.5% | 2.8% | 1.2 |
| Olmsted | 291 | 2.6% | 296 | 2.8% | 560 | 4.0% | 2.7% | 1.5 |
| Scott | 92 | 0.8% | 53 | 0.5% | 2 | 0.01% | 2.5% | 0.01 |
| Wright | 57 | 0.5% | 10 | 0.1% | 12 | 0.1% | 2.4% | 0.04 |
| Counties with <2% of population | 2,907 | 26.4% | 3,062 | 28.8% | 3,017 | 21.8% | 36.1% | .6 |
| Total NABDs | 10,995 | | 10,641 | | 13,833 | | | |

**Table 27: Non-Acute Bed Days and County of Discharge, FY2011-2013. Data in this table include all episodes of care discharged in the fiscal year indicated (e.g., episodes of care discharged in FY2013 had a total of 13,833 non-acute bed days; 39.8 percent of those non-acute bed days were spent by people for whom Hennepin County was financially responsible).**

### 3. Complex discharge planning

To help illuminate why NABDs have increased, Table 28 lists the several concurrent processes that must converge successfully in order for a patient to be discharged from AMRTC. Each of these processes involves levels of bureaucracy, uncertainty, and serendipity that determine how long a patient might wait. For example, some people whose symptoms include aggressive behaviors or who have complicated medical needs might interview with dozens of providers before one is found that is willing and able to serve the individual. Funding proposals are based on the placement sought, so people sometimes encounter the frustration of losing their slot at a particular provider because by the time their funding has been authorized, the available slot has been filled by another client and they must continue to wait or begin the referral (and funding) process again.

[84] A score less than 1 indicates that the county had fewer NABDs than its share of the state's population; a score more than 1 indicates that the county had more NABDs than its share of the population.

| Concurrent Processes | Key Players |
|---|---|
| Patient's psychiatric condition stabilizes enough to make discharge warranted | Patient and family, clinical staff at AMRTC |
| Patient's co-occurring conditions (including physical illnesses, substance use disorders, intellectual disabilities, traumatic brain injuries) and aggressive symptoms are stable and understood well enough to enable discharge planning | Patient and family, staff at AMRTC, county or tribal case manager, local providers |
| Patient's legal status is resolved in way that makes discharge possible | Patient and attorney, county or tribal case manager, county courts |
| An appropriate service and/or recovery supports have been developed and are being offered in the community | DHS, Adult Mental Health Initiative, county or tribal social services, local providers |
| Discharge pre-planning identifies appropriate placement type. | Patient and family, AMRTC social workers, case managers, prospective providers |
| Referrals to community providers are made and patient interviews are held until both patient and provider accept a referral | Patient and family, case managers, providers |
| The support services (e.g., housing or employment) necessary to help the individual pursue recovery have been developed, are available in the community, and currently have capacity | DHS, Adult Mental Health Initiative, county or tribal social services, local providers |
| The patient, guardian, family, county, providers, and other stakeholders come to agreement on the discharge plan | Patient, guardian, family, county or tribal case manager/social worker, county or tribal financial resource managers, providers |
| Funding is applied for and secured | Patient and family, case manager and financial resource managers |
| Patient gets to the top of the provider's waiting list and service becomes available | Provider, provider's other clients |

**Table 28: Concurrent Processes that Make Discharge from AMRTC Possible**

In order to illustrate how these processes come together, Table 29 summarizes one AMRTC patient's discharge planning history. A pseudonym is used, and all identifying information has been removed. This patient spent 205 days at AMRTC after he no longer met criteria for a hospital level of care. The history illustrates how many providers can be involved in a discharge planning process and how long it can take to arrange a discharge setting that works for the patient and all of the other parties involved.

| Day | Action or Event |
|---|---|
| Day 1 | Bill is admitted to AMRTC. |
| Day 9 | Discharge planning meeting held. |
| Day 18 | Contact Provider 1; they have no openings. Case manager attempting to contact Provider 2 about possibility of serving Bill. |
| Day 60-74 | Bill is very symptomatic and emotionally disregulated. Restraints are used as a safety intervention. |
| Day 46 | AMRTC Social Worker provides County Case Manager with Provider 2 vacancy list (as referrals can only come from the county). |
| Day 95 | Social worker works with CSS / Synergy to identify discharge support options. |
| Day 109 | Social worker tries to arrange meeting with Provider 2 and Synergy to discuss possible referral. Referral needs to come from the county however. |
| Day 144 | County Case Manager referring Bill for Provider 2 vacancies. |
| Day 168 | Bill is determined to no longer meet criteria for hospital level of care. |
| Day 172 | Interviewed by Provider 2. |
| Day 185 | AMRTC Social Worker and County Case Manager work with CADI screener for suggestions about referral sites. Case Manager reports that Provider 2 has picked another resident for their vacancy. |
| Day 193 | Interviewed by Provider 3. CADI screen with guardian is being rescheduled by County staff. |
| Day 207 | County Case Manager toured Provider 4 but did not think they could meet Bill's needs. |
| Day 214 | Referral sent to Provider 5. Contact with Provider 3, who took someone else for their opening. |
| Day 218 | CADI screen completed with guardian and County Case Manager. |
| Day 221 | Referral sent to Providers 6 and 7. Neither has an opening that could support Bill's needs. |
| Day 231 | Provider 5 comes to interview Bill. |
| Day 235 | Follow up with Provider 8, they do not have any openings that could meet Bill's needs. |
| Day 249 | Referred to Provider 3 and placed on their waiting list. Referred to Providers 5, 8, 9, 10, 11. |
| Day 256 | Referred to Provider 6; they do not have an appropriate place right now that could meet Bill's needs and do not anticipate any openings in the near future. |
| Day 263 | County Case Manager looking into Provider 2 vacancies that may be a fit for Bill. |
| Day 269 | Referred to Provider 12. |
| Day 277 | Referred to Providers 13 and 14. |
| Day 284 | Provider 5 has an opening and may be able to accept Bill from their waiting list. Meeting is scheduled to review his referral, history and needs in more depth. Budget is approved by County. |
| Day 301 | Provider 5 staff meet with treatment team, CSS/Synergy staff, County Case Manager and guardian to review Bill's history and support needs. Provider 5 agrees that that they can meet Bill's needs and accept him into their program pending final funding approval. Transition to home begins. |
| Day 312 | Bill takes his first transition pass to Provider 5 with CSS/Synergy staff in preparation for discharge. |
| Day 330 | Bill takes transition pass to Provider 5 with AMRTC Occupational Therapist and Social Worker. AMRTC staff bring a tip sheet from nursing about ways to best support Bill's behavioral needs. |
| Day 332 | Updated CADI screen completed with guardian and County Case Manager. |
| Day 347-372 | County and vendor are negotiating on a budget for serving Bill. Provider 5 gives County an ultimatum to have funding in place by Day 354 or lose the bed. |
| Day 364 | CSS/ Synergy Staff and AMRTC Behavioral Analyst train Provider 5 staff about how to support Bill. |
| Day 373 | Bill is provisionally discharged to Provider 5 (an adult corporate foster care home) with plan supported by Bill, the County Case Manager, treatment team and guardian. Aftercare plan includes outpatient psychiatry through AMRTC, support by case manager and CSS / Synergy |
| | At 30 days after discharge, Bill was enjoying his new surroundings and reported that he felt he had found a permanent home at Provider 5. |

**Table 29: Discharge Plan History for AMRTC Patient with High Non-Acute Bed Days[85]**

### 3. Barriers to discharge

In 2012, DCT's Utilization Management department began recording the nature of the barriers that were faced by people with NABDs as the department conducted utilization management reviews. Because a patient's discharge barriers change as the concurrent processes listed in Table 28 unfold, and because people may undergo several utilization management reviews while

[85] "Bill" is a pseudonym. The providers and county are not identified in order to protect the patient's privacy.

they don't meet a hospital level of care, these tallies of discharge barriers represent a snapshot of the incidence of each type of barrier, and contain duplicated counts. They provide a general sense of the relative incidence of each barrier to discharge for people served at AMRTC.

| AMRTC Discharge Barriers for CY 2012 | # of NABD Reviews with this Barrier | % of NABD Reviews with this Barrier | Barrier Detail |
|---|---|---|---|
| Referrals are in process | 134 | 36% | The referral process often involves delays in identifying providers, getting provider response, denials, and re-referrals. |
| Awaiting funding | 75 | 20% | Most delays are in the processing of CADI waivers. |
| Patient is on waiting list | 68 | 18% | Once the patient and provider have agreed to a referral, many people still have to wait for an opening in a residential facility or for the development of support services that will enable them to return home. |
| Patient awaits resolution of legal process | 58 | 16% | Rule 20 process, Mentally Ill & Dangerous commitment process, guardianship process |
| Lack of an appropriate recovery environment | 5 | 1% | This barrier is usually experienced by registered sex offenders or people who need placements that can support multiple issues: medical, psychiatric, cognitive, etc. |
| Lack of alignment among client, AMRTC social workers, and county or tribe on discharge goals | 4 | 1% | |
| Pending communication with county or tribe | 2 | 1% | |
| Other | 30 | 8% | |
| Total | 376 | 100% | |

**Table 30: A Snapshot of Discharge Barriers Experienced by People Served at AMRTC, CY2012[86]**

Table 30 shows that the largest barrier to discharge is the referral process itself. As shown in Table 29, an individual can have several referrals before a provider is found that can fulfill the individual's needs. Funding and legal processes are also complex and protracted. While discharges are delayed, people can relapse and begin to meet criteria for a hospital level of care again, which interrupts recovery (and the placement process) further.[87] Addressing the administrative delays accompanying the discharge process would be a significant strategy to reduce NABDs.

