



2013 Update Brief on the EMSRB 2007 Behavioral Health Report Improving Response to Mental and Behavioral Health Emergencies

Introduction

Faced with an increasing number of behavioral and mental health transports, placing both financial and operational strain on local law enforcement and emergency medical services, the Emergency Medical Services Regulatory Board (EMSRB) created the EMS Behavioral Health Work Group and published the *EMSRB 2007 Behavioral Health Report* in November, 2007. The report proposed numerous recommendations to reduce the demand for EMS mental health transports, increase both the capacity and efficiency of community-based mental health programs, and support system-wide improvements in Minnesota's mental health system. The Rural Health Advisory Committee (RHAC) and the Office of Rural Health and Primary Care at the Minnesota Department of Health sought to investigate what updates have been made to these recommendations and explore the current state of emergency mental health transport.

Many of the programs outlined in the original 2007 EMSRB report were newly implemented and lacked the benefit of time for subsequent evaluation. In 2007, the Community Behavioral Health Hospitals (CBHHs) were in early stages of operation, the Minnesota Hospital Association and Department of Human Services online psychiatric bed tracking system was only a pilot project and the use of alternative approaches to transporting behavioral health patients, such as Crisis Response Teams, had not been widely used across the state. This update brief examines what progress has been made towards these original recommendations since 2007.

Updates on specific solutions recommended for reducing demand and improving the transport of behavioral health patients are discussed, including utilization a web-based tracking tool for locating psychiatric beds and law enforcement trainings on de-escalation in mental health crises. Expanded use of alternative transportation services, such as Special Transportation Services providers assisting with ambulance and law enforcement transfers for behavioral health, are also discussed. Finally, the brief presents related developments on Community Behavioral Health Hospitals (CBHHs) and Intensive Residential Treatment Services (IRTs).

Background and Original Recommendations

Minnesota's ambulance providers are searching for ways to meet the increased demand for transporting patients with behavioral and psychiatric disorders. Ensuring appropriate transportation to mental health treatment facilities can be a struggle for both patients and the health care system. The number of mental and behavioral health transports has been growing in recent years, with patients and their families traveling greater distances due to a lack of available psychiatric hospital beds in their home communities. According to ambulance run data collected through the Minnesota State Ambulance Reporting (MNSTAR) system, the total number of

behavioral disorder transports increased 23 percent from 2005 to 2006 and behavioral health transports took one and a half times longer than other non-psychiatric interfacility transports.¹

Improving management of emergency behavioral transports will require improved coordination and treatment of psychiatric patients, in order to reduce demands on limited EMS resources. In order to minimize stress on transported patients and their families, in 2007 the EMSRB recommended the following solutions:

- Utilize the web-based psychiatric bed-tracking tool developed by the Minnesota Hospital Association and measure the reliability of the tracking tool.
- Promote training in the care of behavioral health patients for law enforcement and ambulance personnel.
- Create a single mental health crisis phone number for the metro area, and consider expanding into the creation of a single statewide number.
- Utilize intermediate or alternative transportation services, such as Special Transportation Service providers.
- Promote alternative response approaches, such as Crisis Response Teams.
- Increase the number of hospital or community-based beds, including residential crisis and treatment options for behavioral health patients.
- Support changes at the state, federal and private payer levels in billing and reimbursement.

Amend state law to require counties to pay for the cost of ambulance transport for mentally ill, chemically dependent persons temporarily confined for observation, evaluation, diagnosis, treatment and care if the person does not have health insurance coverage (MN Statute 253B.045).

Section 1: Updates and Progress since EMSRB 2007 Report

Recommendation 1: “Utilize the web-based psychiatric bed tracking tool developed by the Minnesota Hospital Association and measure the reliability of the tracking tool.”

The Minnesota Hospital Association (MHA), under contract with the Minnesota Department of Human Services (DHS), was in the final stages of piloting an online interactive mental health inpatient bed tracking system at the time of the EMSRB 2007 Report. The web-based tracking system has been operational since 2007 and provides real-time information about available inpatient bed capacity, while also interfacing with the DHS state-operated hospital central admission service. All community hospitals with psychiatric units are now voluntarily participating. Crisis stabilization and Intensive Residential Treatment (IRT) bed availability have also been recently added to the online system.²

¹ “EMS Behavioral Health Report: An Examination of the Challenges of Transporting Behavioral Health Patients in Minnesota and Recommendations for Improvement.” (November 2007). Minnesota Emergency Medical Services Regulatory Board. Available from: http://www.emsrb.state.mn.us/docs/EMS_Behavioral_Health_Report.pdf

² “Mental Health Acute Care Needs Report: A Report to the Chairs of the Senate and House Health and Human Services Committees (Legislative Report).” Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration and Minnesota Department of Human Services (March 2009).

