DEPARTMENT OF HUMAN SERVICES

Legislative Report

Discharge Delay Reduction

Update on County and State Efforts

Direct Care and Treatment

January 2023

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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 $8,756.

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I. Executive summary

Counties and the state have made limited progress in our efforts to reduce delays in discharging patients from state-operated psychiatric facilities. Overall, the number of discharge delays resulting in extra costs incurred by counties has decreased. At the same time, however, overall costs to the counties have not fallen due to increased per diem rates that reflect the rising cost of patient care.

While there has been some improvement, discharge efforts have been hampered by several factors that continue to vex counties and the state. There are many barriers to discharge, the most substantial of which is a shortage of community-based mental health programs that have the capacity to accept patients who are ready for discharge from state-operated psychiatric facilities. Without sufficient community placements, patients cannot be discharged and remain in state-operated psychiatric hospitals long after that level of care is no longer appropriate. In health care shorthand, patients who do not meet criteria for care in a hospital are referred to as "DNMC" patients. These patients continue to occupy beds and substantially delay admission for other patients with serious conditions who do require care in a hospital.[1]

The lack of available placements with community-based mental health care providers is a complex problem in its own right, driven by several factors. Primary among them is a nationwide staffing crisis. In general, the health care labor market has been tight for several years. Competition for staff in a shrinking labor pool is fierce – and health care professionals who specialize in mental health are in higher demand and even shorter supply. The COVID-19 pandemic has worsened the situation markedly as staff at all levels have experienced burnout after nearly three extraordinarily challenging years and have left the field in staggering numbers. As a result, health care providers and systems nationwide are facing unprecedented difficulty with staff recruitment and retention. State-operated programs, counties, and community-based providers all have experienced these challenges. The fact that patients served by state-operated programs have highly complex mental illnesses and potentially aggressive or violent behaviors makes staffing even more difficult. Fewer candidates are willing to work with such patients. Compensation for many direct care positions tends to be lower than in many other industries and workers are often unwilling to accept the potential risk of injury for less pay than they could receive elsewhere. Staffing in outstate Minnesota is especially difficult.

Counties and the state have taken several actions to reduce discharge delays, including, beginning discharge planning upon admission; frequent meetings with internal treatment and case management teams; increased frequency of meetings with external stakeholders to ensure participation in the discharge planning process; evaluation of the treatment environment to support patient success in transition to a community-based care provider; use of grants to enhance and expand community resources; assessments for alternative placements;

[1] This at times creates a ripple effect of delays within the state system itself, because some patients in state-operated programs cannot be discharged timely to move to a clinically appropriate bed in another state-operated program when beds in that secondary program remain occupied with patients that do not require that level of care.

use of transition teams; development of additional community-based programs; enhanced staffing and recruitment initiatives; and use of more targeted resources.

Notably, a joint effort by counties and the state to reduce the fiscal impact on counties for the cost of DNMC patient overstays in state-operated psychiatric hospitals was an important step. This partnership resulted in a new administrative process that permits the Department of Human Services to review the cost of care incurred by the counties when there is a discharge delay. Counties need only request the administrative review in writing. If the review finds that the delay was caused by certain department actions, the department must reduce the county liability for cost of care to a level for a patient whose stay is determined to be clinically appropriate. There are four circumstances in which the department is authorized to reduce the cost of care; however, instances where a discharge delay is due to the inability to discharge a patient from one state-operated program and admit them to another state-operated program do not qualify for a reduction in costs.

Counties are financially liable for 100 percent of the cost of care for every day that patients remain in some state-operated facilities after discharge from the program has been determined to be clinically appropriate. This can place extraordinary financial pressure on counties and wreak havoc on their budgets. In some instances, the cost of care for a single patient has exceeded the amount a county has budgeted for this purpose for an entire year. It should be noted that DNMC charges incurred by counties are deposited into the state's general fund and do not directly benefit DHS or its Direct Care and Treatment administration.

Despite current efforts to address the problem, without substantial investment in community-based mental health treatment options to serve patients being discharged from state-operated facilities, counties and the state will continue to struggle with discharge delays.

II. Legislation

In 2019, the Legislature established a requirement for the Commissioner of Human Services to submit a report that provides an update on county and state efforts to reduce the number of days patients spend in state-operated programs after discharge from the program has been determined to be clinically appropriate. The report must also include information on the fiscal impact of clinically inappropriate stays in these facilities. *See* Laws of Minnesota 2019, 1st Spec. Sess. chapter 9, article 3, section 3, as follows:

> Sec. 3. DIRECTION TO COMMISSIONER; REPORT REQUIRED; DISCHARGE DELAY REDUCTION.
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> No later than January 1, 2023, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services that provides an update on county and state efforts to reduce the number of days clients spend in state-operated facilities after discharge from the facility has been determined to be clinically appropriate. The report must also include information on the fiscal impact of clinically inappropriate stays in these facilities.

III. Introduction

Direct Care and Treatment (DCT) is a highly specialized behavioral health care system operated by the Department of Human Services. It is responsible for the eight state-operated psychiatric programs specifically referenced in this report and many others. DCT serves about 12,000 individuals each year at 200 sites statewide and has several different programs that are part of the continuum of care for individuals with mental illness, chemical dependency, and developmental and intellectual disabilities. DCT patients and clients have complex conditions and behaviors that are challenging, and other health care providers cannot or will not serve them due to lack of capacity or expertise.

DCT psychiatric hospitals are the most intensive treatment option in the state's mental health continuum of care. However, these hospitals are not intended for long-term institutionalization. Rather, their goal is to stabilize patients and provisionally discharge them to other appropriate settings where they can safely continue their treatment. In most cases, this setting is in the community. The illustration below shows the continuum of community-based treatment options by intensity, with outpatient therapy being the least intensive and admission to a state-operated psychiatric hospital being the most intensive.

While counties and DCT are partners and stakeholders in the continuum of care for individuals in need of behavioral health services, each has distinct roles and holds distinct statutory obligations regarding discharge of patients from a state-operated program. DCT's role is to treat and stabilize patients. When patients no longer require the level of care provided in DCT's psychiatric hospitals, the agency is required by law to discharge them. Before discharge can happen, however, counties are obligated to arrange patients' placement in a more appropriate treatment setting, establish an aftercare plan and provide ongoing case management services. When counties have difficulties finding appropriate placements, it delays discharge and new patient admissions and causes a ripple effect throughout DCT.

