

## Chris Steller

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**Subject:** DHS Legislative Report Submission: Mental Health Innovations Grant Report  
**Attachments:** Mental Health Innovation Grant Program Legislative Report.pdf

Happy Friday HHS Chairs and Leads,

Attached is a legislatively mandated report that provides an update on the Mental Health Innovations Grants Program. The Mental Health Innovations Grant Program was created by the 2017 legislature and is intended to test new and innovative approaches to improve access to and the quality of community-based, outpatient mental health services, and reduce pressure on the Anoka Metro Regional Treatment Center (AMRTC) and Community Behavioral Health Hospitals (CBHHs).

If you have questions or would like to discuss this report or the program in more detail, please don't hesitate to get in touch.

Have a great weekend!

-Matt

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# Legislative Report

## Mental health innovation grant program

**State fiscal years 2019/2020**

**Behavioral Health Division**

December 2019

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is \$8,000.

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# I. Executive summary

The Minnesota legislature established the mental health innovation account, appropriating two million (\$2,000,000) in biennium 2017/2018 and each biennium thereafter.<sup>1</sup> The mental health innovation grant program was established to improve access to and the quality of community-based, outpatient mental health services and reduce the number of people admitted to Anoka Metro Regional Treatment Center (AMRTC) and Community Behavioral Health Hospitals (CBHHs).<sup>1</sup> People receiving services for mental illness and co-occurring conditions experience “patient flow” problems, or difficulties moving through treatment from admission to discharge. This is especially true for people needing a level of care provided by state-operated hospitals.

The mental health innovation grant program addresses: 1) unnecessary psychiatric hospital stays and, 2) delayed admissions to psychiatric hospitals. This is a chronic and systemic problem for Minnesotans and their families which results in high costs for payers and low quality of life for service-users and their families. The patient flow problem isn't new to Minnesota's mental health care system and it's been studied many times by various state departments, lead agencies and the Minnesota Hospital Association.<sup>6</sup> It's also impacted the lives of people, families and communities across the state.

DHS' Behavioral Health Division established the mental health innovation grant program advisory panel given the chronic and systemic nature of the patient flow problem. In the last year DHS has worked with a diverse pool of stakeholders across the state of Minnesota to develop ideas and innovate together to address the patient flow problem. The panel has focused on systemic barriers, change and weighed in on real-time results in the context of both the mental health innovation grant program and more globally, i.e. the behavioral health care continuum. The panel is discussed in more detail in *VI. Mental health innovation grant program advisory panel* section of this report.

Grantees from six geographically and programmatically distinct regions delivered services to 700 people in the first year of implementation. Each program was designed according to local and regional care continuum gaps analyses and the unique needs and preferences of people at risk for, or accessing psychiatric inpatient care. Programs funded under the grant encompass diversion, intervention and post-vention models of care to disrupt the patient flow problem. Performing an impact evaluation proved difficult because of the a) relatively short period of time programs have operated and, b) a lack of access to comprehensive data. These programs have addressed the goals of the project by improving access to and the quality of community-based, outpatient mental health services, reducing the number of people admitted to AMRTC and community behavioral health hospitals (CBHHs), and expediting discharges for those that no longer need hospital level of care.

The report was written in concert with each grantee, the DHS Behavioral Health Division's Research, Evaluation and Technical Assistance (RET) team and the mental health innovation grant program advisory panel. Future grant cycles must minimally include a two-pronged approach: 1) increase the workforce and, 2) increase transitional levels of care. These strategies will build capacity for timely, community re-integration efforts. This

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<sup>1</sup> [Minnesota Statutes, section 245.2662](#), Mental Health Innovation Grant Program.

report outlines challenges, opportunities, findings and recommendations during the first year of implementation.

## II. Legislation

Laws of Minnesota 2017, 1st Special Session, Chapter 6, Article 8, Section 2:

### Subdivision. 4. Report to legislature

By December 1, 2019, the commissioner of human services shall deliver a report to the chairs and ranking minority members of the legislative committees with jurisdiction over mental health issues on the outcomes of the projects funded under this section. The report shall, at a minimum, include the amount of funding awarded for each project, a description of the programs and services funded, plans for the long-term sustainability of the projects, and data on outcomes for the programs and services funded. Grantees must provide information and data requested by the commissioner to support the development of this report.

### III. Introduction

This report outlines challenges, opportunities, findings and recommendations during the first year of the mental health innovation grant program’s implementation. The Minnesota legislature established the mental health innovation account, appropriating two million (\$2,000,000) in biennium 2017/2018 and each biennium thereafter.<sup>1</sup> Six contracts were executed in June 2018 and this report covers early results of project implementation.

The mental health innovation grant program’s purpose is to improve access to and the quality of community-based, outpatient mental health services and reduce the number of people admitted to Anoka Metro Regional Treatment Center (AMRTC) and community behavioral health hospitals. The mental health innovation grant program addresses the “patient flow” problem in state-operated Community Behavioral Health Hospitals (CBHHs) and Anoka Metro Regional Treatment Center (AMRTC). Patient flow refers to how people being treated for mental illnesses and often co-occurring conditions move through treatment, how they are admitted and how they are discharged.<sup>2</sup>

There are many, interdependent settings and variables that play into the patient flow problem. A hospitalization or emergency department visit which doesn’t lead to successful recovery may be followed by homelessness, incarceration, commitment and placement in a state-operated hospital. The mental health innovation grant program’s scope goes beyond the bounds of the state-operated hospital system due to the interconnected nature of healthcare and patient flow that happens from one intervention to another, one level of care to another, and one system to another.

The problem the mental health innovation grant program addresses is dual in nature. The project addresses both 1) unnecessary psychiatric hospital stays and 2) delayed admissions to psychiatric hospitals. This is a chronic and systemic problem for Minnesotans and their families. It results in high costs for payers and low quality of life for service-users and their families.

Mental health innovation grant program legislation was introduced to address the patient flow problem and lessen the financial burden on counties of financial responsibility. If a person is seeking treatment in either AMRTC or a CBHH and no longer meets medical criteria (DNMC) the county pays 100% of the cost for medical care and coverage. Each day this costs the county of financial responsibility \$1,396/day, \$41,880/mo., \$502,560/yr. for AMRTC and \$1,524/day, \$45,720/mo., \$548,640/yr. for CBHHs.

The current state of Minnesota’s patient flow problem is complex. A robust analysis and list of factors is featured in the (2016) Governor’s Task Force on Mental Health Final Report.<sup>2</sup> The patient flow problem isn’t new to Minnesota’s behavioral health care continuum and it’s been studied many times. Contributing factors and gaps in the system have been identified repeatedly and in previous legislative reports, including:

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<sup>2</sup> Retrieved from [The Governor’s Task Force on Mental Health Final Report](#) (November 15, 2016).

- 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.<sup>3</sup>

These same contributing factors, and others emerged in the first year of implementation.

The mental health innovation grant program seeks to lessen the patient flow problem by providing access to appropriate community settings and/or services otherwise unavailable.<sup>3</sup> In addition to funding innovative projects across the state of Minnesota an advisory panel was formed to help foster innovation through co-production.<sup>4</sup> Co-production fosters innovative thinking through cross-sectoral collaborating, exchanging ideas and identifying risks and possibilities in a group environment. The mental health innovation advisory panel is covered in more detail in *VI. Mental health innovation grant program advisory panel* section of this report.

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes, section 245.4662, subd. 4. Report to legislature. The mental health innovation grant program lead and key staff on the research, evaluation and technical assistance team in the Behavioral Health Division prepared the report in collaboration with the mental health innovation grant program advisory panel and six grantees. The report includes data and input from each grantee and the mental health innovation grant program advisory panel and was written in concert with these key stakeholders.

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<sup>3</sup> Retrieved from [Plan for the Anoka Metro Regional Treatment Center, Direct Care and Treatment and Chemical and Mental Health Services Administrations](#) (February 14, 2014).

