Chris Steller

From: Kochanski, Alexis R (DHS) <Alexis.Kochanski@state.mn.us>
Sent: Friday, March 29, 2019 12:15 PM
To: Rep.Tina Liebling; Rep.Joe Schomacker; Rep.Rena Moran; Rep.Debra Kiel
Cc: Chris Steller; jim.noble@ola.gov; Chris McCall; Danyell Punelli; Doug Berg; Elisabeth Klarqvist; Joe Durheim; Pat McQuillan; Randall Chun; Sarah Sunderman
Subject: Submission of DHS Legislative Report - Children's Mental Health Intensive Services Study
Attachments: Childrens Mental Health Intensive Services Study Legislative Report.pdf

Dear Legislators,

Good afternoon.

Please find the Children's Mental Health Intensive Services Study attached.

Best,

Thank you.

Alexis Russell Kochanski, MPH
Director of State Legislative Relations | External Relations

Minnesota Department of Human Services
PO Box 64998
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Chris Steller

From: Kochanski, Alexis R (DHS) <Alexis.Kochanski@state.mn.us>
Sent: Friday, March 29, 2019 12:12 PM
To: Sen. Jim Abeler; 'Sen. Michelle Benson'; 'sen.jeff.hayden@senate.mn'; 'sen.john.marty@senate.mn'
Cc: Andrea Todd-Harlin; Dennis Albrecht; Katie Cavanor; LaRissa Fisher; Liam Monahan; Patrick Hauswald; Chris Steller; jim.noble@ola.gov
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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Children's Mental Health Intensive Services Study

Behavioral Health Division

March 6, 2019

For more information contact:

Minnesota Department of Human Services
Behavioral Health Division
P.O. Box 64985
St. Paul, MN 55164-0985

651-431-2321

For accessible formats of this information or assistance with additional equal access to human services, call 651-431-2203, or use your preferred relay service. ADA1 (2-18)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $256500.

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Contents

I. Overview

The Children's Intensive Mental Health Services Study was commissioned by the Minnesota Department of Human Services (DHS) at the request of the 2016 Minnesota State Legislature. The study was commissioned in order to analyze the children's intensive services continuum including children's residential facilities (CRF), many of which have been determined as institution of mental disease (IMD) meaning that federal funding for these services is no longer available. The study also reviews the status of the State's newly implemented psychiatric residential treatment centers (PRTF) service and examines the opportunities for strengthening community-based resources such as intensive treatment foster care and systems of care services including wraparound.

Purpose of report

The purpose of the study was to conduct an analysis of Minnesota's current continuum of mental health services for children with intensive mental health needs and identify potential service models and funding mechanisms to address gaps in the state's continuum of care. Many of the existing CRFs have been declared IMDs as of 2018 and state funding to supplement the lost federal funding for these services is time limited. There has also been a need to examine current screening and placement criteria in addition to treatment practices CRFs are using. Many youth living with a mental illness rather than receiving treatment have ended up in the juvenile justice system or hospital emergency departments which has in turn created a strain on those resources and further exacerbated mental health symptoms for these children. Youth with complex mental health conditions often have not been adequately served in the current continuum of care and some have had to be placed out of state.

II. Study Findings

Children's Residential Facilities

As a result of Centers for Medicare and Medicaid (CMS) determination for IMD for many of Minnesota's CRFs, a total of 371 treatment beds became ineligible to receive federal Medicaid reimbursement. In 2017 the legislature approved the use of state funding to offset the lost federal funding for children's residential treatment services while a longer term solution is being identified.

CRFs were initially designed to stabilize crises and help the child develop skills to return to the community. These services also include family involvement and are intended to prevent placement in a higher level of care. Minnesota has 18 licensed CRFs as well as 6 out of state facilities approved for placing children.

Stakeholder groups were engaged by study researchers to share concerns that homelessness and other vulnerable or marginalized populations of youth have not been adequately served in the current model in addition to youth with complex mental health problems. Many of these youth with complex mental health conditions also display high levels of unpredictable aggression or self-harm. Moreover there is a growing need for inclusion of chemical dependency treatment for co-occurring or dual-diagnosis substance abuse disorders.

The study found that there are areas for improvement within Minnesota's CRFs. Recommendations include:

- **Increase the adoption of effective residential treatment practices.** This a number of best practices, such as the use of trauma-informed treatment models, appropriate for meeting the individualized needs of youth; adoption of organization-level trauma-informed care principles; early and frequent family involvement in treatment planning and services; residential services that are intensive, but focused on youth being home as soon as possible; and strength-based approaches that set expectations for ongoing family and community connections.
- **Expand the capacity of the state's intensive in-home and community-based mental health treatment options.** This includes building up community-based services that reduce the need for and help maintain the gains youth make while receiving residential treatment services.

Psychiatric Residential Treatment Facilities

Psychiatric Residential Treatment Facilities (PRTF) in Minnesota were implemented by the legislature initially in 2015 with 150 beds authorized via Request for Proposal (RFP). Currently, three providers have contracted for these beds and as of June 2018 one provider has begun offering PRTF services in Duluth. The second program plans to open a 42 bed PRTF in Grand Rapids by summer 2019 and the third program plans to open a 60-bed facility in East Bethel that will begin accepting clients in December 2019.