When patients remain in DCT facilities after discharge is clinically appropriate, new patients cannot be admitted from settings such as jails and community hospitals. The lack of patient movement through state-operated programs has resulted in admission substantial waiting lists. For example, one state-operated psychiatric hospital has a daily average of 25 patients with a discharge delay. This hospital could serve an additional 101 patients per year if those 25 patients could be discharged in a timely way.

In addition, the lack of available beds due to discharge delays prevents the movement of patients from state-operated psychiatric hospitals to other DCT programs. For example, a patient at the Anoka-Metro Regional Treatment Center may be waiting for a more appropriate bed at the Forensic Mental Health Program in St. Peter. However, because a lack of community placement options has delayed the discharge of a patient in St. Peter, the Anoka patient must wait. In some instances, despite state and county efforts, no community placement options are viable for a given patient's condition. That makes discharge extraordinarily challenging.

DCT and counties continue to struggle with several significant barriers to discharge. However, the two most pervasive barriers are:

1) The shortage of community-based providers with the capacity and ability to meet patient needs once discharged from state-operated programs; and
2) Staffing challenges across the behavioral health care system.

Discharge delays have an enormous fiscal impact on county budgets. Counties must pay a percentage of the cost of care for patients admitted to state-operated psychiatric hospitals. However, when a patient remains at the Anoka-Metro Regional Treatment Center, a Community Behavioral Health Hospital or the Child and Adolescent Behavioral Health Hospital after discharge is clinically appropriate, the county liability for cost of care increases to 100 percent. In health care parlance, these days are known as "Does Not Meet Criteria" – or DNMC for short – days. The financial obligation for DNMC days can be dauntingly large. In some cases, the charges for a single patient can exceed the total amount counties set aside for an entire fiscal year to cover the cost of all residents who may need psychiatric care.

To mitigate those financial pressures, counties may request a review of the circumstances surrounding DNMC days. Using a special administrative process, DHS may reduce the county liability for the cost of care if discharge delays were caused by certain DHS actions. Such requests have been fully approved, partially approved, and denied if the DNMC days are not caused by circumstances set out in statute. Some counties reported that they have stopped submitting potentially viable review requests after receiving review denials. Also, counties have faced an increase in DNMC days for patients waiting for discharge from Anoka-Metro Regional Treatment Center and admission to the Forensic Mental Health Program in St. Peter. However, these DNMC days do not currently qualify for the administrative review process.

Despite efforts undertaken by the counties and the state to decrease discharge delays, there is no anticipated decline in discharge delays without significant investment in the development and retention of community-based providers. Counties are making efforts to find appropriate placements for patients ready for discharge from state-operated programs, but there are simply not enough providers to meet the current demand. Without an increase in community-based providers, discharge delays will continue, counties will not be able to secure community placements, state-operated program beds will continue to be occupied by individuals who no longer need the level of care offered, and liability for DNMC days will remain an additional financial pressure for counties.

Purpose of report

This report provides an overview of the reasons for discharge delays and the efforts taken by counties and the state to reduce these delays. The fiscal impact of discharge delays is provided from fiscal year 2015 through fiscal year 2022. This includes the estimated number of DNMC days charged to counties, the estimated number of DNMC days by state-operated psychiatric hospitals, the average cost per day for DNMC days, and the daily per diem rates charged by state-operated psychiatric hospitals. In addition, information is provided about the administrative review process that includes the number of days where liability for cost of care was reduced and the amount of the charges reduced since this process went into effect in fiscal year 2020.

IV. Barriers to timely discharge

While there is no legislative requirement to include barriers to discharge in this report, the information is included because the barriers have a profound impact on efforts undertaken by counties and DCT to reduce discharge delays. Nearly all barriers to timely discharge identified in this report are the most common ones experienced by both counties and DCT and are discussed in greater detail below.

A. Lack of discharge options

Under ideal circumstances, once stabilized and no longer in need of care in a state-operated psychiatric hospital, patients would be discharged to continue treatment in other appropriate community-based mental health programs. However, there are far too few beds available in step-down facilities. Many different factors contribute to this lack of discharge options.

Limited community-based placements. While the approach within DCT programs is "discharge planning starts from the day of admission," state-operated psychiatric hospitals face significant internal and external obstacles when discharge planning. There are not enough beds and types of programs to accept all of the patients ready to be discharged. Counties have great difficulty finding community-based providers that not only offer the right level of care but are willing and able to take patients with significant and complex needs.

Provider closures. The closure of community facilities has created a gap in the care infrastructure. Some individuals who do not meet the threshold for care in state-operated programs require a higher level of care than available in communities. Several community-based providers that previously served these individuals have closed, some due to lack of funding required to maintain appropriate staff levels. Remaining community-based providers at this specialized level of need are at capacity, reportedly concerned about expanding due to risks related to the workforce shortage; safety and security of patients and staff; community acceptance; financial viability; and the overall liability for providing a clinically sufficient level of care in a community-based setting for individuals with high clinical, behavioral and often forensic-level needs. Those providers that continue to accept patients have become more selective with admissions, often opting to accept individuals with less intensive needs rather than those that require a higher level of care.

Lack of adult beds at appropriate community-based providers. Often, county case managers and social workers cannot find community-based providers for adult patients due to lack of beds. These providers are full, do not have adequate staffing to admit additional patients, or are not equipped to manage the intensive behavioral health needs of those ready to be discharged from state-operated programs. In some cases, a patient may need an intensive supervision option, but none is available. Or long-term residential services may be needed, but there are none outside of nursing homes and adult foster care programs that are not equipped for this patient population, nor appropriate to meeting the person-centered goals of the individual's treatment plan. Waitlists for admission to community-based providers are common. For example, Intensive Residential treatment Facilities (IRTS), which provide a step down from a hospital for those patients who are rehabilitative, have wait times that average 6-8 weeks. In addition, there are many instances where the typical "up to 90 days"

of treatment at an IRTS facility is not enough for individuals requiring longer periods of support to achieve community-based stability, and length of stays for individuals already receiving treatment can be a barrier for people awaiting the service.

Lack of discharge options for children. The Child and Adolescent Behavioral Health Hospital (CABHH) has faced challenges discharging patients that no longer require a hospital level of care to appropriate community-based mental health programs, such as a psychiatric residential treatment facility (PRTF) or a children's residential facility. There are not enough of these facilities available and the ones that do exist do not have the capacity to meet demand. Without safe and appropriate discharge placement options, the CABHH can end up boarding patients for lengthy periods, just as other community and state-operated hospitals do. While DCT waits to place patients that no longer require hospital level of care in step-down programs elsewhere, its capacity to admit other children who require treatment in a hospital is reduced.