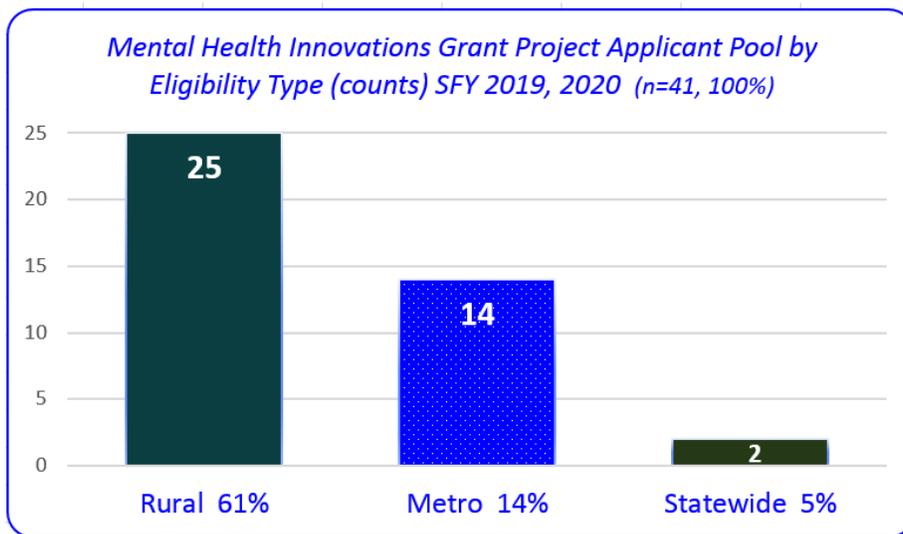
<sup>4</sup> Nabatchi, T., Sancino, A., & Sicilia, M. (2017). Varieties of participation in public services: The who, when, and what of coproduction. *Public Administration Review*, 77(5), 766-776.

# IV. Applicants

Eligible applicants for the mental health innovation grant program includes counties, tribes, mental health service providers, hospitals, or community partnership. For the purpose of the grant, “community partnership” is defined as a project involving the collaboration of two or more eligible applicants. State-operated direct care and treatment facilities or programs under chapter 246 were excluded as eligible applicants. For a complete list of applicants see the appendix of this report for the *mental health innovation grant program applicant pool by eligibility type SFY 19*.

<b>Mental health innovations grant project applicant pool by eligibility type SFY 19/20</b>	Mental health service provider	Community Partnership	Indian Tribe	County	Hospital
<i>Total= 41</i>	29	6	1	3	2

The Commissioner of Human Services was required to a) consult with stakeholders to determine grant awards and, b) award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. The commissioner of human services gathered input and recommendations by establishing a review panel of community members and professionals. The review panel was made up of diverse knowledge, skills, and abilities and represented the interests of metro and rural communities across Minnesota. The panel was trained on the background, goal, purpose and scoring criteria for the project. Based upon their collective recommendations the commissioner of human services awarded grant funds to a total of six applicants. The diagram below illustrates grants awarded based on applicant eligibility criteria.



## V. Grant awards

A total of 41 proposals were received and six contracts were executed in June 2018. Awards were based on available funding (\$2,000,000/biennium) and cumulative scores based on reviews by the community panel. The following describes each grantee’s award amount, service area, service model, and sustainability plan. The goals of the mental health innovation grant program are to:

- **Improve** access to and the quality of community-based, outpatient mental health services;
- **Reduce** the number of people admitted to Anoka Metro Regional Treatment Center (AMRTC) and community behavioral health hospitals (CBHHs); and
- **Expedite** discharges for those that no longer need hospital level of care.

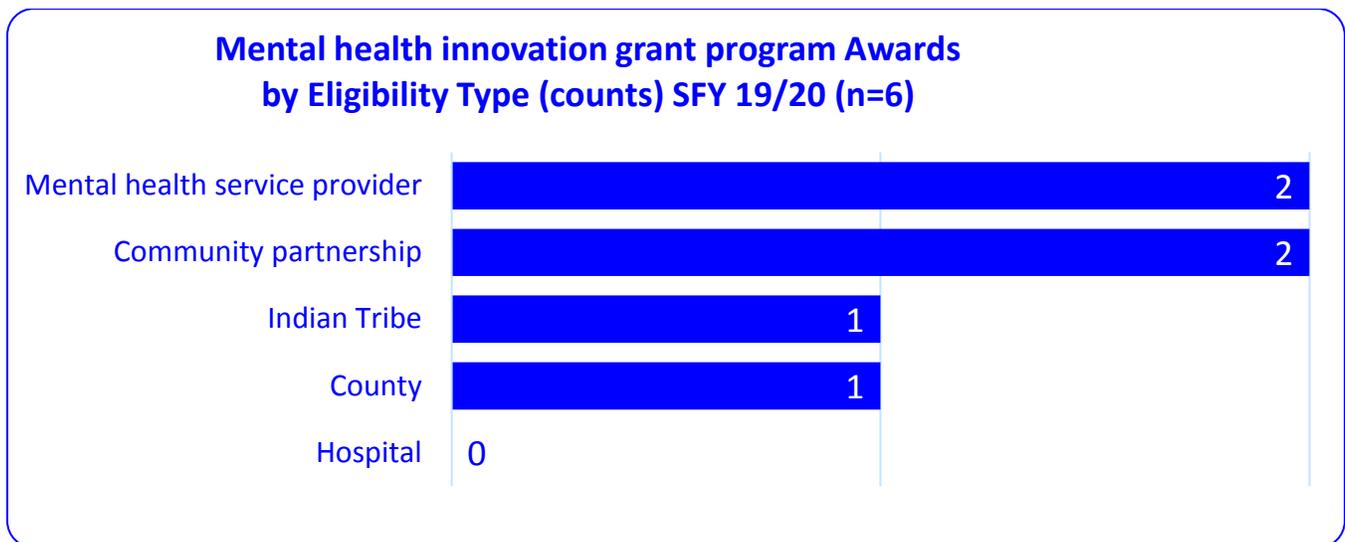


Chart 3. Mental health innovation grant program awards by eligibility type SFY 19/20. Minnesota Statutes, section 245.4662, subd. 2 requires the commissioner to award half of all grant funds to eligible applicants in the metropolitan area and half of all grant funds to eligible applicants outside the metropolitan area. Grant awards were awarded according to this requirement.

### Adult Mental Health Initiative Region V+: Transition Services

#### Award

\$260,958

#### Service area

Serving Aitkin, Cass, Crow Wing, Morrison, Todd and Wadena counties and Leech Lake Band of Ojibwe and Mille Lacs Band of Ojibwe.

#### Service model: regional transition services

Region V+ Adult Mental Health Initiative designed a two-pronged approach for their innovation project. First a new Regional Transition Specialist position was created to get and triage referrals from counties and tribes. They assess people and coordinate services with the goal of diverting people from needing inpatient mental health care. For those that do need higher intensity, inpatient psychiatric treatment, discharge planning starts at admission so that the right level of supports are developed and in place.

Secondly the service model includes a new, full-time position devoted to expansion of a comprehensive, regional re-entry program which helps people returning to the community with no services and who tend to cycle through emergency departments and jails or ordered to competency evaluation. The goal is to safely reduce the number of people with identified mental health needs from cycling in and out of jails as well as reduce the number of civilly committed, treat to competency commitments. This regional service coordinates between mobile crisis teams, hospitals, law enforcement and the counties and/or tribes, as well as state treatment facilities such as Anoka Regional Treatment Center (AMRTC), Community Behavioral Health Hospitals (CBHHs), and Forensic Mental Health Services (formally known as the Competency Restoration Program) located in St. Peter.

Regional Transition Services implemented under the grant span a large, geography and network of providers. It places great emphasis on early contact with care teams and service-users. Whenever possible the regional transition specialist attends care planning in-person and invests in relationships to coordinate the best possible plan of care and at the beginning of service initiation.

### Sustainability plan

AMHI Region V+'s sustainability plan includes a cost-benefit analysis to demonstrate a decrease in hospitalization and medically unnecessary days at Anoka Metro Regional Treatment Center (AMRTC) and Community Behavioral Health Hospitals (CBHHs). The Region plans to work with DHS to further develop and expand this service across the state by including it in regulation and/or becoming a Medicaid benefit to individuals transitioning out of AMRTC, CBHHs and other community hospitals with people on wait lists to AMRTC or CBHH. They're looking at Officer Involved Care Coordination as a Medicaid reimbursable benefit.

Additionally the AMHI Region V+ is working with healthcare providers to discuss the benefits of this program as well as reduced hospitalizations. They're presenting the service model for financial support based upon improved outcomes and reduced hospitalization days. Lastly, the AMHI Region V+ will apply for funding through local and state foundations and utilize existing funds to assist in covering the uninsured and under-insured individuals in need of this service.