[86] This data is based on the total of 376 utilization management reviews that were conducted at AMRTC in CY2012 in which the patient was found to not meet criteria for a hospital level of care.
[87] According to DCT's Utilization Management manager, this occurred 25 times in CY2011, 35 times in CY2012, and 19 times between January 1st and October 30, 2013.

Frustration around the delays in discharges from AMRTC has led to calls for policy changes that would allow the Commissioner of DHS to take control of the discharge planning and referral process from counties after someone has experienced a certain number of non-acute bed days. In fact, the Commissioner already has such authority but only exercises it in very rare cases. In most cases, the situation is a very complicated combination of financial challenges, lack of appropriate placement options, legal difficulties, and changes in the individual's medical or psychiatric symptoms. To achieve a transition to the community that will support the individual's long term pursuit of recovery, all of the parties involved need to agree on a sustainable plan that makes sense to the individual, his or her family, community providers, the county, and AMRTC clinicians and social workers. Discharges achieved by disregarding any of these interests are not likely to lead to sustained stability in the community.

Decreasing the number of NABDs at AMRTC is of paramount importance in order to open up beds for people who do need a hospital level of care. Minnesota's Olmstead Plan clearly prioritizes the development of community services as a means of improving patient flow, improving patient care, and promoting recovery. It sets specific goals for the percentage of total bed days at AMRTC that are spent by people who no longer meet medical criteria. In the following sections, some options for addressing the patient flow problems at AMRTC will be outlined, and AMRTC's role in implementing those options will be described.

## VIII. Improving Minnesota's Service System for People in the Target Population

The goal driving Minnesota's mental health service system is recovery. This report has identified many gaps and barriers in Minnesota's service system that can make the recovery process difficult or impossible for people in the target population. It has also emphasized the interconnectedness of these gaps and barriers: just making changes at AMRTC will not be enough to eliminate the gaps and barriers that have been identified. Changes are needed throughout the entire system.

DHS is using the funding models of health care reform and the transformational principles of the Minnesota Olmstead Plan to create a recovery-oriented service system that fulfills the vision laid out in Chapter I. For the target population, this is a recovery management approach that that will make four important changes in the service system:

1. Adopt decision-making and service-delivery processes at the state, regional, local, provider, and individual levels that are driven by the choices of people with disabilities. People with disabilities should have the opportunity to engage in their community and engage with others in the ways they choose.
2. Increase the recovery support services in communities so that people in the target population get timely access to the services and supports they need (including culturally sensitive services), thereby promoting recovery and avoiding the need for a more acute

level of care whenever possible. These services include housing with services, outpatient psychiatric care, crisis services, residential care, transportation, employment, education, physical health care, and care coordination.

3. Manage service capacity to assure timely access to acute care (inpatient care, crisis services, and urgent care) for the target population. Specifically, when recovery supports are not enough to help an individual maintain stability in the community, there should be ready access to acute services to respond to the individual's needs in the most integrated setting possible.
4. Improve coordination and collaboration among service providers so that people in the target population are supported by recovery management partnerships with a common understanding of the individual's recovery goals, integrated information and records, and regular communication and planning.

As these changes are made, the patient flow problems at AMRTC will resolve and the system as a whole will better support the recovery of the target population. The changes will be gradual and will be brought about by improvements at several scales: changes in individuals, organizations, regional relationships, and statewide policies and processes.

None of these improvements can be accomplished by DHS alone. They require collaboration among consumers, their friends and families, DHS, counties, tribes, providers, health plans, the federal government, and others in order to create changes across the system. DHS does have several significant roles and functions that can help insure that these improvements are realized:

- **Research, plan, and facilitate the creation of policies** to shape Minnesota's mental health and substance use disorder services system to achieve goals set by lawmakers and administrators. This includes DHS's role as the state mental health authority and coordinator of the county and tribal mental health authorities as well as its role as a payer.
- **Facilitate regional collaborations** in which stakeholders set common goals and work cooperatively to improve the service systems in their regions.
- **Oversee and fund the state Medicaid program**, the largest insurer of people served by the public safety net.
- **Oversee and fund the disability services** that support most people in the target population.
- **Channel/manage grant funds** from federal and state programs to achieve policy goals set by lawmakers and administrators.
- **Assess and assure the quality** of services provided in the state, including licensing and certification.
- **Provide direct mental health and substance use disorder services** to people not adequately served by other providers and transition state-operated services to other public and private providers when doing so would strengthen the community-based service system.

Unfortunately, these roles have not been well-coordinated in the past, which has helped lead to the service system problems described in the previous chapters. In the coming years, DHS will better harness each of these roles to drive the four changes listed at the beginning of this section. The following sections describe the specific strategies that will be pursued.

## A. Strategies to Assure that Decisions are Driven by People with Disabilities

The Minnesota Olmstead Plan lays out dozens of strategies that the state will undertake to increase the opportunities of people with disabilities to drive the decisions that shape their lives. These strategies can be summarized specifically in terms of the target population and concerns raised in the OLA report about AMRTC:

- **Develop and fund services that will assist people in the target population to express their needs and preferences about the life they want**. This will include decisions about where they live, what jobs and educational opportunities they want, what kinds of medical and social services they want to receive (and where), and who they want to live with.
- **Review all policies, procedures, laws, and funding to identify barriers to community integration or the rights of people in the target population to exercise their choice**. Establish plans to remove those barriers. These reviews will be required at the state, county, tribe, local, and provider levels, and will include consideration of current service authorization procedures that might implicitly posing barriers to community integration or choice.
- **Develop opportunities for people in the target population to be involved in leadership decision-making in all government programs that affect them.** This will require providing support and training to people in the target population to exercise their leadership.
- **Implement measures that track quality of life outcomes for people in the target population**. This will include ongoing measures as well as well-publicized processes for grievance and dispute resolution.
- **Align government funding to achieve choice and community integration goals and to respond to outcome measures**. Funding priorities will be driven by these goals and outcomes.
- **Train government and tribal staff, providers, insurers, and advocacy organization on person-centered thinking and person-centered planning**. As described in the introduction, this training should be embedded in a larger cultural shift to person-centered awareness.

## B. Strategies to Grow Community-based Recovery Support Services for People in the Target Population

The Minnesota Olmstead Plan also identifies strategies the state will undertake to increase the availability of community-based recovery support services. These strategies emphasize person-centered planning and flexible services, which will be especially beneficial for the target population:

- **Redesign Home and Community-Based Services to flexibly support the needs of people with complex needs, including those in the target population**. Reform 2020 is a package of reforms to Home and Community Based Services to achieve better outcomes, deliver the right services at the right time, and ensure the sustainability of long term services and supports. These reforms include a redesign of the personal care program to provide for increased self-direction and a more flexible service, increasing support to people through transitions to integrated community services of their choice, more employment supports, and changes in the menu of services available. Additional changes authorized by the 2013 legislature provide more flexibility in funding and targeted resources to aid in the discharges of people from AMRTC. Because most people in the target population are eligible for Home and Community-Based Services, these changes will improve access to community-based recovery support services.
- **Address workforce shortages**. Minnesota is already experiencing crippling shortages of mental health professionals. Health care reform and mental health parity laws are going to bring more insured consumers into the service system, further straining the system's ability to meet the demand for services. CMHSA has begun to plan a Workforce Summit to convene statewide stakeholders on this issue. In the meantime, CMHSA is addressing workforce shortages by stepping up training for Certified Peer Specialists, supporting tele-health applications to leverage the existing workforce, and providing specialized education funding for students from underserved populations. DCT, struggling with the same shortages that other providers face, already employs a significant number of Advanced Practice Registered Nurses to help extend the treatment capacity provided by psychiatrists and primary care physicians. DCT hospitals are also training sites for Physician Assistant students, in part with the hope of attracting students to work in the DCT system after graduation. DCT is also experimenting with ways to extend the reach of existing specialists through tele-health applications.
- **Improve integration of mental health, physical health, and substance use disorder services**. The Minnesota *10 x 10 Initiative* is working to develop service improvements that will increase the life expectancy of individuals in the target population *by* 10 years *within* 10 years. This public-private initiative involves AMHD, the Minnesota Department of Health, several large health systems, advocates, and other stakeholders. Assisted by federal grants from SAMHSA and the Centers for Medicare and Medicaid Services (CMS), the initiative has been using the state's 26 assertive community

treatment (ACT) teams as a "laboratory" to explore and test better approaches for integrating mental health services and primary care. Among the major goals are to make sure that (1) every ACT participant has an annual physical exam, (2) the exam includes a basic set of consensually agreed-upon health indicators, and (3) any indicator falling outside of the desirable range is followed up by the treatment team. While the challenges are great and much work remains to be done, initial results are promising.[88] Next steps will include additional coaching and technical assistance for ACT staff, enhancements to AMHD's data tracking system, and expansion of the initiative to other parts of Minnesota's publicly supported mental health system.