The Minnesota Hospital Association and DHS issued a report in June 2009 about the implications, benefits and drawbacks associated with the program.³ According to the report, rural mental and behavioral health providers are now able to make more appropriate and timely decisions regarding use of community mental health resources, through identifying available treatment beds closest to a patient's home and allowing mental and behavioral health providers to advertise their bed availability. Benefits from this program also include expending fewer resources, such as staff time, to locate beds and decreasing wait times for those seeking inpatient admission. Online tracking of bed availability has facilitated increased communication and trust among psychiatric care providers, as well as DHS and the Minnesota Hospital Association. Patients are also more likely to be served closer to their home communities, nearer to family and local support systems.⁴

The introduction of the web-based tracking system has proven effective in reducing travel distances to access inpatient care, but many challenges remain. Factors such as a lack of community-based services can create backlog and limit access to care. For example, data collected on available psychiatric beds over a three-month period in late summer-early fall 2008 reported severe shortages of beds in the Twin Cities metropolitan area on Monday mornings and following holidays.⁵ Furthermore, hospital emergency departments and inpatient units often serve as safety nets due to a lack of community-based services available after regular business hours, on weekends or on holidays.

Many community-based providers still refer those seeking emergency mental health treatment to call 911 or visit the emergency department of their local hospital, as opposed to seeking the services of a local crisis center. Another difficulty is the lack of a service model for those with complex or chronic mental health needs. Those with long-term mental health needs, such as co-morbid psychiatric diagnoses or chronic medical conditions, can occupy beds meant for acute care only and present substantial financial and clinical challenges.⁶

Additional downsides associated with use of the tracking system include apprehension that unauthorized users may use the system inappropriately, such as for data collection purposes, or that particular facilities or services will be flooded with requests. The 2009 MHA/DHS report suggested updates and possible program evaluations for the bed tracking system, including an additional tracking component for detoxification services, partial hospitalization services and community mental health day centers, as well as a comprehensive evaluation of the program in

³ "Minnesota's Internet-Based Psychiatric Bed Tracking System: Two Years Old & Still Growing." Minnesota Hospital Association and Department of Human Services. June 2009.

Available from: <http://www.health.state.mn.us/divs/orhpc/conf/2009/presentations/3a.pdf>

⁴ "Minnesota's Internet-Based Psychiatric Bed Tracking System: Two Years Old & Still Growing." Minnesota Hospital Association and Department of Human Services. June 2009.

⁵ "Mental Health Acute Care Needs Report: A Report to the Chairs of the Senate and House Health and Human Services Committees (Legislative Report)." Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration and Minnesota Department of Human Services (March 2009).

Available from: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_144614.pdf

⁶ "Mental Health Acute Care Needs Report: A Report to the Chairs of the Senate and House Health and Human Services Committees (Legislative Report)." Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration and Minnesota Department of Human Services (March 2009).

the fall of 2009.⁷ There has not been any documented progression towards these suggested goals or additional updates, and no internal review or audit has yet been conducted.

Recommendation 2: “Promote training in the care of behavioral health patients for law enforcement and ambulance personnel.”

Emergency Medical Services (EMS) accounted for about 11 percent of psychiatric and behavioral health interfacility medical transports in 2010 and 2011, a slight increase from 9.79 percent of transports in 2009 and about 10 percent of psychiatric and behavioral health interfacility medical transports conducted in 2007 and 2008 (*Table 1*). Total counts for all psychiatric and behavioral health interfacility medical transports can be seen in *Table 2* and suggest that the total volume of demand has not changed significantly.

Table 1: Psychiatric and Behavioral Calls for 911 EMS Services and Interfacility Transports

	2007	2008	2009	2010	2011*
Percent of 911 Calls Psychiatric/Behavioral	4.57	6.36	6.79	7.02	6.81
Percent of Interfacility/Medical Transports Psychiatric/Behavioral	10.39	10.11	9.79	11.04	11.41

Source: MDH Analysis of Emergency Medical Services Data for Calendar Years 2007-2011.