### Innovation

Throughout the grant AMHI Region V+ has looked for opportunities to expand services based on real-time data and feedback. For example, they're looking more closely at data tracked and asking for additional information on referrals to prioritize these based on need and level of care and analyze factors that contribute to *does not meet criteria* (DNMC) days. People placed at AMRTC, CBHHs and Forensic Mental Health Services located in St. Peter are placed first to expedite discharges for those that no longer need hospital level of care.

## American Indian Family Center: Healing Journey

### Award

\$218,425

### Service area

The American Indian community in Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington counties.

### Service model: healing generations

The American Indian Family Center (AIFC) enhanced their multidisciplinary team of mental health staff and community consultants to improve access to culturally-specific and responsive services to the Urban Indian population. AIFC added community health workers, elders and family empowerment coaches to their staff complement to support the American Indian community in navigating complex medical organizations. AIFC established a care team of 5 professionals to implement their innovation project, i.e. healing generations. Additionally, elders have organized into a formal elder advisory council that has been integrally involved in programming, support and growth and expansion on all levels. This elder advisory council is primarily “in house” employees with a growing list of contracted medicine men, women and community advisors.

AIFC has focused their efforts on metro hospitals that cover their service area. AIFC has ramped up outreach and education to providers and service-users in these settings. They’ve hosted discussions and completed needs assessments with urban Indians on their experience navigating mainstream hospital systems and made culturally-responsive providers and services more available at any point on the patient flow continuum. Referrals come through self-referrals, online inquiries and through a collaboration with Fairview HealthCare.

AIFC’s service model combines preventive, restorative and postvention healing interventions by assessment through a cultural and holistic lens: physical, emotional, mental and spiritual. Trained staff refer people to healing opportunities and make connections to advocates, community and elders following an intake and assessment. Referrals and resources are customized and teach traditional cultural life ways, resiliency and strength. More urban Indians opt to participate in these services thus reducing the need for crisis services, higher intensity, inpatient psychiatric treatment and utilization of emergency departments, jails, CBHs and RTCs.

### Sustainability plan

The sustainability plan for AIFC’s service model includes generating revenue through third-party reimbursement. AIFC has increased their billing potential through the addition of community health workers and seeking licensure to offer chemical dependency treatment. The Clinical Director of the AIFC is a member of the American Indian Mental Health Advisory Council and has actively worked on the traditional healing grants included in the opiate epidemic response legislation to fund service models like AIFC’s implemented under the mental health innovation grant.

### Innovation

Throughout the grant AIFC has looked for opportunities to expand services based on real-time data and feedback. For example AIFC has made connections with key, hospital staff to generate knowledge of and referrals to their system. AIFC has also identified the need for indigenous evaluation methodology to appropriately respond to the needs of their staff, elders and the people served by the grant.

## Hennepin County Adult Behavioral Health: Behavioral Health Care Center

### Award

\$867,074

### Service area

Hennepin County

### Service model: Behavioral Health Care Center

Hennepin County Adult Behavioral Health (ABH) identified conventional healthcare and social service models weren't working well for the population using Community Behavioral Health Hospitals (CBHHs) and Anoka Metro Regional Treatment Center (AMRTC). Hennepin County ABH took an emergent approach to healthcare and social services by taking direction and feedback from service-users to produce better health outcomes.

Hennepin County ABH identified a group of people cycling in and out of detention, emergency departments and hospitals as having the highest risk and greatest need to be served under the grant. Detention, emergency rooms and hospitals were being over-utilized for needs that were better served in the community. Hennepin County took steps to innovate and create an integrative service model with local hospitals, law enforcement and mental health service providers to comprehensively address the clinical and social service needs of people. Services are co-located to ensure continuity of care and reduce the need for higher-intensity psychiatric treatment. Similar to "wrap-around" models of care, this service model was designed to address immediate as well as underlying needs, in a trauma-informed and responsive setting. Through co-located services, people get a respite and welcomed response from staff rather than being shuffled from one provider to the next in hopes of disrupting the patient flow.

Behavioral Health Interim care coordination (ICC) is the new service model being piloted under the mental health innovation grant. ICC proactively works with people to connect them to community providers and services and reduces barriers people experience when they're navigating complex systems. Hennepin County recognized both the need and opportunity to build an integrative healthcare model around the person and their unique needs, strengths and preferences. Behavioral Health ICC and peer specialists work alongside advanced practice providers from Hennepin Healthcare to provide care coordination and urgent health care services in the same setting. ICC and health care services are available at the Behavioral Health and Wellness Clinic: a collaborative triage, urgent care, and care coordination unit. Additional programs within the building that work closely with the ICC model are the Withdrawal/Detoxification Program and the ReEntry House Mental Health Crisis Stabilization program.

The County recently transformed their 50-bed detoxification program at 1800 Chicago Avenue in Minneapolis into a 64-bed Withdrawal Management program (run by American Indian Community Development Corporation) and developed a 16-bed Mental Health Crisis Stabilization Unit (run by ReEntry House) on site. County-operated supported employment and eligibility and work support services that assist with health care, Supplemental Nutrition Assistance Program (SNAP) and emergency assistance are also stationed on site and provide essential access to Medicaid funded programs, including housing and employment support.

### Sustainability plan

Hennepin County ABH expects to achieve full sustainability based on medical billing and county property taxes. Costs may be offset by county savings in hospitalization, emergency room and detention costs attributable to the project. Hennepin County intentionally obtained grant funding to allow for the opportunity to redesign service delivery for a targeted population through its use of flexible funding during the pilot process. This transformative model of delivering services can be studied for a new Medicaid benefit set. Cost-benefit analysis and stakeholder interviews are part of the evaluation design to help achieve this result. Criminal Justice Behavioral Health Initiative staff report to their stakeholder advisory board, County Commissioners and the

legislature to share findings from the project and potentially share fiscal responsibility for project sustainment or the replication of this model to other Minnesota communities. Crisis stabilization and Officer Involved Care Coordination may be Medicaid reimbursable payment sources.

### Innovation

Throughout the grant Hennepin County ABH has looked for opportunities to redesign services based on real-time data and feedback. Hennepin County ABH's mental health innovation grant program seeks to dismantle structures that make it difficult for people to get the help they need and they're taking steps to infuse a trauma-informed approach throughout their operational structures. While the adult mental health system works very well for many individuals in Hennepin, there are clear systemic inequities. Individuals most likely impacted by a fragmented system, system bottleneck, and served in institutional care settings are people with complex conditions and people of color and American Indians. They die earlier, end up in the emergency room more often and are arrested more often than people in the general population. People of different racial groups commit suicide and report more mental distress than others and report more difficulty maintaining health coverage and accessing services.

A recent report explains that population-based differences in health outcomes are closely linked with social, economic, and environmental conditions. Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation are about two to three times more likely than those in the highest strata to have a mental disorder. Hennepin County ABH serves an ethnically and racially diverse community and they've taken steps to making both their physical space more inclusive and welcoming and recruited staff that better reflect community members to better address the realities of health inequities experienced by people of color and American Indians

The pilot is supporting iterative and agile learning. Individuals who receive services participate in market research that is helping advance practice. New policies and procedures have been tried and are expediting care and referrals while reducing trauma. For example, a post-clinic huddle and regular multidisciplinary meetings are tools implemented by staff to consult and share on lessons learned each day and to make timely changes in operational processes to better serve people. The team's ability to change in response to person-led planning has limited the "handoffs" of service-users and has simplified protocols. Their learning has highlighted the need and benefit of adding veteran and vocational resources and services and they've designed an assertive outreach approach through a peer support specialist-led resource group. They've also expanded the referral process to a walk-in/self-referral process and extended hours of operation to improve greater access and ease of use for people.

## Human Development Center: Emergency Department Case Management

### Award

\$348,442

### Service area

Duluth and St. Louis County residents placed in Community Behavioral Health Hospitals (CBHHs) and/or Anoka Metro Regional Treatment Center (AMRTC) and settings across the state.

### Service model: emergency department case management (EDCM)

Human Development Center (HDC) designed a specialized, multi-disciplinary team of professionals trained to respond to the hospital emergency departments. Team members have a vast knowledge and understanding of the community based services regionally available and possess the ability to access these services immediately as opposed to the traditional referral based process.