Challenges developing community-based facilities. Statewide, challenges surrounding staff recruitment and retention have impeded the development of community-based treatment facilities. The rising costs of facility development in the past few years have caused organizations to reevaluate their pre-pandemic to building or expansion plans as construction and renovation costs have risen.

Unwillingness to accept certain individuals. There are limited community-based providers equipped and able to manage the treatment needs of patients with complex mental health and behavioral issues. Some providers are unwilling to accept individuals with intensive psychosocial needs, chemical health needs, criminal histories, and housing instability. This further constricts community-based placement options and creates discharge delays.

Providers are often unwilling to accept the increased costs, risks and liability that come with serving individuals with higher needs. Insurance costs, or even obtaining insurance and certifications for programs that serve individuals with complex mental health, behavioral, and often past or recent criminal behavior make it financially prohibitive for providers to accept certain individuals in their facilities.

Limited beds at other DCT facilities. DCT programs are full and have admission waitlists that can be as long as several months or longer for DCT's forensic facilities.

AMRTC and the six CBHHs are full due in significant part to their inability to discharge patients when clinically appropriate. In December 2022, 44% of AMRTC patients did not meet criteria for hospital level of care. Of the 43.1%, 20.4% were waiting for community placement and 22.7% were waiting for FMHP and can't be admitted to FMHP because patients who do not meet FMHP level of care are waiting to be discharged to community placements.

Admission delays at AMRTC are primarily a result of the increasing number of DNMC patients who remain in these beds, which directly lead to AMRTC's inability to admit more patients. For example, in a hypothetical where the average daily number of patients that remain at AMRTC after they are ready for discharge and no longer need a hospital level of care is 45 per day, this equals 16,425 patient days (45 x 365 = 16,425 patient days) annually. The average number of days patients reside at AMRTC for clinically appropriate treatment is 90 days. Based on the number of patient days and average length of stay, DCT estimates that in this situation

approximately 182 (16,425 patient day ÷ 90 treatment days) additional patients could be served at AMRTC in a year, if the patients who were on DNMC status could have been discharged back into the community, if the county had the placement options available to discharge the patient.

B. Persistent difficulties recruiting and retaining staff

The number of patients DCT can admit to state-operated programs is directly tied to available staffing. DCT cannot admit more patients than can be safely cared for. Staffing shortages can limit DCT's ability to move patients from one state-operated program to another. For example, when the FMHP experienced a staffing shortage it then impacted the number of patients that could move from AMRTC to the FMHP.

Recruiting and retaining staff is an ongoing struggle. The staff vacancy rate across DCT generally hovers around 19 percent and filling key positions is difficult. This is further complicated by a 1.4% unemployment rate in Minnesota. There are simply not enough workers available in the community to fill vacant positions across the state.

Community-based providers are experiencing similar challenges and obstacles that affect staff recruitment and retention. These challenges ultimately impact the ability of these providers to properly staff their programs to provide safe and effective care.

Obstacles that affect recruiting and retention include:

- Fewer people are moving into the direct care workforce resulting in a limited pool of candidates.
- The health care labor market is highly competitive and the labor pool in outstate Minnesota is limited due to the number of jobs that can provide greater opportunity, upward mobility, competitive salary, and a less acute work environment.
- Unemployment remains low with an estimated two jobs available for everyone individual seeking employment.
- Hospitals, nursing homes and other care facilities statewide are all struggling to find much needed staff.
- State-operated programs require a special mix of staff who have experience working with the specific and target populations that have complex (and often multiple) psychiatric and behavioral conditions.
- The patients at some programs have severe and highly complex conditions that are sometimes accompanied by challenging behaviors that could include episodes of harming themselves and/or others. The segment of the healthcare labor pool willing to work with these patients is small. DCT experiences spikes in staff turnover because of perceived safety issues associated with serving aggressive patients and community-based providers choose to not serve these individuals.
- The COVID-19 pandemic exacerbated hiring difficulties as health care professionals at all levels have suffered extreme burnout and have left the field in droves.
- The rates that community-based providers are able to pay are below other employment options and have been hit hard by the great resignation and retirements from the direct care field.

C. Shift in patient acuity and needs

The types of patients that counties and DCT serve has changed. There has been an increase in individuals that are highly symptomatic, with greater substance abuse and mental health needs and a history of involvement with the criminal justice system. The staffing levels and types of environments required to treat these patients decreases the ability to locate a community-based provider willing to admit certain patients.

Higher staffing levels per patient. At DCT, staffing is reviewed annually and grounded on pre-planned staffing patterns based on retrospective years and industry standards for employee to patient ratios. Each day, program staffing may be altered due to changes in patient needs. Sometimes, the number of staff needed changes suddenly due to increasing patient needs based on acuity, individual patterns and needs, and more recently, increasing aggression and volatile behaviors. This requires DCT to quickly move staff who normally care for a few patients to care for a single, highly symptomatic, high-needs or behaviorally challenged patient. In some cases, such a high level of acute care means a patient may require staff to patient care at a ratio of 1:1, 2:1, or 3:1. Without adding more staff to care for the high-needs patient, this effectively reduces the capacity for DCT to admit and safely care for new patients.

More specialized treatment environments. The need for more intensive care areas or low stimuli environments has increased. Creating a safe space for patients and staff takes additional patient beds off-line. For example, one patient may need an entire smaller unit to meet their environmental needs for appropriate levels of care.

D. Inappropriate placement at state-operated psychiatric hospitals

Sometimes patients are placed at AMRTC when they do not require hospital level of care. For example, a patient may be admitted to AMRTC due to safety concerns rather than medical necessity. The patient may be causing property damage to their current environment, threatening staff and peers, and law enforcement custody is not an option. The behavior may be volitional and characterological rather than psychosis-related and amenable to pharmacotherapy. With such limited placement options, the patient is admitted to AMRTC. Under such circumstances, DCT engages county partners to agree to the admission and ensure there is a full understanding that the patient does not meet hospital level of care and a liability for full cost of care will be incurred.

In other cases, a patient presumptively meets hospital level of care upon admission, but does not shortly after the assessment process depending on reasons for admission and diagnosis. For example, the patient may have stabilized in a community hospital while waiting for an open bed at AMRTC or have behavioral challenges but no active mental health issue to treat. The patient is appropriate for discharge but remains at AMRTC awaiting development of a group home (customized living) to help provide a safe environment. The process to develop a group home appropriate for individuals with behavioral challenges can take 12-18 months to complete. Because the patient does not require hospital level of care the patient is deemed DNMC.