Table 2: Total Counts for 911 EMS Services and Interfacility Transports

	2007	2008	2009	2010	2011*
Total 911 Calls	312,397	348,342	355,732	212,458	93,051
Psychiatric/Behavioral 911 Calls	14,266	22,146	24,148	14,904	6,334
Total Interfacility/Medical Transport Calls	45,213	44,764	51,847	31,592	17,279
Total Psychiatric/Behavioral Interfacility/Medical Transport Calls	4,699	4,525	5,074	3,489	1,972

Source: MDH Analysis of Emergency Medical Services Data for Calendar Years 2007-2011.

⁷ “Minnesota’s Internet-Based Psychiatric Bed Tracking System: Two Years Old & Still Growing.” Minnesota Hospital Association and Department of Human Services. June 2009.

The EMS Behavioral Health Work Group recommended that law enforcement and Community paramedics attend training sessions on de-escalation techniques for mental health crises. The Barbara Schneider Foundation (BSF) provides regular trainings related to first responder mental health crisis calls and crisis prevention to law enforcement personnel through the affiliated Mental Health Crisis Reponse Institute.⁸ Training programs include basic information about mental illness and how to recognize these symptoms, information about the local mental health system and local laws, as well as verbal de-escalation, training exercises and role-playing activities.

Funding for the Youth Mental Health First Aid training is now available, and provides training for teachers, social services, law enforcement, and other individuals who may encounter children with mental illnesses. Youth Mental Health First Aid is a new curriculum from Mental Health First Aid USA, and focuses on building expertise on unique risk factors and developing skills in crisis management for youth ages 12 to 18. Participants attend one 8-hour course in order to become certified. Participants focus on role playing and simulations, recognizing warning signs of mental illness and learning how to help young people facing a mental health crisis or substance use challenge.⁹

Community paramedics are able to respond to behavioral health calls and provide referral into the mental health care system, but defer calls of a suicidal or violent nature to local emergency medical services. When conducting mental health assessments, community paramedics assess medication compliance and conduct wellness checks. Mental health strategic goals from the 2007 report included connecting community paramedics with training sessions hosted by the Barbara Schneider Foundation (BSF), but to date there has not been any contact or communication between BSF and Minnesota's community paramedic program.

Recommendation 4: "Utilize intermediate or alternative transportation services, such as Special Transportation Service providers."

Intermediate or alternative transportation services, such as Special Transportation Service (STS) providers, are also utilized to transport psychiatric and behavioral health patients. STS requires that patients have either a physical or mental health condition that requires the transportation provider to provide direct assistance to access these services, which means they require direct assistance from the driver in all aspects of both entering and exiting their residence, transport vehicle and medical assistance facility.¹⁰

The National Alliance on Mental Illness (NAMI) Minnesota chapter has recently provided leadership to a Psychiatric Transportation Workgroup to the Non-Emergency Medical Transportation (NEMT) Committee established in state law, seeking to create a mode of transportation called *protected transport*. People with mental illness or other disabilities would

⁸ <http://www.mentalhealthcrisis.org>

* Data for 2011 from January to March (most recent data available)

⁹ NAMI. "2013 Minnesota Legislative Session: Summary of New Laws Affecting Children and Adults with Mental Illnesses and Their Families" (June 2013). Available from: <http://www.namihelps.org/2013-Legislative-Summary-NAMI-MN.pdf>

¹⁰ "Minnesota Commercial Truck and Passenger Regulations Fact Sheet: Special Transportation Service (STS)." Minnesota Department of Transportation: <http://www.dot.state.mn.us/cvo/factsheets/sts.pdf>

be transported between medical facilities without utilizing law enforcement or ambulance personnel. This method of transportation would be classified as a “middle-tier” service that would be paired with Crisis Response Services, while utilizing the existing STS network.¹¹

The NAMI workgroup envisions that *protected transport* would serve as the initial method of transportation to appropriate mental health services and between mental health service locations. Some advantages associated with this proposed system includes reducing both cost and demand on ambulance and law enforcement personnel for transportation, expanding the current range of appropriate transportation alternatives, and reducing stigmatizing or traumatic experiences for individuals in a mental health crisis.¹²

Recommendation 5: “Promote alternative response approaches, such as Crisis Response Teams.”