In contrast to CRFs, PRTFs have federally and state determined eligibility criteria where medical necessity must be established in order to authorize treatment. PRTFs are also intended to serve youth up to the age of 21 with moderate to high levels of risk of harm to self or others, including evidence of functional impairment.

Currently PRTF providers are required to engage in a rigorous certification and licensing process. Providers have concerns that these requirements are overly cumbersome.

The study provides an overview of various other states that have implemented PRTFs and any applicable models that Minnesota could employ. Other states have found success in utilizing tiered models of PRTF where intensity of services are varied depending on the need of the youth. These models offer an opportunity for facility-specific reimbursement to incentivize improved service offerings. Some states have been able to implement smaller facility designs that have enabled PRTFs to exist in more areas closer to population centers rather than larger congregate group settings that are prevalent in Minnesota.

Expanding Community-Based Services

Effective community-based services can help prevent the need for more costly and disruptive placement in higher levels of care such as CRF. There are a variety of evidenced-based models detailed in the report such as bridging models for residential facilities to community providers, wraparound and targeted case management. Minnesota already employs many of these community-based models such as CTSS, intensive-treatment foster care and school-linked mental health.

Stakeholder input from counties and school districts provided that long waitlists and lack of intensive community-based option make it difficult for youth to get the care they need. These delays in care may lead to great juvenile justice involvement, particularly for children of color. The lack of community-based resources and care coordination was a theme across many of the stakeholders as gaps in the current continuum of care.

III. Report recommendations

Increase the adoption of effective residential treatment practices

- Set expectations for clinicians and therapists to be trained in the state's Managing and Adapting Practice (MAP) model to increase their capacity to implement evidenced-based and individualized mental health treatment modes
- Consider finance mechanisms to encourage the adoption of effective treatment
- Improve continuity of care among counties, tribes, schools and other supports
- Engage tribes directly to improve supports and services for Native youth
- Continue to explore the needs of mentally ill youth engaged in the juvenile justice system
- Explore options to improve payment rates to include transportation or tele-health for family involvement

Increase capacity of Intensive-community based services

- Expand the capacity of in home therapy, respite, skills training, mentoring, wraparound, family peer specialists
- Develop bridging models (post-residential support)
- Eliminate barriers and disincentives to care coordination
- Integrate Systems of Care and Wraparound into children's mental health continuum
- Strengthen mobile crisis response and stabilization services
- Enforce mental health parity for youth with private insurance unable to access needed care

Expand PRTF capacity

- Consider amending licensing rules and statute to expand eligibility and mitigate barriers to opening new PRTF facilities
- Consider provider or facility specific rates to incentivize development of PRTFs nearer population centers and less dependent on economy of scale for revenue

Sustaining Capacity of Children's Intensive Services

- Extend stop-gap funding for CRF IMDs that will no longer be eligible for federal Medicaid reimbursement

Workforce development

- Increase opportunities for mental health professionals to practice in rural areas
- Expand capacity for family peer specialists, particularly from communities of color
- Increase opportunity for student loan forgiveness for mental health professionals

Develop data framework to assess the needs of youth with mental illness

- Improve data collection methods, establish framework to monitor PRTF implantation, capacity and outcomes
- Examine screening processes required to help ensure services are available as early as possible

V. Legislation

2017 Minn. Laws 1st Spl. Sess.Chap. 6 Art. 8 Sec. 74

CHILDREN'S MENTAL HEALTH REPORT AND RECOMMENDATIONS.

The commissioner of human services shall conduct a comprehensive analysis of Minnesota's continuum of intensive mental health services and shall develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment. The commissioner's analysis shall include, but not be limited to:

(1) data related to access, utilization, efficacy, and outcomes for Minnesota's current system of residential mental health treatment for a child with a severe emotional disturbance;

(2) potential expansion of the state's psychiatric residential treatment facility (PRTF) capacity, including increasing the number of PRTF beds and conversion of existing children's mental health residential treatment programs into PRTFs;

(3) the capacity need for PRTF and other group settings within the state if adequate community-based alternatives are accessible, equitable, and effective statewide;

(4) recommendations for expanding alternative community-based service models to meet the needs of a child with a serious mental health disorder who would otherwise require residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy, and outcomes;

(5) models of care used in other states; and

(6) analysis and specific recommendations for the design and implementation of new service models, including analysis to inform rate setting as necessary.

The analysis shall be supported and informed by extensive stakeholder engagement. Stakeholders include individuals who receive services, family members of individuals who receive services, providers, counties, health plans, advocates, and others. Stakeholder engagement shall include interviews with key stakeholders, intentional outreach to individuals who receive services and the individual's family members, and regional listening sessions.

The commissioner shall provide a report with specific recommendations and timelines for implementation to the legislative committees with jurisdiction over children's mental health policy and finance by November 15, 2018.