Another scenario is a patient with complex behavioral care needs who has stabilized and does not need hospital level of care. This patient who is stable, but continues to have these complex needs, may be at a normal base

line and the best solution is to place them in a low-stimuli setting as part of the therapeutic treatment plan. This can occur in a community-based setting and does not necessarily require a state-operated program bed. Patients who have complex needs as part of their routine care can have a significant impact on DCT's ability to treat patients who actually need to be in a state-operated program. For example, a patient that requires a low stimuli environment can use an entire four-bed hospital unit. DCT averages two to three patients in this type of setting, but for the purpose of this example we will use one patient/day/year. Based on the average number of beds (4) taken offline for one patient over the period of one year equals 1,460 patient days. With an average treatment length of 90 days, DCT could have served 16 additional patients annually if a community placement option to move this person who is at baseline but has routine and ongoing complex behavioral health issue existed (1,460 patient days ÷ 90 average treatment days = 16.2 patients that could have been treated).

E. Limited authority for determining patients served

DCT does not have a decisive role in determining which patients are placed under civil commitment and referred to DCT for treatment. This authority rests with the courts and the civil commitment process. DCT is not a party in civil commitment cases. The courts may have limited information about the role of state-operated programs in psychiatric stability, diagnoses better served in other settings, the intersectionality between competency to stand trial in a criminal proceeding and psychiatric stability and the availability of community-based and less restrictive treatment services. This can lead to patients being committed to and referred for treatment in state-operated psychiatric hospitals when they do not require the levels of care offered by DCT. This in turn can lead to the counties incurring high charges for cost of care.

F. COVID-19

While DCT has been proactive in its work to prevent, detect, monitor and control COVID-19 outbreaks in its facilities and has worked closely with state and federal health care regulatory agencies to implement and follow infection prevention and control best practices, COVID-19 continues to limit the number of people that state-operated programs and community-based providers can serve. Nearly three years after the pandemic's onset, DCT continues to experience COVID-19 outbreaks among patients and staff.

Reduced staffing levels. COVID-19 not only affects the ability to recruit and retain staff, but it also affects operations when staff become ill and cannot report for work until they are virus free or symptom free. Nearly 50% of DCT staff have come down with COVID-19 since the onset of the pandemic.

Limited bed availability. Since the start of the pandemic, DCT has at times had to pause admissions as a result of COVID-19. An outbreak can require DCT to close entire programs or various patient care areas (units) of state-operated facilities for several days or weeks because of the regulatory quarantine standards for health care settings. Patients with COVID-19 must quarantine and cannot have a roommate during quarantine. Patients ready for discharge remain in state-operated facilities while they quarantine and recover from COVID-19 before they are discharged to community settings. Community providers face similar challenges and have paused admissions due to patient illness.

G. Concerns about patients with challenging behaviors

Concerns about patients with challenging behaviors continue to be a barrier for placement for a subset of our population. Many community-based providers refuse to accept patients who have challenging or aggressive behaviors or have been involved with the criminal justice system. Many organizations simply do not want the risk, liability or difficulty involved in caring for these hard-to-manage patients. The situation is made even more difficult by a prevailing sentiment among some providers that these patients can only be safely cared for in a secure institutional setting.

H. Insurance challenges

Some patients may have private insurance, but the insurance may not provide coverage for the most beneficial and appropriate community-based providers. This means patients may be discharged to placements that may not best meet their needs. While lack of insurance is not a barrier to treatment at state-operated programs, it can be a barrier to discharge to a community-based provider. The state and counties cannot enroll individuals in insurance plans without their express authorization; however, many patients who do not have insurance are often too ill to discuss insurance options or give their consent to enroll.

Other barriers include patients with an undocumented status, which results in lack of qualification for programs, or other requirements such as spend-downs and the need for guardians and fiduciaries/representative payees to be in place. Many community-based placements require funding (insurance or otherwise) to be in place before fully accepting a patient and allowing admission to their program. This results in long wait times for funding streams and payment rates to be approved.

I. Disagreement on roles

Some counties have infrequent civil commitments to state-operated programs and are unfamiliar with how the process works. In some cases, there is a misunderstanding of county and state roles in the commitment process, simply due to the infrequency of working together and the lack of standardization across counties. This leads to delays in discharge. DCT works with the counties to clarify roles.

By law, each entity has roles and responsibilities to manage care within their respective care settings. Until a patient is admitted to a DCT facility, counties, jails, and others are expected to ensure the medical and mental health needs of patients are met. Once a patient is admitted to a state-operated facility, DCT has sole responsibility for the treatment and stabilization of the individual's condition. The county again assumes responsibility once the patient is treated, stabilized, and discharged from a DCT facility.

J. Differing opinions on appropriate placement

There are some cases in which DCT and counties do not agree on whether a placement is appropriate for a patient ready for discharge. Counties reported that there are instances where an appropriate placement has

been located and DCT clinical staff disagree, leading to a delay in the patient's discharge. This is an allowable administrative review criteria and if the department determines the county's desired placement meets the patient's individualized treatment and safety needs, the cost-of-care liability can be reduced.

K. Lack of participation in discharge planning

DCT is not always able to fully engage stakeholders in discharge planning at the time of admission or throughout a patient's stay at DCT facilities. Discharge planning starts upon admission and counties are highly encouraged to fully participate in preparation for an anticipated discharge. In addition, there are times when guardians do not return calls and complete required forms. While most counties are fully engaged in discharge planning and work tirelessly to find community-based placements for patients, some counties do not participate in discharge planning. In these cases, locating an appropriate community-based placement falls to DCT even though this is a county responsibility under Minnesota law. This refusal to participate in discharge planning results in discharge delays that affect the entire the system.

L. Lack of housing stabilization

Some community-based providers require stable housing in order to provide services. Often, patients lose their housing due to lack of rental/mortgage support or their place on a housing subsidy list while in treatment. While some ACT teams are willing to work with the homeless and unstably housed, this is not so in the majority of cases. Thus, while this treatment option may be appropriate for a patient, lack of housing may prevent discharge to this type of provider.

V. Efforts to reduce discharge delays

Both the counties and state have undertaken a multitude of efforts to reduce discharge delays. These efforts have included internal and external process changes related to discharge planning, increased collaboration between the counties and state, outreach to other stakeholders, provider development, and pooling of additional case management resources.