HDC is working with two local hospitals in Duluth: 1) St. Luke's and 2) Essentia Hospitals. HDC has established a care team of 8 professionals to provide emergency department case management. The multi-disciplinary team includes housing specialists, mental health practitioners and certified peer specialist(s). Team members are available during both traditional and non-traditional office hours, i.e., evening and weekends.

HDC identified gaps in the behavioral health continuum of care for people presenting to the emergency department. Many people come to the emergency department in crisis and for non-life threatening needs such as mental health and substance use disorder related needs. When a person is triaged and does not meet hospital level criteria they're either discharged or admitted to other, lower-level care treatment facilities. Local providers in Duluth identified and tracked a specific subset of people that were cycling in and out of the hospitals, in crisis and with non-life threatening needs. Lack of referral sources and coordinated care delayed access, prevented re-stabilization and compounded these people's needs and symptoms until higher intensity, inpatient psychiatric treatment was necessary. This subset of people were at-risk for, or were admitted to Community Behavioral Health Hospitals (CBHHs) and AMRTC.

St. Louis County, HDC and other local providers are not notified frequently until it's too late. In some cases people are discharged out-state or to the twin cities making it nearly impossible to track them down and coordinate care. HDC's service model places case managers in emergency departments. HDC's service model offers immediate intervention and meets the person where they're at to ensure they're connected with the right services.

### Sustainability plan

The sustainability plan for HDC's model includes cross-training staff in HDC's certified community behavioral health clinic (CCBHC) to provide the service. Secondly, crisis stabilization services may be a Medicaid-reimbursable payment source. Lastly, due to the success of the program a local hospital plans to embed HDC staff and the emergency department case management model into their facility following the cessation of this grant.

### Innovation

Throughout the grant HDC has looked for opportunities to expand services based on real-time data and feedback. For example HDC has met with St. Louis County representatives to collaborate on expediting discharges for people admitted to CBHHs and AMRTC for county residents. HDC will coordinate care for people exiting a CBHH or AMRTC and provide customized, wrap around services to ensure a successful transition. Based on feedback from their advisory panel they started tracking referral sources for people walking-in to their office and expanded outreach to include the in-patient adult behavioral health units (rather than only the emergency departments).

## Kanabec County: Care Connector

### Award

\$195,512

### Service area

Kanabec County and coordination with Pine County.

### Service model: Care Connector

Kanabec County Community Health developed a Care Connector position that assists people with serious mental health issues who are transitioning from one setting to another setting within the community. The Care Connector's role is to help adults at-risk for psychiatric, inpatient treatment and transitioning from one setting to another setting within the community. The Care Connector ensures continuity of care and acts as a systems navigator by working with people, their existing care teams/resources and connecting them to services based upon need. Care Connector services are delivered in the community in some of the following settings: emergency departments, hospitals, treatment centers, and jails. Kanabec County Community Health designed an integrative team to prioritize referrals and coordinate care. The integrative team includes Kanabec County Community Health, Kanabec County Family Services, Welia Health (formerly FirstLight Health System) and Recovery Hope Treatment Center.

Kanabec County is located in rural Minnesota and people served under the grant have less access to mental health services, frequently relying on primary care to meet their psychiatric needs. The Care Connector service model places great emphasis on early contact with care teams and service-users. Whenever possible the Care Connector attends care planning and discharge planning in-person and invest in relationships at the beginning of service initiation. The Care Connector works with people to create a customized plan of care, determine gaps and barriers to needed services, and assists people in overcoming the barriers. As a result of the Care Connector's work, there's greater participation in psychiatric and substance use services and follow through on the part of the person, as well as a reduction of hospitalizations and readmissions, visits to the emergency department, treatment relapse, jail recidivism, and increased quality of life.

### Sustainability plan

Kanabec County Community Health and the integrative team is analyzing cost savings to determine if the position could be sustained by a combined contribution model that may include third party reimbursements and contributions from the entities that are seeing the savings (health system, jail, HHS). The sustainability plan also includes looking at Medicaid benefits such as Officer Involved Care Coordination and Mental Health Targeted Case Management.

### Innovation

Throughout the grant Kanabec County has looked for opportunities to expand services based on real-time data and feedback. For example they identified Welia Health covers an area larger than Kanabec County. The integrative team discussed the county line as a possible barrier for Pine County residents to access the Care Connector. The Kanabec County Family Services Director reached out to the Pine County Health & Human Services Director and agreed to serve Pine County residents under the grant if referred by Welia Health. Lastly the integrative team has increased the Care Connector's community presence and visibility by ramping up

outreach efforts. The Care Coordinator regularly attends provider roundtable meetings, presents at local ministerial group meetings and coordinates more closely with the local jail.

## White Earth Mental Health Program: Holistic Health Practitioners

### Award

\$574,558

### Service area

Enrolled members and descendants of White Earth Nation.

### Service model: Holistic Health Practitioners

White Earth Mental Health Program added 2 Holistic Health Practitioners to their staff complement. Holistic Health Practitioners support the physical, emotional, mental, and spiritual needs of people in their healing and recovering from mental illness. Services are designed according to the needs of community members, gaps in the mainstream behavioral health care continuum and long-held values based on the medicine wheel. Noojimo'iwewin Aazhogan (Healing Bridge) shifts the focus of a medical modality to one that utilizes Anishinaabe prevention and postvention strategies that connect a person to holistic ways of balancing mental health symptomology, recovering from substance use addictions and promoting interest and knowledge in Anishinaabe spiritual and healing traditions.

Noojimo'iwewin Aazhogan offers services to individuals qualifying for or working with the White Earth Reservation Mental Health Crisis Team, Mental Health service providers, Substance Use service providers and White Earth Indian Health Services. Referrals come through community mental health and substance use programs, the Crisis Hotline team, supportive housing programs, child protection programs, White Earth's Cultural Division, Indian Health Services (IHS), Home Health Program and self-referrals. People interested in receiving holistic health services complete an intake packet to determine program eligibility. Individuals then have access to holistic health services through the Noojimo'iwewin Aazhogan program.

The practitioners are part of White Earth Mental Health's overall multi-disciplinary services, providing connections to cultural and holistic healing and recovery services for people in a large rural tribal area. Practitioners office out of the Indian Health Services (IHS) building and Naytahwaush Community Service Center to ensure both coverage on the geographical bounds of the reservation and greater access for service-users. Services are offered twice per week at Oshki Manidoo Center in Bemidji. Transportation to and from these locations is easier for members to access because these locations are frequented by community members. Holistic Health Practitioners work in conjunction with medical, nursing, substance abuse, and mental health clinical teams to provide prevention and post-vention services that are beneficial to people experiencing crisis, detoxifying or recovering from substance dependency.

### Sustainability plan

The sustainability plan for White Earth Mental Health Program's service model includes credentialing Traditional Healers/Holistic Healing Practitioners as a tribally certified practitioner or a tribally licensed professional. Second is to create tribal health care policy for a Traditional Healing Service which will be an added service area available to tribal members seeking behavioral health service. Lastly, is creating a billing structure that aligns with state/federal standards to seek reimbursement for traditional healing services. White Earth Nation is a

member of the American Indian Mental Health Advisory Council and has actively worked on the traditional healing grants included in the opiate epidemic response legislation to fund service models like White Earth's implemented under the mental health innovation grant.

### Innovation

Throughout the grant White Earth Nation has looked for opportunities to expand services based on real-time data and feedback. For example White Earth Nation has placed practitioners at the IHS building and Naytahwaush Community Service Center to ensure both coverage on the geographical bounds of the reservation and greater access for service-users. Transportation to and from these locations is easier for members to access and these locations are frequented by community members. They're actively looking to reduce barriers to accessing services and adjusting eligibility criteria for their members. During the second year of implementation White Earth Mental Health Program will convene a gathering of healers, elders and community members in collaboration with the American Indian Mental Health Advisory Council and DHS to help inform the traditional healing grant implementation passed under the opioid epidemic response bill.

# VI. Mental health innovation grant program advisory panel

DHS is committed to authentically and meaningfully engaging community members, partners and key stakeholders. Therefore a mental health innovation grant program advisory panel was formed to advise the project and evaluate grant recipients' implementation success. Participation on the advisory panel is voluntary and not required by the Minnesota legislature. The mental health innovation grant program advisory panel challenges the status quo, advises grantees and the mental health innovation program lead and contributes to evaluation of services/supports funded under the grant.