- **Add Specialized Intensive Residential Treatment Services (IRTS)**. CMHSA is currently reviewing proposals for providing a specialized statewide IRTS that serves people in the target population. CMHSA will contract for the development of one or more specialty IRTS programs to meet the residential treatment needs of people discharged from AMRTC. The specialty IRTS sub-acute care will provide for further stabilization and comprehensive treatment with the primary goal to assist with the transition to the home community and to outpatient mental health services. The 16 bed unit(s) will be designed to benefit adults with serious mental illness, characterized by cognitive, behavioral and emotional symptoms that severely impair their functioning and complicate their ability to make a successful transition to outpatient, nonresidential mental health treatment and community living. The target date for opening the new facility is July 1, 2014 provided that all license, enrollment, conditional use permits and program standards are met.
- **Increase Adult Mental Health Rehabilitative Services in communities**. ARMHS services help build the capacity of people in the target population to live in the community. ARMHS services rates have historically been so low that some providers have left the business, reducing the availability of ARMHS throughout the state. The 2013 legislature gave DHS permission to restructure rates and the services covered under ARMHS. In 2015, approximately $1.8 million will be shifted from the Adult Mental Health Grants to fund the restructuring of ARMHS, which should make ARMHS available in more communities.
- **Enhance and extend Assertive Community Treatment**. ACT teams have been described as "hospitals without walls"—interdisciplinary professional teams that collaborate frequently to intensively support people with serious mental illnesses in the community. CMHSA will provide more technical assistance to existing ACT teams to enhance their capacity to provide services that prevent hospitalizations when appropriate

[88] According to the DHS Adult Mental Health Division, between January and December of 2012, the proportion of ACT participants having annual preventive exams increased by 50% (from 48% to 72%), and the proportion of those exams that included all or some of the key health and wellness indicators increased by 43% (from 64% to 91%).

and improve transitions to community services. CMHSA also intends to initiate a Request for Proposal process in 2014 to expand ACT to more communities in the state.

- **Encourage the use of more Certified Peer Specialists in community providers.** Peers have been shown to be very effective at helping clients engage actively in their own recovery and in supporting them when challenges arise. They also help clients connect with services in their communities, thus leveraging the investments that communities have already made in creating those services. Currently Certified Peer Specialists can provide reimbursable services in mental health rehabilitation services including ARMHS, IRTS, ACT, and Crisis Stabilization. Because Certified Peer Specialists are a fairly new addition to the mental health workforce in Minnesota, most providers have not yet incorporated them into their staffing plans. CMHSA is currently reviewing the impact of including Certified Peer Specialists as a reimbursable rehabilitation service and working to identify ways to increase the number of individuals that receive training and become Certified Peer Specialists and securing sustainable funding sources for their services.
- **Emphasize transition to community**. DHS re-organized State Operated Services in 2013, creating a new division called "Community Based Services" that has explicit responsibility for facilitating the coordination of services for people who are transitioning out of state-operated residential settings. A Transitions Director position was also created within the new Mental Health and Substance Abuse Services Division to facilitate transition planning for people leaving SOS's hospitals and residential treatment facilities.
- **Increased capacity across DHS's Community Support Services teams**. DHS has increased its nine Community Support Services (CSS) teams from 50 to 70 staff over the past two years. Their focus is to build capacity among community support networks to more effectively support people with complex needs, including those in the target population. CSS consults mostly on individual client situations, especially transitions between levels of care, but also builds capacity by offering trainings such as the recent one-day workshop on Positive Behavior Support, organized by South Central Community-Based Initiative.

## C. Strategies to Assure Timely Access to Acute Psychiatric Care for People in the Target Population

Strategies for assuring timely access to acute care include strategies to influence both the "front door" and "back door" of AMRTC.

### 1. Reduce demand for beds at AMRTC (open the front door)

- **Significantly expand crisis services in Minnesota**. This will divert some people from unnecessary hospitalization (thus saving inpatient capacity) and support recovery for clients who can be served by local providers who are well-integrated with local recovery support services.

- **Provide Crisis Intervention Team training for law enforcement**. DHS is providing funding to train first-responders to recognize mental health crises and coordinate with the local provider system to respond appropriately using all of the resources of the local community.
- **Streamline the Competency Restoration Program**. Approximately 12 beds at AMRTC are filled by people in the Competency Restoration Program. Average length of stay in this program is 30 or more days longer than other stays, mostly due to delays in legal processes. NAMI-Minnesota is leading a workgroup that will propose legislation in 2014 to streamline the competency restoration program by establishing standardized time frames for this process and establishing a community program that could divert some people from AMRTC.
- **Increase the reimbursement rate that community hospitals receive for treating individuals in the target population**. One reason that community hospitals are reluctant to treat individuals in the target population is that the reimbursement hospitals receive for the care of people's multiple complex conditions often fails to cover the costs of the care. If community hospitals did not have to take on such a financial risk, they would be more willing to treat people in the target population. DHS is looking forward to collaborating with hospitals to consider strategies for reducing hospitals' financial risks when they treat people in the target population.

**2. Reduce the number of non-acute bed days at AMRTC (open the "back door")**

- **Assess the impact of the recent increase in the county share** paid for people at AMRTC who no longer meet a hospital level of care (from 50 to 75 percent of costs). In some other states (including Wisconsin), the share of state psychiatric hospital costs is higher (e.g., 100 percent of costs from day of admission). CMHSA will assess whether Minnesota's recent increase has driven a decrease in NABDs while maintaining or improving stability in the community and facilitate dialogue among stakeholders about the best ways to drive expansion of community services for people in the target population.
- **Implement the Transition to Community initiative funded by the 2013 legislature**. This initiative is helping to fund well-planned, supportive discharges once people have completed treatment at AMRTC. Funding was provided to expand availability of waivers, expansion of mental health services for clients with complex needs, and flexible grant funding to help meet individual needs.
- **Disability Services Division Community Capacity Team**. Funded by the 2013 legislature, the team will include five staff members who will be located around the state to increase the capacity of community providers to serve people with complex needs, including those in the target population. They will help ensure that crisis services are in place in the community, provide ongoing consultation and monitoring with Community

Support Services team members, and assure that ACT teams and Crisis Stabilization teams are active in helping clients avoid institutionalization. In addition, it is expected that teleconferencing technology will be used to assure the availability of psychiatric consultation and monitoring to locations in the state currently lacking ready access to psychiatry.

- **Increase disbursement of Bridges housing funds** so that those patients at AMRTC (and other institutional settings) who are homeless or at-risk of homelessness are not blocked from discharge by lack of resources for rent and can thus move directly home. Housing is a basic need that is critical for establishing and maintaining physical and mental health as well as securing access to needed services.
- **Increase access to the Crisis Housing Fund by expanding eligibility:** Eligibility for Crisis Housing Funds could be expanded by changing the statutory eligibility requirement from the (more restrictive) serious and persistent mental illness (SMPI) to the (less restrictive) serious mental illness (SMI). People with SPMI would remain eligible after this change. The restrictive requirement of SPMI is not aligned with the current use of other mental health services. People with a mental illness who are accessing community mental health services such as ACT or ARMHS, for example, do not need to meet SPMI criteria in order to receive services or seek treatment. However, because of the restrictive SPMI requirement they are unable to access the Crisis Housing Fund to help them stabilize their housing while seeking needed treatment.
- **Increase transitional services for people being discharged from AMRTC**: DHS operates three Intermediate Care Facilities, residential treatment facilities for people with developmental disabilities. Following the Minnesota Olmstead Plan, residents in those facilities are now working on their plans to move to more integrated community settings of their choice. As the facilities empty, DHS will explore the possibility that those buildings could be used to provide more transitional services to people being discharged from AMRTC.
- **Establish a consultative service to assist counties and tribes in person-centered planning of services for people in the target population**. DHS's Community-Based Services currently offers such consultations, focusing on support for individuals with developmental disabilities. The services are provided by Community Support Services (CSS)/Synergy and have been effective in helping some people stuck at AMRTC to move back to the community. Funding for CSS/Synergy services is included in the individual's waiver budget when the discharge planning team determines that consultative/monitoring services are needed after discharge. In addition, CSS/Synergy is providing early intervention consultant services for individuals with developmental disabilities who are at risk of commitment to the Commissioner and referral to AMRTC. DCT is also partnering with the Adult Mental Health Division and the Disability Services Division to support transitions, and Disability Services' Community Capacity Team is making

consultations available through a contract and supporting the development of community expertise.