A. Discharge planning begins upon admission

When an individual is admitted to a state-operated psychiatric hospital, discharge planning begins on the same day to avoid delays. This planning involves the treatment team, county caseworker, the individual patient, and family or guardian. Counties are expected to be an active participant throughout the entire discharge planning process. DCT has experienced varying degrees of county participation in the discharge planning process. Some counties are deeply involved in discharge planning. These counties attend weekly and biweekly discharge meetings, may already have a discharge plan when someone is admitted to a state-operated program, and continue to partner with DCT on identifying appropriate discharge placement options. Those involved with joint discharge planning report improved state and county relationships and discharge speeds overall.

This is one area that is recognized as having more opportunities for improvement. Some counties report that they do not receive regular invitations to discharge planning meetings, or if invited, meeting times are moved, are scheduled with little notice and impede their ability for the county staff to attend. DCT is working with counties to ensure meeting invitations are provided and counties are able to attend discharge planning meetings. Currently, if a county is not involved in the discharge planning process and DCT auditing indicates the county was invited, DCT contacts the county case manager to solicit engagement and resolve issues surrounding discharge planning meetings.

B. Discharge review meetings

DCT holds a variety of internal meetings at its state-operated programs for more efficient discharge planning. These meetings can occur on a weekly, biweekly, or monthly basis, depending on the staff component and patient. For example, at AMRTC unit social workers meet weekly to collaborate and move discharges forward and the social work and psychiatry teams meet monthly to increase cross-discipline collaboration and ensure that timelines related to discharge delays are better communicated. Some counties report holding internal weekly meetings to review individuals on waitlists and those placed in state-operated programs.

DCT also meets with county partners. These meetings can involve case reviews to discuss discharge options and ensuring proper appropriate representation from a variety of stakeholder groups such as county case managers, MNChoices, financial assistance, agency administration, DCT treatment teams, correctional mental health, and DCT Central Preadmission staff. For example, a cross-section of stakeholders from AMRTC and one of the larger metro counties meets weekly to review and assess the list of individuals admitted to AMRTC and for those on AMRTC's waitlist, to identify possible diversion to another program like a CBHH or Minnesota Specialty Health System (MSHS). This effort has been successful at ensuring that both DCT and the county are fully engaged in the discharge process from time of admission. DCT is currently working on replicating this structure with another large metro county.

In addition, some counties extend their collaborative efforts to other stakeholders along the continuum of care. This includes monthly meetings with representatives of the civil commitment court and criminal court to review individuals in jails and community hospitals waiting for admission to a state-operated program.

C. Evaluation of the treatment environment

At AMRTC, the treatment teams evaluate various evidence-based treatment methodologies for individuals with high behavioral challenges to successfully transition back into the community. For some patients, the use of low stimulation environments or intensive care units make it more difficult for these patients to shift back into the community. The treatment teams work to reduce the use of these environments when clinically appropriate.

D. Transition to community and innovation grants

In 2013, the Legislature approved new funding and grants to support the transition of patients from AMRTC and the FMHP to community resources of their choosing. This funding was to enhance and expand existing resources that support individuals living in the community and to develop new services to cover existing community service gaps. Since enactment, funding has continued. DHS has taken a variety of steps to address barriers to timely discharge that include creation of additional waiver services, creation of waiver-like services for those who do not quality for medical assistance, establishment of a Transition to Community Work Group made up of staff across DHS programs that serve DCT patients, expanded funding for housing and rent subsidies, and expanded specialty community placements for individuals requiring supervised care.

One example of a recent effort under these grants is the Bed Hold Program. The length of time it takes a patient who has been civilly committed as a person who has a mental illness and is dangerous to the public (MI&D) to be provisionally discharged from the FMHP in St. Peter to a less restrictive setting has been identified as a barrier to discharge. Once a provisional discharge plan is completed, it may take several months for a Special Review Board (SRB) hearing to be scheduled. Until the patient is provisionally discharged, a provider is unable to bill for waiver services and in most cases, providers are reluctant to make a commitment to serve a person in this circumstance because the provider cannot afford the lost revenue from holding the vacancy open until the patient is discharged.

The Transition to Community Initiative made funds available as an incentive for a licensed residential provider to hold a vacancy open for an individual waiting for final approval from the SRB and DHS Commissioner to be provisionally discharged. The Bed Hold program is contingent on the availability of Transition to Community Initiative funding as it is a “first-come, first-served basis.”

E. Assessment for alternative placement

When DCT is unable to appropriately serve some referred patients due to their clinical needs, the Central Preadmissions Office works to help find other supports that meet patient needs, but DCT has limited referral options.

F. Transitions team

DCT has a team that focuses on transitioning patients to the next appropriate placement to divert patients from state-operated programs and decrease discharge delays. The transitions team works on getting referrals for placement in the community if there are no barriers to other placement types.

G. Development of community-based programs

One county reported the development of an additional program to alleviate the demand for services and reduce discharge delays. This county indicated a decrease in the liability for cost of care for DNMC days in calendar year

2022. However, additional data is needed to determine if the decrease is the result of the additional community-based program or due to decreased admissions to DCT hospitals from that county.

H. Staffing recruitment and retention

To help alleviate staff shortages exacerbated by the pandemic, DCT enhanced recruiting and retention efforts across the state-operated behavioral health care system, offering retention and hiring bonuses in an attempt to backfill hundreds of vacant positions. DCT experienced some success but recruiting and retaining staff remains a challenge. Some facilities used incentives, sign on bonuses, retention bonuses, and voluntary overtime to incentivize and compensate existing employees for covering shifts that do not have a sufficient staffing ratio to ensure quality of care and delivery of service to the people served within DCT.

I. Targeted resources

Some counties have pooled resources to enhance aspects of case management. One example is a six-county area that collaborated and contracted with an entity to address the number of DNMC patients at state-operated facilities. The counties have hired a Regional Transitions Specialist to serve as a point of contact for stakeholders, making referrals, participating in treatment meetings, and identifying viable community placements based on availability and reasonable accessibility.

Stakeholders report several positive outcomes as a result of implementing this position. Communication with county and state stakeholders occurs with greater frequency, collaboration among stakeholders is initiated earlier than in the past, discharge planning is perceived as more balanced, and stakeholders are more aligned with patient needs and placement overall. While discharge delays have not been reduced to zero in these six counties, such delays are more likely due to some unforeseen circumstance such as a placement that has fallen through or delayed discharge paperwork.

This is just one example of a targeted resource that counties developed to enhance case management and potentially reduce discharge delays. Resources like this provide a greater level of support for patients and increase the potential for timely discharge.