The mental health innovation grant program seeks to lessen the patient flow problem by providing access to appropriate community settings and/or services otherwise unavailable.<sup>3</sup> In addition to funding innovative projects across the state of Minnesota an advisory panel was formed to help foster innovation through co-production. Co-production fosters innovative thinking through cross-sectoral collaborating, exchanging ideas and identifying risks and possibilities in a group environment.<sup>4</sup>

## A. Goals

Primary goals of the advisory panel:

- Act as an advisor to DHS' Behavioral Health Division and grantees
- Includes recommendation(s) for sustainability
- Complete evaluations of each grantee based upon periodic oral reports
- Review and provide feedback on a draft legislative report, and
- Participate in discussion on Minnesota's mental health continuum of care (constraints & opportunities)

Ancillary goals of the advisory panel:

- Each grantee will learn about strategies other grantees are implementing that may work well for them
- Provides accountability and tracks progress toward goals/objectives
- Panel formation and participation will uphold the principles of civic engagement<sup>5</sup>
- Recruit future responder's panel

## B. Scope

The advisory panel's program evaluation influences the design and strategic direction of the mental health innovation project (in scope). The advisory panel does not have any authority to de-fund and/or term contracts (not in scope).

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<sup>5</sup> "Meaningful engagement strengthens our democracy as it reaffirms the consent of the governed. Meaningful engagement also increases the efficiency of government as the ideas of all innovative and creative people are considered and the level of trust in society increases in the identified solutions sought to be implemented by government" (Retrieved from [MN Civic Engagement Plan 2016](#)).

Advisory panel meetings for the purpose of evaluation convene approximately every 6 months throughout the grant cycle. In-between panel meetings and approx. every 3 months panelists come together for mental health continuum analysis and visioning (see *meeting descriptions*).

The advisory panel functions as a resource and evaluative body to grantees. Panelists combine their knowledge, skills and abilities and collectively evaluate each project during scheduled meetings. Panelists don't contribute their resources or time beyond scheduled panel meetings and time needed to read and edit a draft copy of the legislative report. Advisory panel meetings are virtual and therefore, virtual capability/presence is required and in-person/travel isn't required.

The advisory panel's main objectives include: 1) act as an advisor to DHS' Behavioral Health Division and grantees and, 2) grantees and advisory panel will review and provide feedback on a draft legislative report 3) complete evaluations of each grantee based upon periodic oral reports, and 4) participate in discussion on Minnesota's mental health continuum of care (constraints & opportunities). The periodic oral reports will be given by grantees and synthesize all data sources to date.

## Meeting descriptions

The mental health innovation grant program advisory panel meets on a quarterly schedule.

- a) Evaluation & learning community meetings: includes an oral report provided by grantees and the advisory panel will offer (oral) feedback and complete a written evaluation of each project. In September 2019 a draft legislative report was circulated for review/feedback.
- b) Mental health continuum analysis & visioning: macro-level systems analysis of the 'patient flow' problem in state-operated Community Behavioral Health Hospitals (CBHHs) and Anoka Metro Regional Treatment Center (AMRTC).

## Panel composition

DHS received and processed 164 applications for the mental health innovation grant program advisory panel. Panelists were screened based on multiple factors including personal and professional experience, responses to foundational questions and their connection to rural and metro/urban Minnesota communities. The mental health innovation grant program advisory panel was established on January 10, 2019. The advisory panel consists of 30 members and functions in both an advisory and evaluative capacity to the project lead and grantees. The panel combines experience from the following settings:

- Counties and/or Minnesota Association of County Social Service Directors (MACSSA)
- Forensic Mental Health Service and/or Community Behavioral Health Hospitals (CBHH)
- DHS Behavioral Health Division management/leadership
- Community Supports Administration Assistant Commissioner
- National Alliance on Mental Illness (NAMI) Executive Director and/or designee
- MN Hospital Association
- Certified Peer Specialist and/or person(s) with lived experience and/or family member(s)
- Tribal representative
- Cultural broker, provider of services to under-served communities

- Representative of community mental health providers and/or association
- Health plan, county purchaser
- Minnesota Department of Health
- Minnesota Department of Corrections

## VII. Findings

The mental health innovation grant program was developed to lessen the patient flow problem by providing access to appropriate community settings and/or services otherwise unavailable.<sup>2</sup> Outcomes were challenging to measure given the nature of the programs developed, their varied implementation, the delay evident after implementing a new service prior to seeing an impact, and the indirect relationship of the programs on the patient flow problem experienced by state-run hospital facilities. The goal of the data collected across grantees is to demonstrate the implementation of services to the demographic which tends to experience the most significant flow concerns per reports from Direct Care and Treatment (DCT), to model an increase in community based supports to divert from hospital admission, and to ultimately demonstrate an increase in admissions and a decrease in DNMC days experienced by people who are admitted to state-run hospital facilities.

All grantees were required to report data into the Mental Health Information Reporting System (MHIS). Data which are required includes basic demographic data and clinical information (mental health or substance use disorder diagnosis as available, additional screening scores). This report does not include the diagnostic composition of people served because it's not a requirement of the grant. These data were selected to determine if grantees were providing services to the population most impacted by patient flow problems during their state-run hospitalizations.

Grantees were also asked to provide data regarding the breadth of their services. This information included the number of program staff they utilized, tracking the number of referrals made and if those referrals were to community based services or hospitals. Grantees were also asked to provide the number of ceremonies they performed if applicable to their program.

MHIS data is reported by the contracted agency providing service or a designated reporting entity. Data is submitted using a unique client identifier (PMI, SMI or AMH ID) which has allowed for unduplicated counts below. Grantees were instructed to report clients served under the grant separate from all other program reporting if applicable to the agency. This ensures grant specific start dates, end dates and reasons for discharge. MHIS data was collected and reported at intake, on a monthly basis following intake and once again at discharge. Data presented in the following tables represents MHIS submissions from each grantee covering July 2018 – July 2019.

### Demographics

Demographic data including gender, age, race and legal status were collected by grantees from July 2018 – June 2019. Demographic data may be reported differently from one reporting period to the next. Client counts in the Gender and Race tables below are unduplicated counts that capture the most recent status reported. Client counts in the Age and Legal Status tables are unduplicated at each response level, however a client may be reported under more than one category due to changes over time or a return to service.

#### Gender

Gender	Distinct Client Count	% of Total Clients Served
Female	327	46.71%

<b>Gender</b>	<b>Distinct Client Count</b>	<b>% of Total Clients Served</b>
Male	373	53.29%

### Age

<b>Age</b>	<b>Distinct Client Count</b>	<b>% of Total Clients Served 18 and older</b>
18 - 25	112	16.00%
26 - 35	212	30.29%
36 - 45	165	23.57%
46 - 55	118	16.86%
56 - 64	53	7.57%
65 and Over	29	4.14%

\*Age is represented by age at time of reporting.

\*\*Clients reported under age 18 have been excluded.

### Race

<b>Race</b>	<b>Distinct Client Count</b>	<b>% of Total Clients Served</b>
American Indian and Alaska Native	132	18.86%
Black	67	9.57%
Multiple Races	36	5.14%
Some other race alone	37	5.29%
White	408	58.29%
Unknown	20	2.86%

### Legal Status

<b>Commitment Status</b>	<b>Distinct Client Count</b>
Civil Commitment MI	29
Civil Commitment MI/CD	<10
Court Hold	186
Provisional Discharge	<10
Voluntary - Other	38

<b>Commitment Status</b>	<b>Distinct Client Count</b>
Voluntary - Self	324
Unknown	214

\*Clients may have reported one or more statuses over the course of service.

### Service Details

Mental health innovation grantees reported a total of 700 distinct clients served from July 2018 to June 2019.

### Clients Served

<b>Grantee</b>	<b>2018 July - Dec Distinct Clients Served</b>	<b>2019 Jan - June Distinct Clients Served</b>	<b>Grand Total Distinct Clients Served</b>
American Indian Family Center	26	23	37
AMHI Region V+	14	331	340
Hennepin County Adult Behavioral Health	45	74	98
Human Development Center	74	70	137
Kanabec County	2	21	21
White Earth Mental Health Program	0	67	67
<b>Grand Total</b>	<b>161</b>	<b>586</b>	<b>700</b>

Of the 700 recipients served by the grant, 23 recipients were reported as returning to the program after discharge under the same service provider.

### Repeat Clients

<b>Repeat People Served</b>
23

Of those who have completed or discontinued the program, average length of time served is 26 days.