- **Provide training on Home and Community-based Services**. CMHSA will partner with staff from DHS's Disability Services Division and social workers from AMRTC to hold trainings for county and tribal social workers on Reform 2020 and how Home and Community-Based Services can be used flexibly to meet the unique needs of people being discharged from AMRTC.

## D. Strategies to Improve Coordination Among Service Providers to Promote Recovery for People in the Target Population

- **Provide technical assistance on electronic health records.** As part of the state's SIM grant, DHS and the Department of Health will begin offering technical assistance in 2014 to health care providers (including mental health providers) to hasten adoption of interoperable electronic health record systems that will make it easier for providers to share information about clients they jointly serve.
- **Identify and fund up to fifteen "Accountable Communities for Health."** Minnesota has received a three-year $45 million grant from the federal Center for Medicare and Medicaid Innovation to improve coordination and value-based health care for Minnesotans. The grant will be used to test new ways of delivering and paying for health care that encourage patient-centered, team-based care that is integrated across physical medicine, mental health, substance use disorder services, long-term care, and community prevention. Funds will support the infrastructure needed for integration as well as the establishment of up to fifteen "accountable communities for health" that will develop and test these integration strategies.
- **Establish Behavioral Health Homes**. DHS is currently developing a new Medicaid state option to support coordinated care for people with serious mental illness: the Behavioral Health Home. Standards for the new service will require integration of mental health, substance use disorder, and physical health services for Medicaid beneficiaries, with consideration of consumer preferences, social and cultural factors, and individual functioning in addition to traditional medical criteria. Funding for this person-centered, integrated care model will address several of the barriers to recovery for people in the target population. The goal is for CMS approval of the state's Medicaid State Plan Amendment by the end of 2014, with initial sites implementing the approach early in 2015.
- **Facilitate regional collaborations**. CMHSA and DCT are planning to re-invigorate their facilitation and support for regional collaborations aimed at improving Minnesota's mental health and substance use disorder service system, especially for people in the target population. Modeled after the successful South/Central Mental Health Task Force, this effort will undertake collaborative projects driven by regional needs and implemented by multi-stakeholder workgroups.

- **Improve appropriate use and efficiency of the civil commitment process**. Minnesota state government is working on a cross-agency effort to consider possible changes to the civil commitment process in Minnesota. Legal changes of this magnitude are likely to take several years to develop. In the meantime, DHS can encourage collaborations among county and tribal courts, social services, consumers, and providers to improve efficacy and efficiency in the commitment process. The Mayo/Blue Earth County collaboration (MBECC) is an example of a promising effort. Law enforcement, courts, social services, crisis services, and the local hospital are collaborating to support specific individuals—identified through their repeated use of county and private services—before they are in a psychiatric crisis in order to avoid hospitalizations when possible. Such local improvements could help inform the larger statewide effort to examine the commitment process.
- **Streamline service eligibility decision-making**. At county and regional levels, DHS can help facilitate collaborations among county and tribal social services, consumers, and providers to streamline funding decisions so that people in the target population do not wait in inappropriate settings while funding decisions are made.
- **Provide person-centered thinking training**. DHS can undertake statewide coordination and training to implement the Olmstead Plan and person-centered principles across the health service system (including mental health and substance use disorder treatment providers, physical health care providers, emergency response and public safety personnel, courts, jails, corrections, and other systems that touch people in the target population).

## E. Summary

The strategies described in this chapter will move Minnesota toward a service system that allows people to receive the right services at the right time and place so that they can pursue recovery in their own communities. This involves not just the mental health system; it involves the entire social safety net. To better support people in the target population, both mental health and social service delivery organizations need to:

- Adopt decision-making and service delivery processes that are driven by the choices of the people receiving services
- Increase recovery support services in communities
- Manage service capacity so people can get timely access to acute care; and
- Develop better mechanisms for coordinating among service providers.

As these changes are made, the patient flow problems at AMRTC will gradually resolve and the system as a whole will better support the recovery of the target population. The improvements

will be gradual and will be brought about by changes at several scales: changes in individuals, organizations, regional relationships, and statewide policies and processes.

# IX. Plan for AMRTC

The Office of the Legislative Auditor asked DHS to prepare a plan for AMRTC that would address these issues:

- Long waiting lists for admission to AMRTC
- Too many non-acute bed days (days that people spend in a hospital when they no longer meet the criteria for a hospital level of care)
- AMRTC's ineligibility for Medicaid payments for most people
- Question of the appropriate number of beds at AMRTC
- Possible need for additional legislative action to improve the community integration opportunities for people served at AMRTC
- How AMRTC should collaborate with non-state hospitals (especially in the Twin Cities)

This report has attempted to show that the changes necessary to address these issues encompass a very large system. They are wider than AMRTC, wider than DHS, and wider than the mental health system; they are even wider than the entire health care system. The changes will require action from people in the target population and their families, friends, and communities; health care; social services; housing; education; transportation; and law enforcement and corrections.

Chapter 7 presented dozens of changes that are being made in those systems to address aspects of the patient flow problems that were the focus of the OLA report. This chapter will focus specifically on ARMTC, as the report requested. The plan outlined here will be carried out by leaders and staff of AMRTC in collaboration with all of the stakeholders identified in Chapter VIII.

## A. AMRTC Vision, Goals, and Role

AMRTC subscribes to the same vision and goals outlined in Section II-D of this report, which can be summarized by the vision that people in the target population will have access to the right services at the right time and place so that they can successfully pursue their recovery in the communities of their choice. As the historical portion of this report illuminates, AMRTC has played a fluid role in the Minnesota service delivery system over the course of its history based on evolving needs. DHS expects that AMRTC's role will remain basically the same for the next five years: a statewide specialized psychiatric hospital for adults with severe and persistent mental illnesses and complex co-occurring conditions who have been committed to the Commissioner of DHS. Although there have been a few calls in recent years to shrink or close AMRTC and transfer its services (and funding) to community-based providers, almost all stakeholders are currently in agreement that AMRTC's role as a facility to provide treatment in a secure setting for people with special psychiatric, medical and behavioral challenges is essential

to the service system and that DHS should not shrink or close AMRTC until the demand for its services has decreased (i.e., until there are robust replacement services available in the community).

One of the factors motivating the calls for closing AMRTC is the fact that it is not eligible to receive Medical Assistance reimbursements for people aged 22-64, regardless of their diagnoses, because it is larger than 16 beds (see Section B-3 in this chapter). While it might be tempting to shrink or close AMRTC to shift treatment to providers who are eligible for reimbursement, AMRTC's current size and structure are a key part of its ability to assure safety and manage risk. AMRTC is a vital piece of the state's service array because it is able to bring together a concentration of specialized psychiatric expertise with the staff, funding, and physical plant necessary to provide unique treatment while protecting the safety and security of both patients and staff. Small hospitals find it difficult to amass the depth and breadth of specialized expertise that is needed to serve people in the target population safely. AMRTC has established long-term relationships with consumer advocates, social services, and law enforcement in order to optimize treatment, create community connections, and assure public safety.

During the next five years, AMRTC will focus on improving its internal operations and coordinating with patients and their families, counties, tribes, providers, payers, advocates, and other stakeholders. The specific strategies are outlined in the following sections.

## B. AMRTC Operational and Collaborative Projects

### 1. Reducing non-acute bed days at AMRTC

DHS is keenly focused on reducing the number of non-acute bed days at AMRTC. In addition to the many collaborative, system-wide efforts described in Chapter VIII, AMRTC is also making changes to assure that people can make timely transitions to the community once they no longer meet criteria for a hospital level of care.

#### *a. Goals for reducing non-acute bed days*

In accordance with Minnesota's Olmstead Plan, DHS's goals for reducing the number of non-acute bed days at AMRTC are as follows:[89]

- By December 31, 2014, the average percentage of people at AMRTC who no longer need a hospital level of care will be reduced to 30 percent.

[89] In November of 2013, the percentage of people at AMRTC who did not meet criteria for a hospital level of care averaged 31%. This percentage is smaller than the 38% figure shown in Table 25. The reason for this discrepancy is in the way that the two percentages are calculated. The 38% number was calculated by identifying all of the people who were discharged in FY2013, and then dividing the number of NABDs they had by the total number of bed days they spent at AMRTC (even if those happened in a prior year). The new calculation represents the current reality at AMRTC: that about one-third of people on a given day do not meet criteria.

- By December 31, 2015, the average percentage will be reduced to 25 percent.
- By December 31, 2016, the average percentage will be reduced to 20 percent.
- By December 31, 2017, the average percentage will be reduced to 15 percent.
- By December 31, 2018, the average percentage will be reduced to 10 percent.