Crisis response teams are an alternative to ambulance transport or law enforcement mobilization, and include mental health professionals who are trained to intervene effectively. These mental health crisis teams were created through the 2007 Mental Health Initiative, which was a bipartisan effort between the Governor and the Minnesota Legislature to reform Minnesota’s mental health system. In 2013, the state expanded mental health crisis response services by adding four additional mobile mental health crisis teams that will serve 16 additional counties and two tribal regions.¹³

These crisis response teams meet with an individual undergoing a mental health crisis to assess and de-escalate the situation. Mobile crisis response teams are available for adults in all 87 counties and for children in 57 counties. Among those who utilized this service in 2010, about 28 percent struggled with suicidal ideation, about 28 percent reported depression, 14 percent reported psychosis or delusions and 12 percent reported anxiety or panic.¹⁴ According to NAMI-Minnesota, there were over 5,000 mobile crisis interventions for adults and 3,000 for children in 2009. From these, about 11 percent of adults and 28 percent of children were referred to a hospital emergency department or inpatient treatment center.¹⁵

Services are provided on a county basis and include stabilization services for up to 10 days, rapid access to psychiatrists, intervention services and crisis prevention planning, health care navigators, mental health crisis beds, and referrals to community mental health providers or mobilization of Emergency Medical Services. Mobile crisis response services include up to two trained crisis responders who will travel to meet the patient. Residential crisis services include services provided in a facility where they can stay until the crisis is under control. Crisis stabilization services include follow-up services that help connect the patient with other service providers in the same area in order to prevent future crises.

¹¹ “Getting There with Dignity.” Psychiatric Transportation Workgroup – State Operated Services Redesign. NAMI Minnesota.

¹² “Getting There with Dignity.” Psychiatric Transportation Workgroup – State Operated Services Redesign. NAMI Minnesota.

¹³ “NAMI Minnesota Legislative Update – January 22, 2013.” Newsletter Dated 01/22/2013.

¹⁴ “Adult Mental Health Crisis Response Services.” Minnesota Department of Human Services Webpage: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=136343

¹⁵ “Mental Health Mobile Crisis Response Teams” Factsheet. National Alliance on Mental Illness – Minnesota

Residents of every county in the state can now access some form of Crisis Response Services. Fifty counties have both mobile and residential services, while five provide only mobile services and 32 counties offer only residential stabilization beds. Crisis teams are also covered by Medical Assistance, Minnesota Care and many private health plans. CRTs are available 24 hours a day, seven days a week and manage a 24-hour crisis hotline in each county.

While EMSRB's 2007 recommendations suggested developing a single mental health crisis phone number for the metro area, as well as expanding it into a single statewide number, there has not been any progress towards these goals to date.