Within each service provider the average length of time served ranges from 19 – 42 days. At the close of reporting for July 2018 – June 2019 service dates, American Indian Family Center had not yet reported a client who discontinued the program. Due to service design, this figure is not applicable for White Earth Mental Health Program.

### Average Length of Service - Days

<b>Grantee</b>	<b>Average Length of Service - Days</b>
Hennepin County Adult Behavioral Health	42
Human Development Center	33

<b>Grantee</b>	<b>Average Length of Service - Days</b>
Kanabec County	32
AMHI Region V+	19

\*6 records removed from consideration due to start dates prior to 7/1/2018.

\*\* Data not applicable for American Indian Family Center and White Earth Mental Health Program.

In addition to data collected in MHIS, grantees reported data on the number of referrals made to community based services and hospitals, the number of program staff utilized, and the number of ceremonies performed by their program.

<b>Grantee</b>	<b>Referrals to community based services</b>	<b>Referrals made to hospitals</b>	<b>Number of program staff</b>	<b>Ceremonies performed</b>
AMHI Region V+	731	10	2	0
American Indian Family Center	108	0	5	15
Hennepin County Adult Behavioral Health	633	24	6	0
Human Development Center	176	0	8	0
Kanabec County	10	0	5	0
White Earth Mental Health Program	15	3	3	2

## VIII. Report recommendations

“This kind of work takes time and fortitude, which usually means patiently-believing-money rather than quick-win and observable-win money.” –mental health innovation grant program advisory panelist (February 20, 2019)

The mental health innovation grant program’s purpose is to improve access to and the quality of community-based, outpatient mental health services and reduce the number of people admitted to Anoka Metro Regional Treatment Center (AMRTC) and community behavioral health hospitals. The mental health innovation grant program addresses the “patient flow” problem in state-operated Community Behavioral Health Hospitals (CBHHs) and Anoka Metro Regional Treatment Center (AMRTC). Patient flow refers to how people being treated for mental illnesses and often co-occurring conditions move through treatment, how they are admitted and how they are discharged.<sup>2</sup> Hospitals across the state form a healthcare network; for example, a hospitalization or emergency department visit may be followed by a commitment and placement in a state-operated hospital. The mental health innovation grant program’s scope goes beyond the bounds of the state-operated hospital system due to the interconnected nature of healthcare and patient flow that happens from one level of care to another.

There are many complicating and contributing factors to the patient flow problem and a variety of healthcare settings that play into the problem. Recommendations to address the patient flow problem emerged from the following sources:

- Informal interviews with people and providers interacting with the grant(s) and behavioral healthcare system
- Monthly meetings with grantees
- Quarterly reports completed by grantees
- Quarterly meetings with the mental health innovation grant program advisory panel

### Care coordination

**There needs to be better care coordination.** When a person is admitted to a hospital, hospital staff and community providers must work together. There needs to be a clear understanding of the role(s) played by both Direct Care and Treatment (DCT) staff, other hospitals’ staff and county case managers and direct communication.

Hospital staff and county case managers don’t consistently work as a team on discharge planning and/or there’s communication breakdown. For example, although many efforts are made by both counties and DCT to work together on discharge planning, there is a common and shared experience that this doesn’t always happen. Poor communication and coordination can create barriers to quality patient care, person/family-centered care and creates distrust and frustration. To strengthen teamwork and communication a workgroup convened in fall 2018 between DCT and the County Social Service Directors. As a result, County Social Service Directors now receive a letter that outlines mutual role expectations. These kinds of practices should be scaled across the healthcare system.

Delays in discharge happen for multiple reasons. One reason that emerged is that hospital staff may develop a discharge plan that’s either unavailable or unrealistic in the person’s community. This illustrates the need for more transitional levels of care, especially in outstate and rural Minnesota. If hospital staff recommends a specific level of care and an opening does not exist in the person’s preferred community or location, the county

must continue to pay for the person to remain in the hospital. County case managers must be able to weigh in on actual resources available as people prepare to leave the hospital. To ensure this practice DCT's social work department attempts to make weekly contact with county case managers and plans regular treatment team meetings and encourages county case managers to attend.

Some counties don't believe they are notified until it's too late. County representatives described they often don't receive notification until the day a person no longer meets medical criteria (i.e., *does not meet medical criteria* or DNMC) and is ready to discharge. If a person no longer meets medical criteria (DNMC) in either Anoka Metro Regional Treatment Center (AMRTC) or a Community Behavioral Health Hospital (CBHH) the county pays 100% of the cost for medical care and coverage. Each day this costs the county of financial responsibility \$1,396/day, \$41,880/mo., \$502,560/yr. for AMRTC and \$1,524/day, \$45,720/mo., \$548,640/yr. for CBHHs. These scenarios burden both DCT staff, hospitals, counties and the people relying on them for care. Money is spent on keeping people in institutional settings rather than care teams creating alternative levels of care and spaces for people that offer prevention and early intervention.

**Coordination is fundamental to a person/family-centered care system and may produce cost savings.** If care teams and multiple providers are working toward the same goal there's streamlined communication, coordination, work is complementary and admissions/discharges expedited; this may result in cost savings. Care plans should be developed in partnership with the person using services and their entire care team to minimize delays in discharge.

**There needs to be an investment on the front end that will produce cost savings on the back end.** For regular communication and planning to occur between county assigned case managers and DCT it's recommended there be a pool of county case managers that specialize in working with people in these settings. Some counties have conducted a cost/benefit analysis that showed savings when counties themselves, rather than contracted vendors, work directly with people leaving AMRTC and/or CBHHs. Counties tend to have ease of access to financial workers and other social services offered and paid for by the county. These specialized case managers must be paid according to their knowledge, skills and abilities to navigate a complex healthcare system and advocate for peoples' health, safety and rights to live in community. Developing competitive salaries will ensure successful recruitment, through improved hiring and retention practices. By creating a pool of case managers designated to work with both DCT staff and people in these settings, it will develop and preserve the knowledge base and relationships needed to navigate the patient through the complex healthcare system. It may also reduce delays in communication between DCT staff and case managers while simultaneously clarifying roles, building trust and mutual respect with a defined focus on patient care and the individual ongoing continuum of care needs.

**Communication between Direct Care and Treatment (DCT) and lead agencies needs to be better.** Frequently lead agencies raised the need for more intentional and proactive coordination, communication and discharge planning for people leaving a CBHH or AMRTC. Its best practice to begin aftercare and discharge planning upon admission to a hospital level of care or other inpatient setting. Lead agencies described a common and shared experience of not being included in key decisions such as assessments and care team meetings that examine a person's readiness to be treated at a lower level of care, thus delaying their ability to act on discharge plans. DCT has changed this practice by shifting culture and practices to be more inclusive of county case managers

throughout the course of patient treatment. For example, DCT’s social work department provide weekly contact with county case managers and plans regular treatment team meetings and encourages county case managers to attend. It’s recommended that care team meetings continue to include case managers and natural supports like family so aftercare and discharge planning is intentional, proactive and as transparent as possible.

“True innovation and system change will occur when collaborative, problem solving processes are hardwired into the system. It would be a mistake to think... different service providers [included] will automatically or organically communicate with each other.” –mental health innovation grant program advisory panelist (February 20, 2019)

## Capacity

**There needs to be better access to beds and more inpatient beds.** There is a lack of space<sup>6</sup> and long waiting lists for admission to AMRTC and CBHs. The same is true for many hospitals and inpatient care settings across the state. This causes people to wait for a bed, forego services, or to receive services in sub-optimal settings, including emergency rooms and jails. Emergency departments use the term “psychiatric boarding” to describe the boarding that occurs in emergency departments while people wait for treatment.<sup>7</sup> Lastly, some Intensive Residential Treatment Services (IRTS) providers and hospitals aren’t maximizing bed capacity and community providers report there’s beds open that aren’t being filled.

**There needs to be more options on a local and regional level for people to go to upon discharge.** This is especially true for rural Minnesota. Due to a lack of options for housing, community placement and services there’s a belief that private providers have too much latitude in who they will or won’t admit. There’s disagreement on who’s responsible to develop and offer safety net services for people that providers reject helping and serving due to complex needs.<sup>2</sup> Complicating factors such as poverty, alienation, very little medical clinics and providers contribute to a lack of resources. There’s a need to build community capacity and solve the broader problem of where state-operated hospitals, in particular, can transition people to and from.