As described in Chapter VIII, most of the solutions to the high number of non-acute bed days at AMRTC are outside the control of AMRTC. However, DHS expects that the solutions described in Chapter VIII—especially the development of more community-based services and the reduction of delays in processing financial eligibility applications and legal decision-making—will yield reductions in non-acute bed days that meet or exceed the goals listed above.

While the real solution to non-acute bed days is the development of adequate community services to support people as they pursue recovery in the community, AMRTC's primary role in reducing non-acute bed days is in discharge planning. By collaborating with the patient, family members, county and tribal social workers and other providers, AMRTC staff can help minimize non-acute bed days. The Minnesota Olmstead Plan outlines goals for effective transitions from institutions like AMRTC:[90]

- Good planning to understand what is important *to* people as well as *for* people, and the future they would like;
- Timely transitions;
- Support to live in the most integrated and inclusive setting; and,
- The right services at the right time to support people in successfully implementing their plans.

To achieve these goals, the Olmstead Plan identifies several specific requirements:[91]

- Each person and the person's family and/or legal representative shall be permitted to be involved in any evaluation, decision-making and planning processes, to the greatest extent practicable, using whatever communication method the person prefers.
- To foster each person's self-determination and independence, the state shall ensure the use of person-centered planning principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, and abilities and strengths, as well as support needs.
- Each person shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality of life.

[90] *Putting the Promise of Olmstead into Practice: Minnesota's 2013 Olmstead Plan* (Saint Paul: State of Minnesota, November 1, 2013), 53.
[91] Ibid., 52.

- The state shall undertake best efforts to provide each person with reasonable alternatives for living and working.
- It is the state's goal that all people be served in integrated community settings with adequate supports, protections, and other necessary resources that are identified as available by service coordination.

### *b. Projects to reduce non-acute bed days at AMRTC*

To play a strong role in assuring that these requirements are met for all people at AMRTC, AMRTC is undertaking the following projects:

- **Continue to implement person-centered training and ongoing support**. AMRTC has held eleven 2-day workshops for AMRTC staff on person-centered thinking and AMRTC leadership has completed person-centered thinking training. Staff and leadership turnover at AMRTC has complicated the efforts to implement person-centered thinking in the organization, however. AMRTC leaders recognize that person-centered thinking is a significant cultural transformation that could take several years to effect, so they are committed to continuing to provide training for new staff and ongoing support for existing staff. Meetings are being planned to assess progress to date and to develop targets and strategies to achieve those targets in 2014. AMRTC managers will also be involved in the definition of best practices in person-centered planning that are due to be delivered to the Olmstead Subcabinet by January 1st, 2015. These best practices will be used by state agencies, including AMRTC, to evaluate their current assessments, plans, and practices, and to revise them to be in line with the best practices.
- **Improve discharge coordination and support for people who are being discharged from AMRTC**. AMRTC managers will be involved in the team assigned by the Olmstead Plan to develop "protocols and processes to facilitate successful transitions, problem-solve and reduce barriers that limit the individuals' ability to live in the most integrated setting."[92] The newly-appointed Transition Services Director of SOS's Mental Health and Substance Abuse Services Division (of which AMRTC is a part) will help facilitate discharge planning for people served at AMRTC and act as a liaison with the new Community Based Services Division and non-state community services.

  AMRTC's involvement will be informed by the extensive process that AMRTC has already developed for collaborating with metro county case managers around discharges. This process includes weekly discharge planning meetings and weekly data reports on all people at AMRTC from each county. AMRTC has begun to implement a similar system with non-metro counties called the "liaison case management process." This system has been implemented by two Adult Mental Health Initiative regions in Minnesota and has shown promising reductions in non-acute bed days by improving person-centered

[92] Ibid., 53.

discharge planning and coordination. AMRTC will explore the possible expansion of the liaison case management process to other non-metro regions. When the Olmstead protocols and processes are developed, AMRTC will undertake any changes needed in its current practices to align with those expectations.

- **Reduce delays in competency evaluations**. Although the current primary Competency Restoration Program is at the Minnesota Security Hospital, some people with complex mental illnesses and co-occurring conditions who have been civilly committed under Rule 20.01 are treated at AMRTC. There can be legal delays that slow their transfer back to jail once they have completed treatment and no longer meet criteria for a hospital level of care. AMRTC will continue to work on better communication with the County Attorneys and the Courts in an effort to shorten or eliminate these delays and will identify liaisons with County Attorney's Offices whenever possible to promote better communication and more efficient resolution of these cases. More expansive changes to the Competency Restoration program are being considered by a statewide workgroup led by NAMI-MN that AMRTC staff members are participating in.
- **Expand involvement of peer supports**. Peers are currently active at AMRTC through the ongoing meetings of several volunteer groups, including Alcoholics Anonymous, Narcotics Anonymous, Hearing Voices Network Peer Support Group, and others. Because peers play such a positive role in the recovery process, AMRTC would like to expand the involvement of peers at AMRTC by hiring Certified Peer Specialists to join the staff. The goal is to add Certified Peer Specialists beginning in CY2014.
- **Provide more psychiatric consultations following discharge**. As resources allow, AMRTC will also explore providing psychiatric transitional services to facilitate a planned transition to a community provider after treatment at AMRTC. The goal is to provide, at minimum, one consultation concerning each patient, so that the community provider has direct contact with the AMRTC practitioner and can be briefed on AMRTC's experiences and recommendations for each patient. This strategy can help counter both the shortage of psychiatry in some areas of the state (such that people discharged from AMRTC don't see a psychiatric professional soon after discharge) and the inconsistent coordination that can result in a lack of continuity of care that can derail the patient's recovery. Tele-medicine could be used to support these consultations for clients in rural areas.

### 2. Strategies to address the long waiting lists for admission

There are many inter-connected factors that affect the length of the AMRTC waiting list: the availability of community-based services to support the recovery and prevent unnecessary hospitalization of people in the target population; the effectiveness of those community-based services, especially crisis response services; the number of people being committed as Mentally Ill in Minnesota; the number of acute psychiatric beds available at AMRTC, the CBHHs, and community hospitals and the appropriate utilization of those beds (i.e., the number of non-acute bed days); legal and financial incentives that encourage counties, tribes, and community

hospitals to commit people and refer them to AMRTC; and trends in arrests and sentencing that affect people with mental illnesses in the criminal justice system. Many of these factors are in flux right now, due to changes in state policy and funding as well as implementation of health care reform and Minnesota's Olmstead Plan.

It's not clear how all of these factors will affect the waiting list at AMRTC in the coming year. Everyone agrees that individuals who need the level of services provided by AMRTC should have quick access to those services. The current waits for beds at AMRTC are too long. DHS expects that the strategies identified in Chapter VIII will have a significant impact on the waiting list, but until the effects of those strategies are felt, DCT intends to undertake (or continue) the following projects:

- **Open transitional facility in Miller North.** The Miller North Project is being proposed for individuals at AMRTC who no longer meet criteria for a hospital level of care but are not yet ready for discharge to a community placement. The target population for the Miller North project will include people whose symptoms include aggressive, self-injurious, or inappropriate sexual behaviors as well as other challenging behaviors that interfere with community placement. The project (as currently proposed) will create 16 transitional beds to provide a sub-acute level of care to engage individuals in comprehensive treatment and rehabilitation to support their recovery and successful reintegration into the community setting of their choice. The physical space for the new unit is already available within currently vacant space in the Miller North unit at AMRTC, but a financing model for the project has not yet been established. DHS estimates that the facility could open within six months after financing is secured.
- **Streamline the competency restoration process**. As described in Chapter VIII, NAMI-Minnesota is leading a planning effort to improve the competency restoration process in Minnesota, including introducing legislation support the creation of a community-based program. While AMRTC is participating in that effort, staff members have also formed an internal workgroup to improve AMRTC's operations and processes for treating people in the program and to identify more diversion opportunities. These efforts could help reduce the number of people admitted to AMRTC under Rule 20.01 (subd.7) and reduce the number of non-acute bed days they spend, thereby making more beds available for other people.
- **Increase capacity at DHS's Community Behavioral Health Hospitals to assist people whose symptoms include aggressive behaviors.** The Legislative Auditor's report that requested DHS to prepare this report also recommended that DHS add security arrangements to at least two CBHHs that would enable them to admit individuals whose symptoms include very aggressive behaviors. DCT recently completed a feasibility study of increasing the capacity of a single CBHH to serve these individuals (similar to the capacity that AMRTC has). The study considered the feasibility of reducing the census and enhancing the staffing, case planning, programming, physical plant and support

provided by Central Preadmission to pilot a program at the Community Behavioral Health Hospital in St. Peter consistent with the OLA recommendation. The study concluded that renovations would be prohibitively costly and that it would be difficult to financially to compensate the landlord of the hospital building for their capital investments. Moreover, it would be difficult to staff the hospital at a level that ensures an adequate capacity to quickly respond to emergencies to keep patients and staff safe. Therefore, DCT executive management decided it would be unfeasible to significantly improve the Community Behavioral Health Hospitals' capacity to assist people whose symptoms include aggressive behaviors and that those people should continue to be served at AMRTC, where there are adequate numbers of staff to respond to emergencies. However, another option is for the hospitals to serve more of the other sub-populations now being served at AMRTC, allowing AMRTC to focus its capacity on the sub-population of people whose symptoms include aggressive behaviors.