Hospitalization after Crisis Response Services

Figure 1: Crisis Response Services Number of Episodes

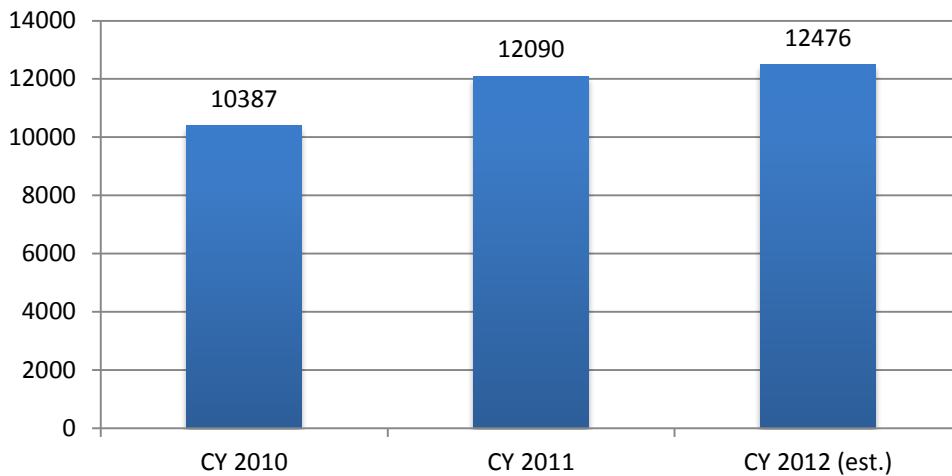
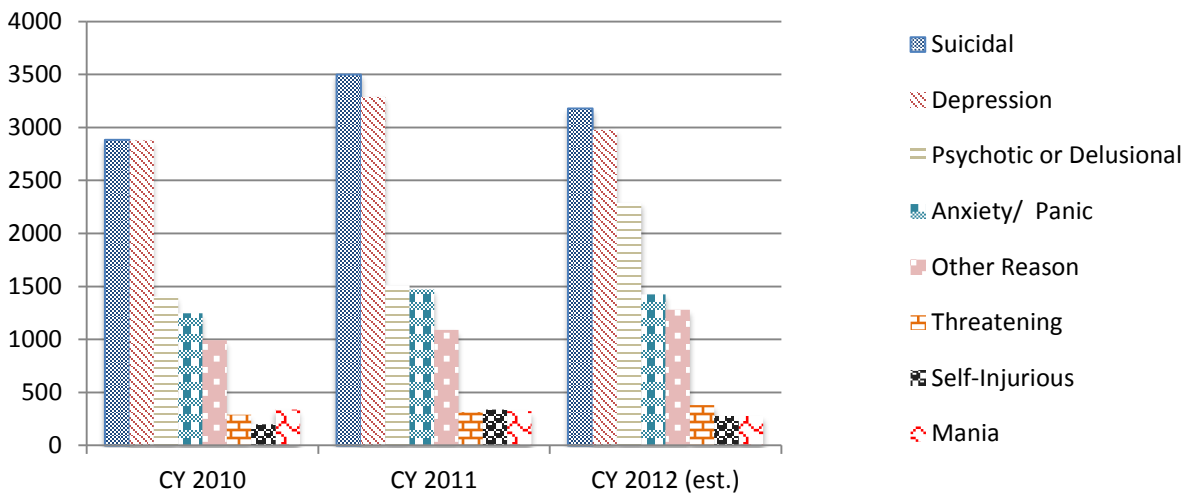


Figure 2: Presenting Problems among Adult Crisis Response Services



DHS data indicate the number of mental health crisis episodes has been gradually increasing, with 10,387 crisis response episodes in 2010, 12,090 episodes in 2011 and an estimated 12,476 episodes in 2012 (*Figure 1*). Among adult patients presented to crisis response services, the most common problems from years 2010 to 2012 were suicidal behaviors, depression, psychotic or delusional symptoms, and anxiety and panic (*Figure 2*).

Recommendation 6: “Increase the number of hospital or community-based beds, including residential crisis and treatment options for behavioral health patients.”

The Minnesota Psychiatric Society reported 981 inpatient mental health beds statewide in 2005, with 16.8 beds per 100,000 people. This was well below the national average of 28.2 beds per 100,000 people.¹⁶ In 2010, the Minnesota Hospital Association reported over 1,200 inpatient mental health beds statewide, with 63 percent of Minnesota hospitals offering some kind of mental health or behavioral health services and 54 percent collaborating with other providers in their local community to provide mental health services.¹⁷ This low bed availability means that patients must travel farther from their home communities for services, and is an indicator of inadequate access to local mental health care.

Minnesota Community Hospital psychiatric bed statistics are presented below (*Table 3*). Total hospital admissions, rural admissions, psychiatric bed admissions, and rural psychiatric bed admissions are included, with urban and rural classifications based on metropolitan statistical areas. Community hospitals are defined as any hospitals that are not part of a university or health system, state hospital, VA system or Indian Health Service facility. Community Behavioral Health Hospitals (CBBHs) are included in these calculations.

Table 3 = Psychiatric Bed Utilization 2006 - 2011

	2006	2007	2008	2009	2010	2011
Total MCH Admissions	35,781	33,940	37,237	42,521	35,520	39,001
Rural Admissions	6,370	4,825	6,489	6,517	5,570	6,545
Total MCH Psych Beds	*	1,055	1,479	1,475	1,456	1,436
Total Rural Psych Beds	*	169	275	315	299	291

Source: MDH Analysis of Select Hospital Statistics from Minnesota Community Hospitals, Hospital Data (HCCIS) for Fiscal Years 2006-2011.