Strategies outlined in the Governor’s Task Force on Mental Health (2016) included expanding community-based competency restoration, strengthening community infrastructure, making changes to the civil commitment process, expanding options for parents and children, supporting efforts to reform addiction treatment, and assessing the impact of increases in the counties’ share of payments for stays at state-operated hospitals;<sup>2</sup> these strategies hold true and remain relevant today. The mental health innovation grant program is responding to a handful of these strategies; any success as a result of the mental health innovation grant program should be analyzed, made sustainable and scaled across the state. The [Community Competency Restoration Task Force](#) convened July 23, 2019 to begin tackling the significant uptick in people deemed incompetent to stand trial and the lack of resources available to respond. These efforts must intersect and work together on common goals.

**The 48 hours rule prioritizes access to inpatient beds for some, over others.** Application of the “48 hrs. Rule” is a barrier to accessing state-operated hospital beds. Under this rule the Commissioner of Human Services prioritizes patients being admitted from jail or a correctional institution who are:

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[Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot](#). Wilder Research. July 2016.

<sup>7</sup> <https://www.leg.state.mn.us/docs/2014/other/140294.pdf>

- Ordered confined in a state hospital for examination as to competency or criminal capacity;
- Under civil commitment after a finding of incompetency and continuing supervision;
- Found not guilty by reason of mental illness and under civil commitment; and
- Committed following dismissal of criminal charges (i.e., misdemeanors).

**The sheer volume of people being admitted from jails or correctional institutions has delayed admissions by weeks and months for some people.** The number of people deemed incompetent to stand trial has significantly increased compounding the backlog issue to get a state hospital bed. A lack of beds at AMRTC and CBHs accounted for 21% of avoidable days of psychiatric hospitalization in 20 community hospitals across Minnesota from March 15, 2016 through April 30, 2016. Avoidable days are days in inpatient hospital care when a patient is stabilized and ready to be discharged, but is unable to be discharged. Lack of beds in DHS facilities accounted for the greatest percentage of all reasons patients were unable to be discharged from community hospitals.<sup>8</sup>

## Housing

**There needs to be more affordable and customized housing options.** When people are ready for discharge from a psychiatric hospital admission or other level(s) of care a lack of affordable and appropriate housing remains to be a barrier. It was recommended that mental health innovation grant program funds, or new funding streams be secured for bricks and mortar and capitol purchases. This was prohibited in the first round of mental health innovation grant funding. Specific examples of how funding could help to simultaneously offer services/supports and temporary housing were provided by a handful of grantees.

“Next time we should partner with [for example] Catholic Charities and Dorothy Day... [there could be a] room reserved just for this program... at 10p or 11p at night, all drop-in centers are full and there’s no feasible place to go. We should partner with another agency to have a dedicated room for this program...”. (Mental health innovation grantee, 2018).

**It may help to reduce wait times by designing and making transitional beds or placements available specifically for people discharging from state-operated hospitals.** Transitional settings would cover the interim timeframe when people are ready to leave one level of care for another level of care. Presently the county of location and not the county of financial responsibility must complete MnCHOICES assessments to determine eligibility for waivers which pay for community-based services/supports. For example, if more suitable transitional settings were available and someone was ready to leave AMRTC the person could “step-down” into transitional care while placed on a wait list. Another option is to look at the hospital model of swing beds in rural Minnesota for sub-acute patients. Rural areas have been using a step-down and/or swing bed model for years in response to the patient flow problem and as a cost savings mechanism.

**Some counties are paying Intensive Residential Treatment Service (IRTS) providers to hold beds for people leaving state-operated hospitals.** IRTS are often used to help people transition from a hospitalization back to the community. A general consensus is that there’s not enough IRTS placements across the state to meet the demand, so much so that some counties are paying IRTS providers to hold beds for people leaving state-

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<sup>8</sup> [Reasons for Delays in Hospital Discharges of Behavioral Health Patients Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot \(July 2016\).](#)

operated hospitals; doing so offsets medical care costs paid by the county of financial responsibility and may help people return to the community faster.

**More IRTS beds need to be available for people leaving state-operated hospitals.** If more IRTS beds were available to meet this specific need (i.e., to transition people out of state-operated hospitals) people could transition to their home community and the county of financial responsibility could address the person's needs more efficiently and swiftly. This would also bring the person closer to any natural supports and relatives that offer comfort in an already chaotic and distressful time in their life. Another potential solution is to offer crisis and peer respite for people that need an intermediary, higher level of care but don't need to come back to the hospital.

## Mental health workforce shortage

**There needs to be more providers.** When it's time for a person to leave a psychiatric hospital there's frequently no community psychiatric provider appointments available due to workforce shortages. Anoka Metro Regional Treatment Center (AMRTC) and the Community Behavioral Health Hospitals (CBHH) have resolved this to some extent by offering psychiatric phone appointments and check-ins for discharged patients that cannot access appointments in their own, local community. Possible solutions to address the mental health workforce shortage include these "gap appointments", discussion with payers on a mandatory, Medicaid (MA) recipient minimum quota and maximizing telemedicine resources. Lastly, expanding scholarships and student loan reimbursement may incentivize the workforce in outstate and rural Minnesota to better meet cultural and identified need(s).

**Cross-sectoral and inter-governmental departments should pool their institutional knowledge and resources together to address workforce shortages.** For example, the Minnesota Department of Human Services Behavioral Health Division, the Office of the Inspector General's Background Studies Division and the Minnesota Department of Health's Office of Rural Health and Primary Care should communicate and coordinate at the policy level on efforts to a) remove barriers to employment and, b) incentivize the recruitment and retention of the behavioral healthcare workforce.

## Paperwork processing and turnaround times

**There needs to be faster and simpler paperwork processes.** One grantee working with state-operated hospitals on discharge planning talked about the bureaucratic inertia that exists due to policy implemented by DHS: (for example) when a person is ready to transition back into the community, and to be eligible for placement in Minnesota State-operated Community Services (MSOCS) the county case manager must produce documentation to prove that they've referred the person to between 4 to 8 adult foster care (AFC) homes and been denied in order for the person to qualify for MSOCS placement. The number of denials required is contingent upon whether the person is from a metro or rural community and "metro" and "rural communities" aren't clearly defined in this specific context. This eligibility requirement creates administrative and paperwork burden on the county case manager and AFC homes. In cases where contract case managers are responsible to assist and make referrals to AFCs, their denial paperwork has been rejected by MSOCS because of the technicality they be a *county* case manager rather than a *contracted*, county case manager.

**There needs to be re-entry and re-assessment opportunities that activate funding quickly.** If a person is in the hospital for 30 days they lose their Community Access for Disability Inclusion (CADI) waiver and must be re-assessed for eligibility. This is a significant barrier to getting people home and in their communities. MnCHOICES assessments must be completely re-done according to statutory requirements which delays transitioning someone back to the community. MnCHOICES assessors are oftentimes over-utilized and under-staffed making it nearly impossible to meet the demands of assessments and re-assessments they're assigned to complete. Historically it was possible to complete a "re-entry" assessment for people leaving the hospital. This was a brief, condensed assessment to expedite funding and start community-based services. Re-entry assessments no longer exist. A recommendation to address this problem is to make more brief, re-entry assessments an option again. Another recommendation is to create a presumptive eligibility option to fast track funding. Lastly, a recommendation emerged to create a clearinghouse to channel, expedite and prioritize paperwork processing for people in certain settings and provisional approvals to jumpstart services. Eligibility criteria for MSOCS or other placements should be clearly defined, consistently enforced and reasonable based on either the robustness, or lack thereof, of behavioral health resources in a specific community.

## Rate setting & payment

**Community providers need information and support to access Medicaid-funded home and community based services (HCBS), including services available under the Community Access for Disability Inclusion Waiver (CADI).** People using state-operated hospitals have some of the most chronic and complex needs requiring costly, specialized living arrangements and support from providers. Access to services can be difficult when providers aren't knowledgeable about which service to use and how the rate for the service is determined. Community education and support for providers is needed to assure people are authorized for the right service and that the rate determination fully accounts for the person's needs as intended under existing state law.

## Assessment & placement

**There needs to be a clearer diagnostic picture.** When examiners go out to see people they're not taking into account if the person being examined is under the influence of substances and ultimately it's the wrong service at the wrong time. In some circumstances people have mental health issues due to substance use. In these cases while a person is using and under a mental illness/chemical dependency (MICD) commitment they're sent to CBHHs or some other hospital until they're ready for substance use disorder treatment. Once they stop using and no mental health symptoms are present they no longer meet medical criteria. Overcrowding and lack of available beds is a reality and prevents many people needing this level of care from accessing it in a timely fashion or from accessing it altogether.