- **Improve Central Preadmission's (CPA) collaboration with stakeholders**. CPA is the intake department of DCT and county case managers often consider CPA the gatekeeper to access as they try to assist a client in gaining admission to AMRTC. AMRTC intends to implement a project to improve relationships between CPA and stakeholders so that there is more transparency in the referral and admission processes and fewer misunderstandings. This project should help transform the perception that CPA as a gatekeeper to that of a gateway and will include:

    - Regular meetings with county and tribal stakeholders and community hospitals
    - Development of a CPA-specific website with content including current bed availability, admission criteria, links to forms and resource information, and news and department updates
    - Invitations to stakeholders to visit the CPA offices to better understand the referral process, meet the staff and share experiences, and engage in joint problem-solving.

- **Reduce Readmissions**. The Minnesota health care community is collaborating to reduce avoidable hospital readmissions statewide. The RARE campaign (Reduce Avoidable Readmissions Effectively) has shown significant impact on readmissions for physical illnesses, and has released a report describing best practices for reducing readmissions for mental illnesses and substance use disorders. AMRTC and the Rochester CBHH are joining the RARE campaign to implement a readmission-reduction project in 2014, focusing on discharge planning improvements.
- **Assure the availability of outpatient services**. In addition to the many private outpatient service providers, AMRTC operates a small outpatient clinic to provide outpatient transitional gap services to people who have been discharged from AMRTC. The services include medication management, routine lab work, psychiatric assessment, and therapy. These services are provided to people while they are waiting for

appointments for the services to be provided in community settings. AMRTC is assessing the availability of outpatient services for people discharged from AMRTC in order to assure that all people have access to services that help them remain in the community rather than being readmitted to the hospital. Telecommunications could be used to help support such consultations.

- **Conduct post-discharge surveys**. In addition to changes in the discharge process that might be implemented as part of the RARE project (see above), AMRTC plans to implement a system for surveying people after they are discharged to gauge their satisfaction with AMRTC services and to assess whether they are receiving the community support services they need as they pursue recovery.
- **Change the commitment process**. Changes to the commitment process will require collaboration among a wide variety of stakeholders and state agencies. While AMRTC is just one player in this larger system, AMRTC staff look forward to participating in such statewide efforts because the commitment process has such a direct effect on AMRTC's waiting list. If changes could be made to align the commitment process more with Olmstead principles, it is likely that some individuals could be better served by avoiding court-ordered commitments to the Commissioner (and automatic referrals to AMRTC).

### 3. Address AMRTC's ineligibility for Medicaid payments for most patients

As a means of reducing states' reliance on large state regional treatment centers, CMS does not allow MA reimbursements for care that people ages 22-64 receive in psychiatric facilities of more than 16 beds (these are called "institutions for mental disease, or IMDs). This *IMD exclusion* forces the state of Minnesota to fund AMRTC with appropriated dollars (approximately $35 million for FY2014), with much of the care being non-reimbursable by MA.

As part of the Reform 2020 proposal to CMS in 2012, DHS requested a waiver of the rule that prohibits Medicaid reimbursement for expenditures for services provided by hospitals with more than 16 beds that are primarily focused on the treatment of mental illness (IMDs). The proposal explained that this waiver would allow AMRTC to serve as a statewide resource to provide diagnosis and treatment for people with the most complex mental illnesses and co-occurring conditions. In a conference call held on February 26, 2013, CMS verbally informed DHS that they would not approve the IMD waiver request.[93] DHS is continuing to look for alternative financing models and incentives to fund the care provided at AMRTC for the target population.

[93] While CMS has maintained that Medicaid will not fund treatment in public IMDs for people ages 22-64, it is currently operating the "Medicaid Emergency Psychiatric Demonstration," a project that tests whether Medicaid can support higher quality care at lower total cost by reimbursing *private* psychiatric hospitals for certain psychiatric services for which Medicaid reimbursement has historically be unavailable. The demonstration program invited all State Medicaid Program Directors to apply for up to $75 million in federal Medicaid matching dollars over three

### 4. Determine the appropriate number of beds at AMRTC

There are many factors that must be considered to determine the appropriate number of beds at AMRTC, including:

- The availability of community-based services to support the recovery and prevent unnecessary hospitalization of people in the target population
- The risk-management philosophy and approach of particular providers and county and tribal staff (including courts)
- The number of people in the target population in a given year (which is itself driven by scores of factors, including changes brought by the health care reform)
- The number of acute psychiatric beds available at the CBHHs and community hospitals
- The impact of the Affordable Care Act and how that will affect community hospitals' decisions that drive capacity for providing acute psychiatric care
- The utilization of existing psychiatric beds (i.e., the number of non-acute bed days)
- The legal and financial incentives that encourage counties, tribes, and community hospitals to civilly commit people and refer them to AMRTC
- Changes in treatment approaches
- Trends in arrests and sentencing that affect people with mental illnesses in the criminal justice system
- The costs of increasing the number of beds at AMRTC
- The financial/political tradeoff of funding more psychiatric beds vs. funding more community-based services that would ameliorate the need for those beds
- The availability of public funds and the competing demands for those funds.

Many of these factors are in flux right now due to changes in state policy and funding as well as implementation of health care reform and Minnesota's Olmstead Plan. This makes it very difficult to determine an optimum number of beds at AMRTC.

In 2013, CMHSA contracted with SAMHSA consultants to help the administration assess Minnesota's inpatient psychiatric bed capacity. The consultant's report contained several specific recommendations about how to model, measure and track bed capacity, and CMHSA is considering how it could implement those recommendations. The consultants also identified fragmented authority within the public mental health system as a critical barrier to effective patient flow through the system.

> *". . . [D]ecisions regarding policy, establishment of programs, and access to programs are governed by the actions of various state agencies, county*

---

years to fund treatment in private psychiatric hospitals that were IMDs. The program began in 2012 with 12 states participating. Results of the project will not be available before 2015.

*governments, tribal governments, healthcare plans, multicounty community mental health centers, and large hospital systems, including those in bordering states."*

The consultants concluded that given the fragmentation of authority, one of CMHSA's most important roles could be as a convener of other authorities and constituents around the state to build consensus on problems and solutions. They recommended that CMHSA convene key players in each Adult Mental Health Initiative Region to improve collaboration, formulate joint projects and implement solutions. To that end, CMHSA is creating a new position to oversee and support regional collaborations. CMHSA hopes to have someone working in this position by spring of 2014. One focus of the collaborative work will be on addressing patient flow and bed capacity issues for the target population.

DHS expects that short-term solutions like the Miller North Project and the RFPs for specialized IRTS services will help alleviate the intense pressure on AMRTC beds. DHS believes that the largest share of the state's resources are best spent on implementing the long-term solutions to the problem that are congruent with the state's Olmstead planning: expansion of community-based services and re-design of core processes like the commitment process and competency restoration.

### 5. Possible need for additional legislative action to improve community reintegration options for people served at AMRTC

As described in Chapter VIII, DHS and stakeholder partners are in the process of implementing several major projects that will improve the community reintegration options for people served at AMRTC. DHS will provide periodic updates to the Chairs of the Health and Human Services, Policy, and Finance Committees of the Minnesota Senate and House of Representatives. The updates will inform legislators about the progress of the projects and about any needs for additional legislative action that may emerge.

### 6. Collaborate with non-state hospitals and other service systems

AMRTC is a member of the Minnesota Hospital Association and regularly attends its meetings and participates in its workgroups, especially the Mental and Behavioral Health Task Force. In addition to this ongoing participation, AMRTC has several partnerships with community hospitals, especially in the metro area:

- **Mercy Hospital**: AMRTC has a very significant collaboration with Mercy Hospital in Coon Rapids that provides AMRTC with essential medical services. AMRTC could not operate effectively without this partnership.
- **Allina Health Systems**: AMRTC has been collaborating with Allina Health Systems since early 2012 to address long length of stays in emergency rooms and in psychiatric units. Data from CY2008 through CY2010 showed that over 600 people currently receiving waiver (disability) services were seen in an emergency room for a mental