¹⁶ “In 2005, Minnesota had 16.8 mental health beds per 100,000 people, far short of the national average of 28.2 beds per 100,000.” Minnesota Mental Health System, Demand Capacity and Cost 2006 Update, Minnesota Psychiatric Society, 2006.

¹⁷ “In 2010, Minnesota’s hospitals reported over 1,200 inpatient mental health beds statewide. The vast majority of these beds are for adults.” Minnesota Hospital Association, Minnesota Hospital Policy and Advocacy, Priority Issues: Mental Health.

Section 2: Related Developments in Mental Health Treatment Since 2007
Community Behavioral Health Hospitals Update

Community Behavioral Health Hospitals (CBHHs) exemplify a transition in the public mental health system, and seek to build adult mental health treatment capacity throughout Greater Minnesota in settings that are closer to communities. Following increased funding from the legislature and shifts in both funding and staff from state operated services to community based treatment providers, CBHHs were created as a way to deliver an integrated treatment approach providing prevention, treatment and recovery services for people with mental illness based in their communities.¹⁸ CBHHs provide short-term acute psychiatric inpatient care for adults until patients can be discharged to home or to less intensive service providers in their communities.

There has been a net increase of rural CBHH beds since 2007. While 10 CBHHs opened between 2006 and 2008, there are only seven CBHHs currently (*Figure 3*). Cold Spring was closed in 2009 due to staffing shortages and duplication of services already available in the Saint Cloud area. In addition, Willmar and Wadena locations were converted to statewide Intensive Residential Treatment Services (IRTS) in 2011 to provide a medically monitored residential level of care to patients who yet stable enough to return to existing communities. About 95 percent of CBHH patients are from non-metro counties.¹⁹

Numerous treatment and counseling services are offered, including an assessment of the patient's mental, social and physical health, creation of an individualized treatment plan, medication management and 24 hour nursing care. Family, group and individualized counseling sessions are provided and a recovery model of care using a person-centered approach, which includes family members and the community in treatment planning and implementation, is used. An integrated dual diagnosis treatment plan for mental health and chemical dependency is also offered, and patients have individualized discharge planning to better navigate the transition back into their communities.²⁰

In 2011, all seven CBHHs operated at 69 percent licensed psychiatric bed capacity and 84 percent of their overall service capacity. CBHHs operated at 79 percent licensed psychiatric bed capacity and 91 percent overall service capacity in 2012, suggesting that these utilization rates are gradually increasing. Despite this growth, there remain serious gaps in Minnesota's mental health continuum of care. For example, CBHHs are not able to admit patients with acute medical conditions, do not staff 24-7 primary care physicians and cannot accept patients who have serious mental illnesses or who are aggressive or violent. These restrictions can limit access to care among patients who require intensive supervision or acute medical attention.²¹

¹⁸ "Report on the Utilization of the Community Behavioral Health Hospitals." Minnesota Department of Human Services, Chemical and Mental Health Services Administration. March 30, 2012.