In cases where mainstream assessment doesn't lead clinicians to the correct diagnosis, it can also lead to treatment that's ineffective.<sup>9</sup> Proper training and assessment applies to both conventional, medically necessary

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<sup>9</sup> Angela Hirsch, LICSW, American Indian Mental Health Clinical Coordinator, Minnesota Department of Human Services Behavioral Health Division, July 24, 2019.

diagnoses and symptoms but also those stemming and/or compounded by intergenerational trauma and social determinants of health. Systems should be put in place to ensure capacity building across the mental health system that embeds cultural responsiveness and cultural formulation interviews, assessments and interventions. Licensing boards and the education system must be included to develop and institutionalize best practices, consultation and peer review standards.

## Data collection

There needs to be better coordination between systems to truly examine the patient flow problem at a policy level and identify policy alternatives. There's inconsistent access to data and therefore an incomplete understanding of a) who is accessing and needing state-operated hospital care, b) relevant patterns and trends and c) which regions across the state are successfully diverting and reducing the need for state-operated levels of care. To truly understand the magnitude of the patient flow problem and perform an impact evaluation of the mental health innovation grant program, future iterations must include:

- Collaboration with DCT's Executive Team and Chief Medical Officer
- Access to relevant Direct Care and Treatment (DCT) data to look at regional trends in admissions, discharges and *does not meet criteria* (DNMC)
- Access to demographic data that explores the impact on the priority populations outlined in DHS' Equity Policy, including communities of color, American Indians, veterans, lesbian, gay, bisexual, transgender, queer (or questioning), intersex, and asexual (or allies) (LGBTQIA), and persons with disabilities
- Interview(s) and focus group(s) with service-users and their family of choice, natural supports, informal observation, feedback and reflection(s)
- Requirement for grantees to report diagnoses of people served under the grant must be explored
- An analysis of the return on investment for diverting admissions and expediting discharges from state-operated CBHs and AMRTC

## Early intervention & Prevention

**Efforts and resources need to prioritize prevention and early intervention.** In meeting with the mental health innovation grant project advisory panelists much emphasis was placed on the need to be proactive, rather than reactive to the patient flow problem. This idea falls in line with several project models funded under the grant but in many cases helpers, family members and providers across the state are in a constant state of reacting and responding to crises. There's not enough access, appropriate housing and resources which is especially true in rural Minnesota. Travel time and transportation is a barrier to mental health care. For example, the Governor's Task Force on Mental Health (2016) recommended promoting better collaboration between rural hospitals and mobile crisis teams.<sup>2</sup>

**Prevention needs to include a multi-generational framework.** Current funding is for adults only and excludes children. Prevention and early intervention with children and transition-aged youth may reduce civil commitments, mental health crises and the need for residential psychiatric treatment. Families shouldn't be forced to wait until their family members' health is so poor that they're committed. Problems and symptoms should be identified and treated well before a full blown crisis.

## IV. Conclusion

“The problems we have cannot be solved at the same level of thinking that created them.” – Albert Einstein

The patient flow problem is not new to Minnesota and change is possible. The same complicating and contributing factors have been raised repeatedly throughout the history of de-institutionalization. In some cases, there are basic and sensible solutions for short-term wins such as better coordination and teamwork.

There are many, interdependent settings and variables that play into the patient flow problem. A hospitalization or emergency department visit which doesn't lead to successful recovery may be followed by homelessness, incarceration, commitment and placement in a state-operated hospital. The mental health innovation grant program's scope goes beyond the bounds of the state-operated hospital system due to the interconnected nature of healthcare and patient flow that happens from one intervention to another, one level of care to another, and one system to another.

To truly address the patient flow problem a cross-sectoral collaboration must occur across systems. This includes the healthcare system, education, housing, employment, transportation, criminal justice, public health, and social services.<sup>2</sup> These systems need to value the personal experience of people at the center of the patient flow problem and look at the return on investment that prevention and early intervention produces. Based on the first year of implementation, future iterations of funding must increase both the workforce and transitional levels of care. These strategies will build capacity for timely, community re-integration efforts and improve the quality of peoples' health outcomes and lives.

## X. Glossary

Avoidable days: days in inpatient hospital care when a patient is stabilized and ready to be discharged, but is unable to be discharged.<sup>6</sup>

Community partnership: a project involving the collaboration of two or more eligible applicants.

Co-production: fosters innovative thinking through cross-sectoral collaborating, exchanging ideas and identifying risks and possibilities in a group environment.<sup>4</sup>

County: “County” rarely needs additional definition except to limit its application or to define it as a shorthand reference to the county board or some other entity covered by the law.<sup>10</sup>

Hospital: Hospital services include inpatient and outpatient services provided in a facility certified to participate in Medicare. Hospital services must be medically necessary and provided by or under the supervision of a physician, dentist or other provider having medical staff privileges in the hospital.<sup>11</sup>

Interdependent settings: places people go or end up as a result of the patient flow problem.

Mental health service provider: Mental health providers include agencies and individuals (professionals and practitioners). Each mental health agency must have at least one mental health professional on staff. Providers may be eligible to enroll as Minnesota Health Care Program (MHCP) providers. Chemical dependency treatment programs with co-occurring service lines were eligible to apply under this definition.<sup>12</sup>

Metropolitan area: the area over which the Metropolitan Council has jurisdiction, including only the counties of Anoka; Carver; Dakota excluding the cities of Northfield and Cannon Falls; Hennepin excluding the cities of Hanover and Rockford; Ramsey; Scott excluding the city of New Prague; and Washington.<sup>13</sup>

Patient flow: refers to how people being treated for mental illnesses and often co-occurring conditions move through treatment, how they are admitted and how they are discharged.<sup>2</sup>

Tribe: [Indian] tribe means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

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<sup>10</sup> [House Research Terms Used in Local Government Legislation](#), Deborah A. Dyson (updated October 2016).

<sup>11</sup> See [Minnesota Health Care Programs Provider Manual, Hospital Services](#).

<sup>12</sup> See [Minnesota Health Care Programs Provider Manual, Mental Health Services](#).

<sup>13</sup> [Minnesota Statutes, section 474.121, subd. 2](#).

# XI. Appendix

Mental health innovation grant program applicant pool by eligibility type SFY 19/20					
<i>Applicant Pool</i>	Mental health service provider	Community Partnership	Indian Tribe	County	Hospital
<i>Total= 41</i>	29	6	1	3	2
American Indian Family Center	1				
Anoka County Community Social Services				1	
Aruba Emotional Health Services	2				
Center for Victims of Torture	3				
CommUNITY Adult Mental Health Initiative		1			
Community Involvement Programs (CIP)	4				
Fairview Range					1
First Call for Help	5				
Hamm Clinic	6				
Healtheast & East Metro Crisis Alliance		2			
Hennepin County Adult Behavioral Health Division				2	
Hiawatha Valley Mental Health Center	7				
Human Development Center	8				
Kanabec County Community Health		3			
Lakewood Health Systems	9				
Life House, Inc.	10				
Mains'l Services, Inc.	11				
Minnesota Behavioral Health Network (MNBHN)	12				
Minnesota Community Healthcare Network (MHCN)	13				
Minnesota Indian Women's Resource Center	14				
Natalis Outcomes	15				
Northland Counseling Center, Inc.	16				
Northwest Indian Community Development Center	17				

Mental health innovation grant program applicant pool by eligibility type SFY 19/20					
Oakridge Woodview	18				
Olmsted County Community Services				3	
Progressive Individual Resources, Inc.	19				
Radias Health and HealthEast-Fairview (St. Joseph's)		4			
Range Mental Health Center	20				
Region V+ Transition Services		5			
Riverwood HealthCare Center					2
Sandford Health Behavioral Health	21				
Solutions Behavioral Healthcare Professionals	22				
South Central Community Based Initiative (SCCBI)		6			
Stellher Human Services	23				
The Autism Society of Minnesota (AuSM)	24				
The Family Development Center Foundation	25				
Thrive Behavioral Network	26				
Tri-County Health Care	27				
Wellness in the Woods	28				
White Earth Tribal Mental Health Program			1		
Wilder Foundation	29				