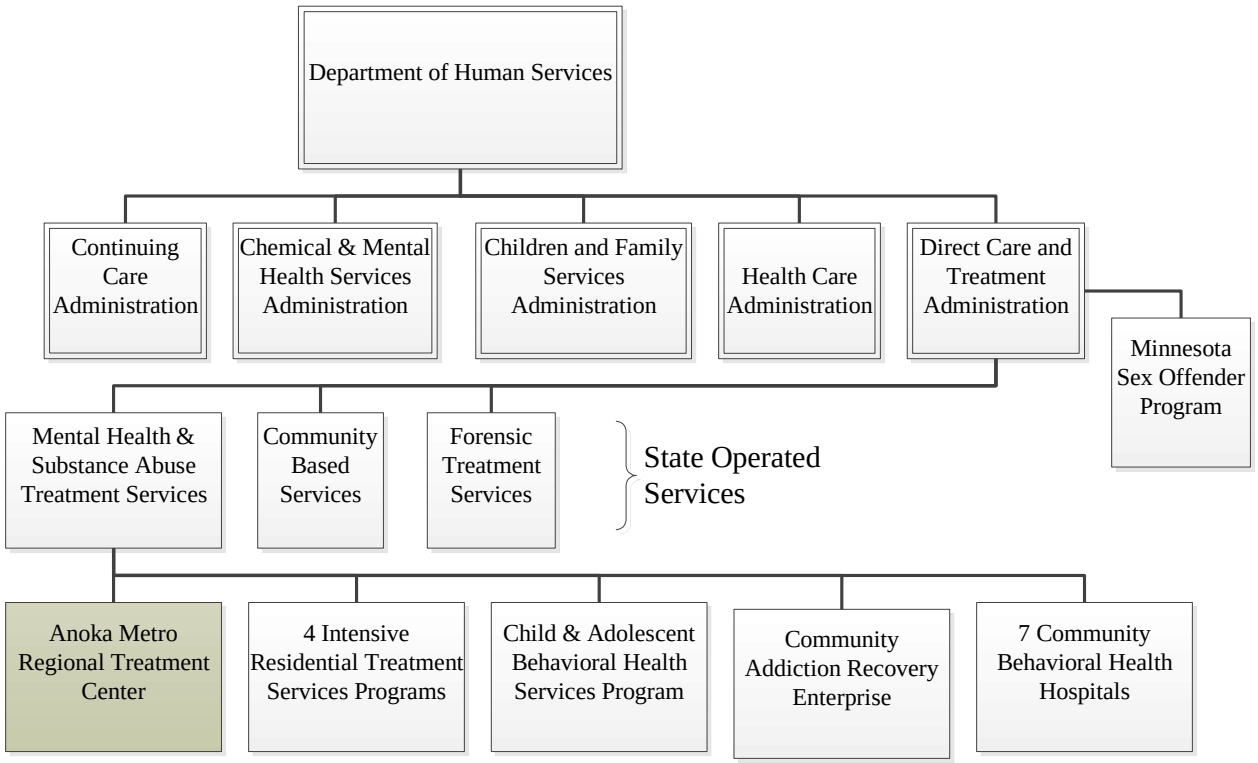
illness or substance use disorder. Over 60 percent of those who were admitted were not receiving consultation services from a mental health or substance use disorder professional and did not have a functional crisis service plan in place. Moreover, the majority of crisis service plans reviewed by Allina Health System only identified calling 911. The collaboration with Allina helped drive support for the 2013 legislative funding to support Community Capacity Building team members to address deficits in crisis community support services for people with intellectual disabilities.

- **Mental Health Crisis Alliance**: AMRTC and CSS/Synergy are collaborating with the Mental Health Crisis Alliance and the Metro Crisis Coordination Program (a metro county alliance of mental health and substance use disorder professionals) to better identify barriers that have resulted in AMRTC readmissions and to divert potential admissions of people with mental illnesses and intellectual disabilities into crisis beds and other community services in the Metro area. The collaboration is also looking at ways to better coordinate discharge planning and comprehensive crisis service planning to potentially include mobile crisis team deployment.
- **Hennepin County Medical Center**: About 35 percent of people served at AMRTC come from Hennepin County, and they spend about 40 percent of AMRTC's total non-acute bed days. HCMC is one key to alleviating the patient flow problems experienced at AMRTC, but HCMC itself faces quite similar problems. AMRTC staff members have been meeting with HCMC leaders in 2013 to improve collaboration and explore options that will improve care for people served at both hospitals. For example, staff members from both organizations have begun an extensive review of HCMC's financial processes to help assure that HCMC is getting maximum reimbursement for the mental health services it is providing.
- **Remote provisional discharges**: AMRTC has implemented a process for "remote provisional discharges" from community hospitals that serve people who have been committed to the Commissioner. This has reduced delays in discharges at community hospitals and thus improved care. AMRTC is committed to continuing to collaborate to refine this process so that remote provisional discharges can happen quickly and efficiently.

# X. Appendices

## Appendix A: AMRTC in the DHS Organizational Structure

In response to the recommendations in the report from the 2013 Office of the Legislative Auditor, DHS re-organized State Operated Services. A new Administration was created, called Direct Care and Treatment (DCT), under direction of the Deputy Commissioner. DCT comprises State Operated Services and the Minnesota Sex Offender Program. State Operated Services was organized into three Divisions: Forensic Treatment Services (including the Minnesota Security Hospital); Community Based Services (including Minnesota State Operated Community Services and Community Support Services); and Mental Health and Substance Abuse Treatment Services (MHSATS). AMRTC is one facility within MHSATS, along with the Community Behavioral Health Hospitals, the Community Addiction Recovery Enterprise (C.A.R.E.) program, the Child and Adolescent Behavioral Health Services program, and four state-operated Intensive Residential Treatment Services.



## Appendix B: Acronyms Used in this Report

ACT: Assertive Community Treatment
ADA: Affordable Care Act
AMRTC: Anoka Metro Regional Treatment Center
ARMHS: Adult Rehabilitative Mental Health Services
CADI: Community Alternatives for Disabled Individuals
C.A.R.E.: Community Addiction and Recovery Enterprise
CBHH: Community Behavioral Health Hospital
CMHSA: Chemical and Mental Health Services Administration
CMS: Center for Medicare and Medicaid Services
CSS/Synergy: Community Support Services/Synergy
DCT: Direct Care and Treatment
DHS: Department of Human Services
DRG: Diagnosis-related group
ED: Emergency Department
HCBS: Home and Community Based Services
HCMC: Hennepin County Medical Center
IMD: Institute for Mental Disease
IRTS: Intensive Residential Treatment Service
MA: Medical Assistance
MHSATS: Mental Health and Substance Abuse Treatment Services
MSOCS: Minnesota State Operated Community Services
NABD: Non-acute bed day
OLA: Office of the Legislative Auditor
SAMHSA: Substance Abuse and Mental Health Services Administration
SOS: State Operated Services
SPMI: Serious and persistent mental illness
UM: Utilization management

# Appendix C: DCT Service Units, FY2002 & FY2012

This table shows DCT's service units and the episodes of care they provided in FY2002 and FY2012. The services units are categorized as institutional, community-based, and forensic.

| DCT Service | Service and Population Served | Episodes of Care FY2002 | Episodes of Care FY2012 |
|---|---|---|---|
| **Institutional** | | | |
| Anoka Metro Regional Treatment Center (AMRTC) | Psychiatric services for people who have acute mental illnesses requiring a hospital level of care and who are civilly committed. AMRTC currently operates as an acute psychiatric hospital. | 804[94] | 535 |
| Child & Adolescent Behavioral Health Services (CABHS) | Range of mental health services for children and adolescents with serious emotional disturbances whose needs exceed the resource capacities of their families and community providers. | 336 | 65 |
| Brainerd, Fergus Falls, St. Peter, and Willmar Regional Treatment Centers | Originated as asylums, the Regional Treatment Centers evolved into institutions that provided integrated psychiatric services for people with severe mental illnesses. | 2,095 | 0[95] |
| Ah Gwah Ching Nursing Home | Psychiatric nursing home for adults. | 2015 | 0[96] |
| **Community-based** | | | |
| Chemical Addiction Recovery Enterprise (C.A.R.E.) | Inpatient and outpatient treatment for people with substance use disorders, most with complex co-occurring conditions. Approximately fifty percent are civilly committed. | 2,603 | 1,783 |
| Community Support Services | Direct service and provider consultation in the community for individuals with mental illnesses, substance use disorders, traumatic brain injury, acquired brain injury, and intellectual disabilities. | 732 | 335 |
| Minnesota Specialty Health System | Residential rehabilitation services for people with complex mental health needs and/or traumatic brain injury or acquired brain injury. | 95[97] | 298 |
| Community Behavioral Health Hospitals | Short-term psychiatric services for people with acute mental illnesses requiring a hospital level of care. About a third of the people served are committed, and most of the rest are admitted under judicial or emergency holds. | 0[98] | 1,462 |
| Dental clinics | Dental services for people with intellectual disabilities and/or other disabilities who cannot access dental services anywhere else. | 0[99] | 10,212 |

[94] Excludes Como, which is included in MN Specialty Health Services.
[95] Brainerd RTC closed in February 2007; Fergus Falls RTC closed in September 2006; St. Peter RTC closed in May 2006; and Willmar RTC closed in August 2008.
[96] Ah Gwah Ching Nursing Home closed in August 2008.
[97] FY2002 includes only Como and MN Neuro-Rehabilitation Services. These were wrapped into MN Specialty Health Services in July 2011.
[98] The Community Behavioral Health Hospitals opened between 2006 and 2008.
[99] Dental Clinic data for 2002 was not available. The 2012 data represents total number of patient visits.