M. Engagement with the judiciary

Because the judiciary and DCT have distinct roles in the civil commitment process, both agencies meet regularly to increase the understanding about the role of each agency in this process, discuss issues of mutual concern and identify potential solutions. Part of this engagement has included providing the judiciary with more robust information about DCT services and programs since courts often have limited information related to the role of state-operated programs in psychiatric stability, diagnoses better served in other settings, the intersectionality between competency to stand trial and psychiatric stability and the changing demographics of the patients that DCT currently serves. While this engagement is ongoing, DCT most recently provided the judiciary with an overview of DCT services and programs in December 2022.

VI. County liability for cost of care

Counties incur a liability for cost of care when a patient remains in a state-operated psychiatric hospital and hospital level of care is no longer clinically appropriate. This liability has evolved over time and became uniform across state-operated psychiatric hospitals in fiscal year 2022.

A. Legislative history

County liability to pay a portion of the cost of care for each day a patient spends at a regional treatment center was first enacted in 1959. At that time the county liability was $10 per day per patient. In 1981, the county liability changed to 10% and remained at that level until 2003 when the percentage changed to 20%. In 2007, a tiered approach was enacted at the Anoka Metro Regional Treatment Center (AMRTC) with a 50% liability for the cost of care when the treatment program determined that a patient is clinically appropriate for discharge. This percentage increased to 75% in 2013 and 100% in 2015 as an incentive for counties to facilitate discharge in a more expedient manner.

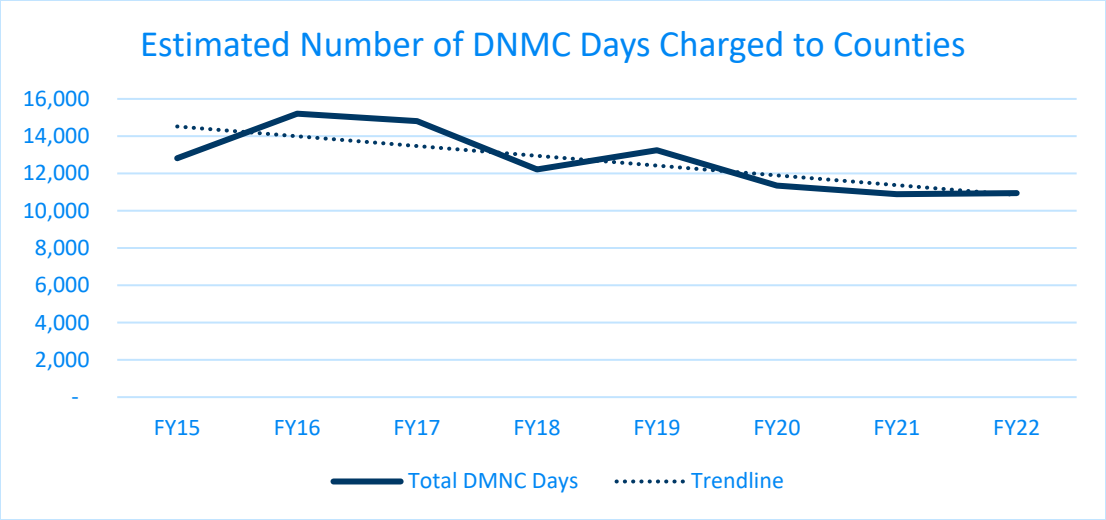
When the Community Behavioral Health Hospitals (CBHHs) opened there was no county liability for the cost of care. In 2016, a county liability of 100% was added for patients deemed clinically appropriate for discharge. There continues to be no county liability for a patients stay at a CBHH if the stay is clinically appropriate.

In the 2021 legislative session, the Legislature increased the county liability for cost of care from 0% to 100% for services provided at the Child and Adolescent Behavioral Health Hospital (CABHH) for patients deemed clinically appropriate for discharge, aligning with the billing practices of the CBHHs.

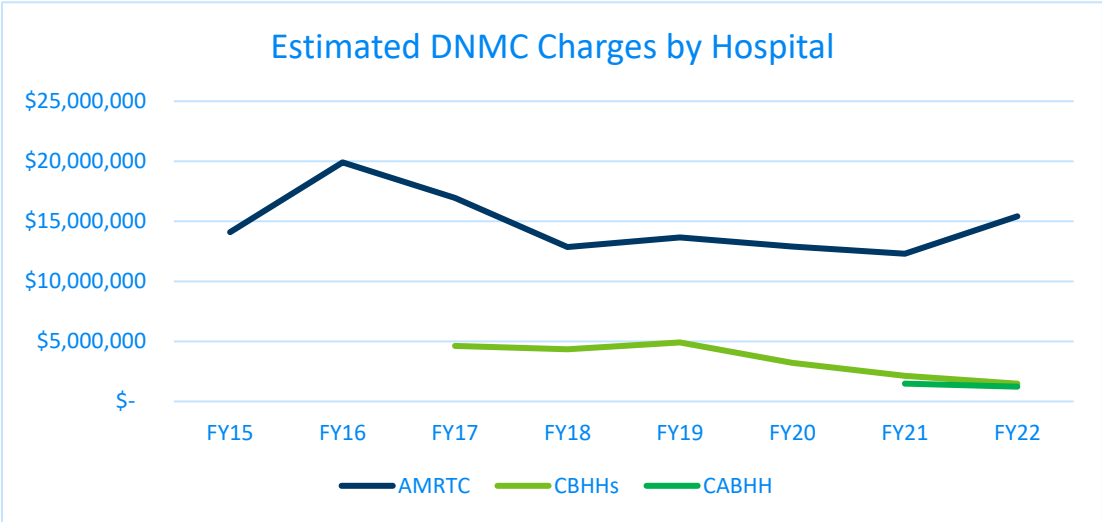
B. Impact of liability for cost of care

Overall, since the liability for cost for care was increased to 100% when it is determined that a patient is clinically appropriate for discharge, there has been a decline in the total number of DNMC days across state-operated psychiatric hospitals. As a result, the total number of DNMC days charged to counties decreased.

Below is a chart that shows the estimated number of DNMC days charged to counties from fiscal year 2015 through fiscal year 2022.