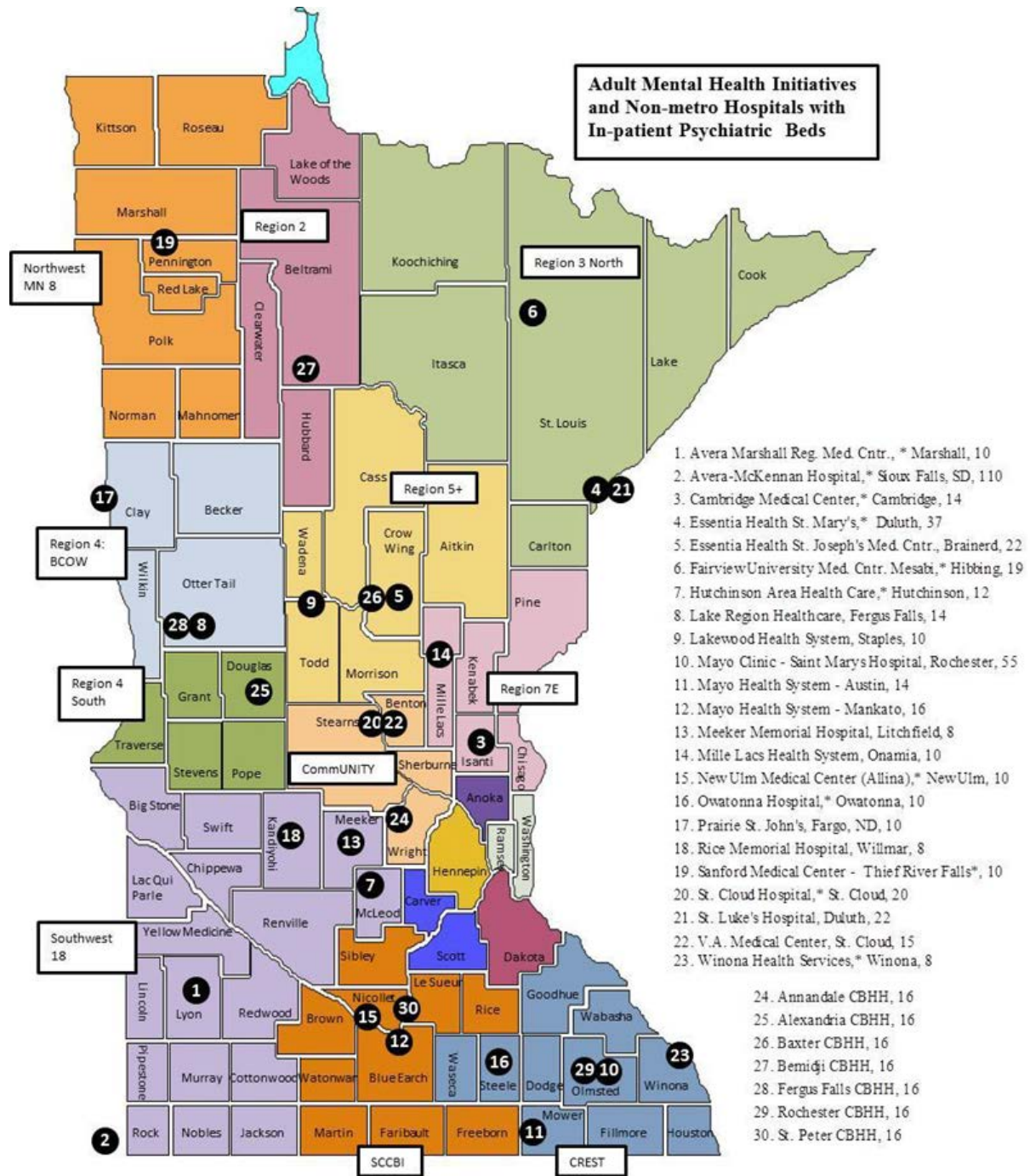
Available from: <http://archive.leg.state.mn.us/docs/2012/mandated/120412.pdf>

¹⁹ "Report on the Utilization of the Community Behavioral Health Hospitals." Minnesota Department of Human Services, Chemical and Mental Health Services Administration. March 30, 2012.

²⁰ "Report on the Utilization of the Community Behavioral Health Hospitals." Minnesota Department of Human Services, Chemical and Mental Health Services Administration. March 30, 2012.

²¹ "Report on the Utilization of the Community Behavioral Health Hospitals." Minnesota Department of Human Services, Chemical and Mental Health Services Administration. March 30, 2012.

Figure 3: Adult Mental Health Initiatives and Non-Metro Hospitals with In-Patient Psychiatric Beds (Adapted Figure)²²



²² "Report on the Utilization of the Community Behavioral Health Hospitals." Minnesota Department of Human Services, Chemical and Mental Health Services Administration. March 30, 2012. Available from: archive.leg.state.mn.us/docs/2012/mandated/120412.pdf

Intensive Residential Treatment Services Update

Intensive Residential Treatment (IRT) facilities were created in 2003 in order to provide mental health services to individual who no longer require acute inpatient care, but still require 24-hour supervision.²³ Treatment is provided in a residential setting, with enhanced staffing, shorter stays and rehabilitative services with an emphasis on psychiatric stability, personal and emotional adjustment, self-sufficiency and independent living skills. There are currently 42 Intensive Residential Treatment (IRT) providers located in Minnesota. IRT patients require settings that are more restrictive and pose significant risk of functional deterioration should they not receive these services, as opposed to community settings provided in CBBHs. Similar to CBHHS, however, IRTs are not able to treat patients who have both mental health and acute medical care needs. This restriction is a critical gap in the system.