| DCT Service | Service and Population Served | Episodes of Care FY2002 | Episodes of Care FY2012 |
|---|---|---|---|
| Mental Health Clinic | Outpatient mental health clinic serving people with intellectual disabilities. | 0[100] | 1,778 |
| Minnesota State Operated Community Services | Residential and vocational support services for people with developmental disabilities, traumatic brain injury, acquired brain injury and other disabilities. | 452 | 480 |
| **Forensic** | | | |
| Minnesota Security Hospital | People with serious and persistent mental illnesses who have been committed as Mentally Ill and Dangerous. | 228 | 309 |
| Competency Restoration Program | Competency restoration services for people civilly committed under Rule 20. | 0[101] | 82 |
| Forensic Nursing Home | Adults who pose a public safety risk and require a nursing home level of care. | 0[102] | 40 |
| Forensic Young Adult & Adolescent | Adolescent and young adult people who have been civilly committed as Mentally Ill and Dangerous. | 0[103] | 24 |
| Forensic Transition Programs Outside of MSH[104] | Supervised residential settings for people who have been civilly committed as Mentally Ill and Dangerous and who have completed treatment and been approved for reduction of custody. | 72 | 108 |

**Table 31: DCT Services and Episodes of Care in FY 2002 and FY2012**

[100] Mental Health Clinic data for 2002 was not available. The 2012 data represents total number of patient visits.
[101] Competency Restoration was transferred to St. Peter in March 2010.
[102] The Forensic Nursing Home opened in March 2008.
[103] The Forensic Young Adult Services opened in September 2007.
[104] DCT provides forensic transition services at the Minnesota Security Hospital and at other sites. The service episodes provided at MSH are included in the MSH row, above; this row includes the episodes provided at other sites.

# Appendix D: Minnesota's Definition of Serious and Persistent Mental Illness

In Minnesota statute, "serious and persistent mental illness" is defined as follows:

> *For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:*
>
> *(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;*
>
> *(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;*
>
> *(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;*
>
> *(4) the adult:*
>
> *(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;*
>
> *(ii) indicates a significant impairment in functioning; and*
>
> *(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or(2), unless ongoing case management or community support services are provided;*
>
> *(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or*
>
> *(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6 ; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.*[105]

[105] Minnesota Statutes, section 245.462, Sec. 3., Subd. 20 (c) (3).

# Appendix E: Greater Minnesota Adult Mental Health Initiative Regions

| Initiative | Counties |
|---|---|
| Northwest Minnesota 8 | Polk, Kittson, Mahnomen, Marshall, Norman, Pennington, Red Lake, Roseau |
| Region 2 | Hubbard, Beltrami, Clearwater, Lake of the Woods |
| Region 3 North | Lake, Carlson, St. Louis, Cook, Itasca, Koochiching |
| BCOW | Becker, Clay, Otter Tail, Wilkin, White Earth Reservation |
| 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 |
| CommUNITY | Sherburne, Benton, Stearns, Wright |
| Southwest 18 | Cottonwood, Big Stone, Chippewa, Jackson, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Yellow Medicine |
| South Central Community Based Initiative (SCCBI) | Blue Earth, Brown, Watonwan, Faribault, Martin, Freeborn, Le Sueur, Nicollet, Rice, Sibley |
| CREST | Olmsted, Winona, Fillmore, Goodhue, Houston, Mower, Steele, Dodge, Wabasha, Waseca, Prairie Island Reservation |

**Table 32: Counties in Greater Minnesota Adult Mental Health Initiative Region**

## Appendix F: Gaps Analysis Survey of the Adult Mental Health Service System

The recently completed 2013 Gaps Analysis Survey of counties, mandated by the Minnesota Legislature, revealed a number of significant gaps and shortages in the adult mental health service array.[106] Although many of these issues can be especially problematic in rural or frontier areas, others transcend geography. Here are the most commonly mentioned adult mental health service gaps:

- There are chronic shortages of certain types of services, especially by psychiatrists and other qualified psychiatric care providers, mental health services for individuals in local jails, housing with supports, integrated services for co-occurring mental health and substance use disorders, and evidence-based supported employment services.
- There is a need for better integration and care coordination across the traditional service delivery "silos": mental health, substance use disorder services, primary care, public health, and others.
- Throughout the state, there is a serious shortage of decent, affordable housing with consumer-chosen supports.
- Only three counties (Hennepin, Ramsey, and St. Louis) have specialized mental health courts for people who have been charged with crimes and also have mental health service needs, despite the obvious advantages of this effective and person-centered approach to problem resolution.
- There is a need for more Certified Peer Specialists – that is, current or former recipients of mental health services who have successfully completed a DHS-approved training program and are ready and eager to help their peers make progress on the road to recovery.
- There is a need for more sensitive and effective outreach to diverse cultural communities that are often underserved or inappropriately served in the mental health system.

[106] *2013 County Long-Term Services and Supports Gaps Analysis Survey: Adult Mental Health, Full Report* (Saint Paul: Adult Mental Health Division, Chemical and Mental Health Services Administration, Department of Human Services, August 2013), 33.

# Appendix G: Diagnostic Categories and ICD-9 Diagnostic Codes

These categories were used to identify the categories of diagnoses for each episode of care at AMRTC in Table 12, Table 21, and Table 23. They are adopted from J.A. Buck, J.L. Teich, and K. Miller, "Use of Mental Health and Substance Abuse Services among High-Cost Medicaid Enrollees," *Administration and Policy in Mental Health*, 31 (2003), 2-14. Some outmoded and offensive language for people with disabilities that was used in the original diagnostic categories in the quoted article was changed to reflect currently-accepted "People First" language.

| Diagnostic Category | First Three Digits of ICD-9-CM Diagnosis Code | Example Conditions included within Diagnostic Category |
|---|---|---|
| Schizophrenia | 295 | Chronic and acute schizophrenic conditions |
| Major Depression and Affective Conditions | 296 | Manic, depressive, and bipolar conditions |
| Other Psychoses | 297, 298 | Paranoid states, delusional conditions, and reactive psychoses |
| Childhood Psychoses | 299 | Infantile autism, disintegrative conditions, and childhood-like schizophrenia |
| Neurotic and Other Depressive Conditions | 300, 311 | Anxiety states; phobic, obsessive-compulsive, and other neurotic conditions; and unspecified depressive conditions. |
| Personality Conditions | 301 | Affective, schizoid, explosive, histrionic, antisocial, dependent, and other personality conditions |
| Other Mental Conditions | 302, 306, 310 | Sexual deviations, physiological malfunction arising from mental factors, and on-psychotic mental conditions due to organic brain damage |
| Special Symptoms and Syndromes | 307 | Eating conditions, tics and repetitive movement conditions due to organic brain damage |
| Stress and Adjustment Reactions | 308, 309 | Acute reaction to stress, depressive reaction, separation conditions, and conduct disturbance |
| Disorders of Conduct | 312 | Aggressive outbursts, truancy, delinquency, kleptomania, impulse control condition, and other conduct disorders |
| Emotional Disturbances | 313 | Overanxious condition, shyness, relationship problems, and other mixed emotional disturbances of childhood or adolescence such as oppositional condition |
| Hyperkinetic Syndrome | 314 | Attention deficit with or without hyperactivity, and hyper-kinesis with or without developmental delay |
| Pregnancy/Childbirth Conditions | 648.40-648.44 | Mental conditions associated with pregnancy or childbirth |

**Table 33: SAMHSA Diagnosis Codes to Identify Mental Illnesses**

| Diagnostic Category | First Three Digits of ICD-9-CM Diagnosis Code | Example Conditions included within Diagnostic Category |
|---|---|---|
| Alcohol Abuse | 291, 303, 305.0 | Alcoholic psychoses |
| Drug Abuse | 292, 304, 305.2-305.9 | Drug psychoses and mood conditions, drug dependency |
| Tobacco Use Disorder | 305.1 | Tobacco use disorder |
| Pregnancy/Childbirth Conditions | 760.71, 648.3-648.34, 779.5 | Substance abuse-related pregnancy or childbirth |
| Drug Poisoning | 965.00-955.09 | Poisoning by opium, heroin, methadone, or other opiates |

**Table 34: SAMHSA Diagnosis Codes to Identify Substance Abuse Disorders**

| Diagnostic Category | First Three Digits of ICD-9-CM Diagnosis Code |
|---|---|
| Autism | 299 |
| Mild Intellectual Developmental Disorder | 317 |
| Moderate/Severe/Profound Intellectual Developmental Disorder | 318 |
| Unspecified Intellectual Developmental Disorder | 319 |
| Congenital Anomalies | 742 |
| Down Syndrome | 758 |

**Table 35: SAMHSA Diagnosis Codes to Identify Developmental Disabilities**