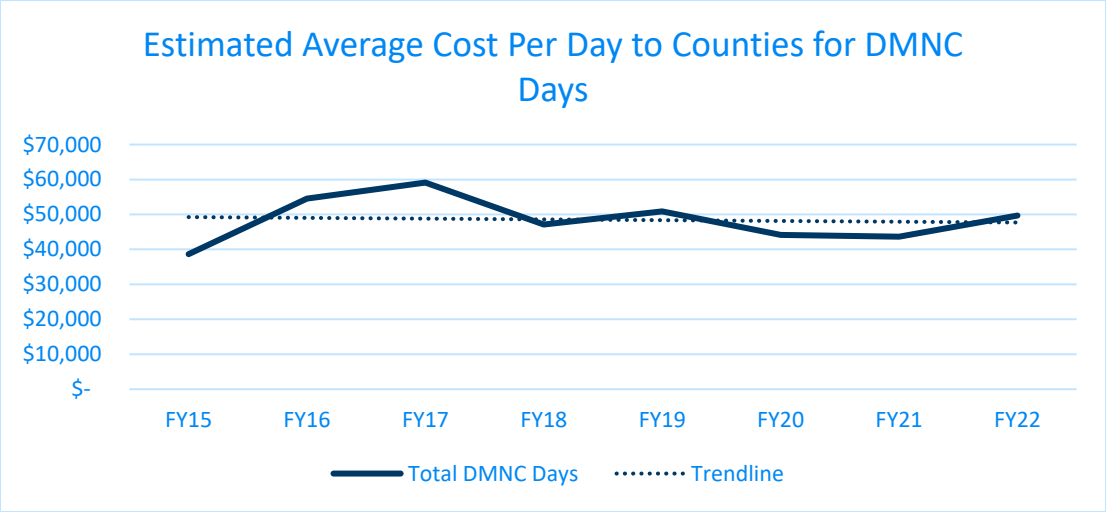


The downward trend in DNMC days is continuing for the CBHHs and CABHH. However, the number of DNMC days has started to increase for patients at AMRTC. Most often, these patients are awaiting discharge to another state-operated program but there are no available beds due to patients remaining in those beds when that level of care is no longer required. Below is a graph of estimated county liability for cost of care for DNMC days by state-operated psychiatric hospital from fiscal year 2015 through fiscal year 2022.



AMRTC = Anoka Metro Regional Treatment Center
CBHHs = Community Behavioral Health Hospitals
CABHH = Child and Adolescent Behavioral Health Hospital

While the prior chart showed the total DNMC charges to counties by program by fiscal year, below is an average of the estimated daily liability for cost of care for DNMC days charged to counties for all state-operated psychiatric hospitals from fiscal years 2015 through fiscal year 2022.



The cost of care rate is based on per diem rates published by DCT by facility each fiscal year. These rates are used to bill Medical Assistance, Medicare, private insurance, counties, and individuals for patient stays. The per diem rate is calculated by dividing the sum of all anticipated costs by the funded bed capacity. The per diem rates have increased every year except for fiscal year 2021 when the fiscal year 2020 rate remained in effect. Below are the per diem rates in effect from fiscal year 2014 through fiscal year 2022.

Daily Per Diem Rates
By Psychiatric Hospital and Fiscal Year

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
AMRTC	$1,011	$1,100	$1,309	$1,375	$1,390	$1,385	$1,396	$1,396	$1,615
CBHHs	$1,061	$1,127	$1,209	$1,866	$1,465	$1,452	$1,524	$1,524	$1,644
CABHH	$1,643	$1,765	$2,248	$3,562	$3,933	$2,105	$2,198	$2,198	$2,473

AMRTC = Anoka Metro Regional Treatment Center

CBHHs = Community Behavioral Health Hospitals
CABHH = Child and Adolescent Behavioral Health Hospital

C. Administrative review process

In 2018 representation from the Minnesota Inter-County Association (MICA) and Minnesota Association of County Social Service Agencies (MACSSA) partnered with DCT to address issues related to DNMC days. These efforts resulted in a 2019 statutory change that created an administrative review process that provides counties the ability to contest financial liability for DNMC days in certain situations:

- The facility did not provide the county notice that the facility determined it is clinically appropriate for the patient to be discharged;
- The notice to the county that the facility determined it is clinically appropriate for the patient to be discharged was communicated on a holiday or weekend;
- The required documentation or procedures for discharge were not completed in order for the discharge to occur timely; or
- The facility disagrees with the county's discharge plan.

COVID-19 waiver. For a limited time, a waiver related to COVID-19 was available for counties to request as part of the administrative review process. On March 13, 2020, Governor Walz issued Executive Order 20-01 which declared a peacetime emergency in response to the COVID-19 outbreak. On March 20, 2022, Governor Walz issued Executive Orders EO-20-11 and EO 20-12 relating to DHS programs.

EO 20-12 gave the Commissioner of Human Services flexibility to temporarily waive or modify laws and regulations that govern DHS programs. EO 20-12 provided time-limited authority for an additional administrative review criteria relating to a county's liability for cost of care when a patient no longer met criteria to remain at a program, but discharge was delayed due to diminished community capacity or program restrictions resulting from COVID-19. This additional administrative review criteria was enumerated in COVID Waiver CV-31 and added additional criteria to the administrative review process that allowed partial waiver of county cost of care when COVID-19 delayed discharge from state-operated psychiatric hospitals. Counties were able to submit review requests for discharge delays that occurred on or after the Governor's declaration of a peacetime state of emergency under Executive Order 20-01. This waiver was approved on April 19, 2020, and remained in effect until the end of the peacetime state of emergency.

During the 2020 legislative session, the Legislature enacted waivers and modifications to Department of Human Services programs pursuant to Executive Orders EO 20-11 and EO 20-12. This waiver was extended by the Legislature to June 30, 2021.

Due to anticipated discharge delays related to COVID-19, DCT estimated that patients would remain at facilities for approximately 60 days after an individual no longer met criteria for hospital level of care rather than the 10 days previously estimated in the February 2020 revenue forecast. This increase in DNMC days would have resulted in approximately $9.1 million in county liabilities for the cost of care. The waiver was expected to result in savings of approximately $7.6 million to the counties.

Some counties reported halting the submission of administrative review requests under the temporary COVID waiver after receiving denials to submissions. As a result, it is possible that viable requests that qualified under the COVID waiver were never submitted, resulting in a missed opportunity to have all or a portion of the liability for cost of care waived.

Utilization of administrative reviews. From fiscal year 2020 through fiscal year 2022, counties requested 59 administrative reviews. In 24 requests, DHS lacked the statutory authority to conduct a review, with the most common scenario being a discharge delay due to the inability of DCT to discharge a patient to another state-operated program. Of the 35 viable administrative review requests, 15 were partially approved and 10 were fully approved. Reasons administrative review requests were not approved include treatment program not at fault, dates predated statute effective date, unrelated to COVID-19, and the expiration of the COVID-19 waiver.

While this process has been somewhat successful as a tool to consider some of the circumstances surrounding discharge and the ability for counties to reduce DNMC days, counties express challenges remain in certain circumstances. One of the costliest scenarios in which DNMC days are charged to counties is when an individual is awaiting a bed at another state-operated program. Because this scenario is not part of the current administrative review process established in 2019 DCT has no authority to review requests based on this scenario and reduce the cost of care for DNMC days.