Recommendations Awaiting Further Action

Several recommendations made in the 2007 report have not yet been addressed. These include the development of a single mental health crisis phone number for the metro area, and the additional development of expanding it into a single statewide number. Because crisis phone numbers are constantly changing in the metro area, patients are not easily able to access help prior to contacting 911. The 2007 work group felt a reliable crisis line might reduce the number of trips to the hospital emergency room. There has not been any progress to date for current billing and reimbursement practices for mental health transport, and no current amendments in state law to require counties to pay for the cost of ambulance transport for mentally ill, chemically dependent persons temporarily confined for observation, evaluation, diagnosis, treatment and care if the person does not have health insurance coverage.

²³ “Mental Health Acute Care Needs Report: A Report to the Chairs of the Senate and House Health and Human Services Committees (Legislative Report).” Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, and Minnesota Department of Human Services (March 2009).

Conclusion

While sufficient time has elapsed to allow for a cursory evaluation on the above recommendations, it is not clear to what extent the circumstances that prompted the EMSRB 2007 Report have changed.

No published reports have analyzed mental health ambulance runs since the original EMSRB 2007 report, though law enforcement officials and EMS providers have numerous anecdotes that suggest current transportation options for people in behavioral health crises and related circumstances are less than ideal. Recent Minnesota State Ambulance Reporting System (MNSTAR) data on mental and behavioral health patients also have yet to be analyzed, and there have been no evaluative studies conducted on psychiatric bed tracking in Minnesota. MNSTAR data was not available for this update.

While there appears to be sufficient acute care inpatient psychiatric beds throughout Minnesota, many barriers prevent access to the system. Behavioral health patients with comorbid acute medical conditions or complex mental illness present considerable clinical and financial challenges, and may have trouble accessing community based mental health care. For example, CBHHs and IRTs are not able to admit patients with acute medical conditions and do not staff 24-7 primary care physicians, and cannot accept patients who have serious mental illnesses or who are aggressive or violent.

A major difficulty is creating a system-wide approach to change, including garnering political support for changes in billing and reimbursement structures for long distance transports and amending Minnesota Statute 253B.045 to require counties to pay the cost of ambulance transport for patients without health insurance who are experiencing mental health crisis. Encouraging greater preventative services, such as EMS education in crisis de-escalation and expanding the capacity of crisis response teams and community based mental health treatment services, however, can work to reduce the demand of emergency mental health transport. Continued attention is critical.

Appendix: Minnesota DHS Developments in Adult Mental Health Services since 2007

Service Description	2007	Most Recent
Community Behavioral Health Hospitals	“Nine or ten” 16-bed Community Behavioral Health Hospitals had opened since 2006 across the state. Reported poor staffing ability and could not yet meet need.	Only seven Community Behavioral Health Hospitals. + 1 large center (Anoka-Metro Regional Treatment Center). + 2 additional Minnesota Specialty Health Systems, with individualized approaches.
Assertive Community Treatment (ACT): Medicaid-reimbursed service provided by multidisciplinary treatment teams with low client to staff ratios (10-1)	26 teams	Unchanged.
Intensive Residential Treatment Services (IRTS): short-term, time-limited Medicaid-reimbursed services	32 treatment facilities	As of December 17, 2013: 42 programs
Adult Rehabilitation Mental Health Services (ARMHS): Medicaid funding stream permitting rehab services provided one-to-one or in groups within the home or community by qualified staff	Implemented in 2002 with 5 providers. 2007: 111 providers in all 87 counties.	As of December 9, 2013: 348 providers in all 87 counties plus 4 reservations.
Medicaid (MA) Crisis Response Service	Implemented in 2003: 28 crisis providers in 31 counties.	As of March 15, 2011: 43 crisis providers in 87 counties.
Community-Based Extended Psychiatric Hospitals	16 community hospitals with inpatient psychiatric units are under contract with DHS.	Unchanged.



For more information, contact:
The Office of Rural Health & Primary Care
Minnesota Department of Health
85 East 7th Place, Suite 220
PO Box 64882
St. Paul MN 55164-0882
Phone: 651-201-3838
Fax: 651-201-3830
Email: health.orhpc@state.mn.us
www.health.state.mn.us/divs/orhpc

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