Other counties report difficulty with the administrative review process and have opted to not submit reviews due to failed attempts in the past. This is something that DCT and counties continue to work on collaboratively to address procedural concerns.

The chart below shows the total number of administrative review requests, DHS statutory authority details and approval outcomes by fiscal year.

Administrative Review Requests
By Fiscal Year

	FY 2020	FY 2021	FY 2022
Total administrative reviews received	19	26	13
DHS lacked statutory authority to review	2	18	4
DHS had statutory authority to review	17	8	9
Reviews partially approved*	6	6	3
Reviews fully approved^	7	0	3
Reviews not approved	4	2	3

*A partial approval means that a reduction in the liability for cost of care was granted for some, but not all DNMC days in the request because some of the days requested did not qualify.
^A full approval means that a reduction in liability for cost of care was granted for all DNMC days in the county request.

For the days that qualified for review under the administrative review process, there was a reduction in the county liability for the cost of care for DNMC days. In fiscal year 2020, the cost of care was reduced for 118 days, in fiscal year 2021, the cost of care was reduced for 37 days, and in fiscal year 2022 the cost of care was reduced for 136 days. Based on the per diem rates by state-operated psychiatric hospital and fiscal year, the reduction in the liability for cost of care for the DNMC days listed above was approximately $408,477.

The chart below shows the total number of DNMC days reduced by psychiatric hospital program and fiscal year.

DNMC Days Reduced
By Psychiatric Hospital and Fiscal Year

	FY 2020	FY 2021	FY 2022
Anoka Metro Regional Treatment Center (AMRTC)	69	36	135
All Community Behavioral Health Hospitals (CBHH)	49	1	1
Child and Adolescent Behavioral Health Hospital*	----------	---------	0
Total DNMC days waived	118	37	136

*County liability for cost of care for DNMC days at the CABHH began in FY 2022. There were no administrative review requests in FY 2022.

VII. Conclusions

Discharge delays continue to be an ongoing problem shared by the counties and state that make it difficult for patients to be moved to the next appropriate treatment setting. The cyclical impact on admissions across the state-operated system restricts the number of patients that state-operated programs can serve. This means that individuals that require care in a state-operated psychiatric facility are often unable to immediately receive it and may remain waiting in settings such as jails and community hospitals. Those settings also then have inappropriately used beds and are unable to use them for others where appropriate. Counties are unable to move patients out of state-operated programs due to a lack of community-based programming available. The effect is felt across the entire health care system: Patient movement to clinically appropriate placement can be limited, waitlists for both community-based providers and state-operated programs grow, and counties incur a liability for cost of care. This cycle has created an untenable situation where DCT and counties cannot adequately meet their obligation for timely discharge and placement in the next appropriate setting.

There are many barriers to timely discharge. The most impactful barrier is the lack of appropriate discharge options in communities. Counties are unable to move patients out of state-operated programs due to the lack of community-based programming available. More complex patients, such as those with criminal histories, behavioral challenges, housing instability, or multifaceted needs, particularly if specialized environments need to be developed have even fewer community-based provider options.

The lack of discharge options is caused by the limited number of community-based placements, provider closures creating a gap in the care infrastructure and remaining providers are at capacity and/or not equipped to

serve certain patients, resulting in providers being more selective about admissions and reducing the options for those with the most complex needs. Providers are also apprehensive about expanding due to the inherent risks associated with serving this patient population and the rising costs of facility development are prohibitive.

Another significant contributor to discharge delays is that the state, counties, and community-based providers have struggled with recruiting and retaining staff. These challenges have negatively impacted health care providers across the state and facilities are not able to meet current patient demand since certain required staffing levels are based on patient acuity and to ensure both patient and staff safety. As a result, high staff vacancy rates mean there are less beds available across Minnesota and waitlists that continue to grow for both community-based providers and state-operated programs.

The population of patients has become more acute, and their needs have changed. The frequency of justice-informed patients and patients that need specialized treatment to mitigate risk to themselves and others has increased. Highly symptomatic patients with substance abuse and mental health needs and a history of involvement with the criminal justice system are more challenging to serve. These patients also require more specialized treatment environments and higher staffing levels that are not always readily available in community-based provider options.

COVID-19 has also resulted in discharge delays due to the need to quarantine and has limited admissions to DCT and community-based providers. Challenges with insurance willingness to provide coverage for the most appropriate placement can create a barrier to admission to certain placements. Also, sometimes there are misunderstandings about the commitment process that result in process delays or difficulty engaging stakeholders in the discharge planning process.

Not one of these barriers exists in a vacuum. Rather, they are cumulative and interconnected. As barriers continue to mount, the pressure on state-operated programs and community-based programs will only increase, discharge delays will continue, DNMC costs will strain county budgets, and the number of patients that can be served in state-operated programs will be limited and waitlists will grow.

Since enactment, the administrative review process has reduced the financial liability for counties for the cost of care for DNMC days. However, the current statute does not contain a mechanism for the department to reduce the cost of care when the delay is due to the inability of DCT to discharge a patient to another state-operated program. While addition of this mechanism will not reduce the number of DNMC days, amending the statute to include this scenario would provide an opportunity to alleviate some of the financial pressure counties face related to DNMC days.

The state and counties have taken a number of actions to reduce delays in discharge. These steps have improved communication between stakeholders, helped providers address challenges to timely discharge and allowed for the exploration of alternatives to state-operated psychiatric hospital admission. However, there is no foreseeable decline in the level of discharge delays or DNMC days without significant investment to remove or reduce the existing barriers to discharge. Investment in the reduction of barriers that prevent access to appropriate discharge placements is necessary, particularly options to pull individuals into care with wrap-around in-home case management, rental and mortgage assistance for those in treatment, and holding placement on a rental subsidy list for when discharge. In addition to an increase in outpatient therapy,

investment in the creation and stabilization of more community-based providers such as Mental Health Targeted Case Management (MH-TCM), Adult Rehabilitative Mental Health Services (ARMHS), Mobile Crisis, Day Treatment/Partial Hospitalization, Assertive Community Treatment (ACT), Intensive Residential Treatment Services (IRTS) are needed. However, the challenges faced by current community-based providers must be recognized. Increasing the number of community-based providers and available beds means that appropriate staffing levels and skill mixes need to be in place to serve individuals in nonhospital settings. Without these in place, counties and the state will be unable to significantly reduce discharge delays.