MENTAL & BEHAVIORAL HEALTH
Options & Opportunities for Minnesota
Mental & Behavioral Health:
Options and Opportunities for Minnesota

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Executive Summary

Minnesota’s mental and behavioral health delivery system features a complex and broad array of community-based services. These services received a much needed $51 million investment of additional public funding in the 2015 legislative session. Even with the enhanced capacity that will be built with the new funding, community-based services are unlikely to have the capacity necessary to effectively and efficiently meet the growing demands of Minnesotans suffering from mental illness and substance use disorders without additional policy reforms, clinical innovations, and financial resources.

Minnesota’s hospitals and health systems have a significant interest in exploring alternatives to further improve the care individuals receive, prevent the need for or escalation of care required, and expedite the flow of patients to the most appropriate settings based on their individual needs.

Our hospitals and health systems also understand the scope of challenges that need to be overcome to move from today’s environment to one in which residents receive optimal mental and behavioral health care regardless of geography, socio-economic status, cultural background, etc. There is no one right answer or off-the-shelf solution to addressing mental illness and substance use disorders.

Likewise, hospitals and health systems cannot solve the challenges facing the state on their own. Successfully addressing mental illness and substance use disorders will take all stakeholders in their respective communities working together, taking responsibility, and holding each other accountable.

The Minnesota Hospital Association’s (MHA) Board of Directors has articulated mental and behavioral health as one of the organization’s highest priorities. During its most recent planning retreat, the Board examined multiple delivery and service models being pursued across the country and in Minnesota. Based on the research summarized in this report, discussions by MHA’s Board, and in conversations with MHA members throughout the state, MHA offers the following short- and long-term recommendations for further investigation, experimentation and implementation:

- **Decrease Stigma; Increase Awareness**
  Continue to decrease the stigma too often associated with mental and behavioral health, increase residents’ knowledge and understanding of mental and behavioral health issues, and build greater awareness of existing resources, such as crisis hotlines and texting services, telemedicine solutions for assessments and therapy, community mental health providers, and crisis teams.
• **Reduce Variations that Impede Optimal Care**
  Inventory available services and protocols across the state, and complete a value stream mapping exercise to reduce clinical, policy and service variations that impede people from receiving optimal care.

• **Implement Evidence-Based Practices**
  Seek ways to extend and implement evidence-based programs and practices, such as those available through the Substance Abuse and Mental Health Services Administration’s (SAMSA) national registry and the National Alliance on Mental Illness, Minnesota’s (NAMI) mental health first aid training with a particular focus on “upstream” interventions that will prevent mental or behavioral health illnesses or treat them earlier before they become a health care crisis or a chronic condition for individuals.

• **Leverage Telemedicine Technology**
  Explore ways to increase or extend access to mental and behavioral health care services through the use of telemedicine technology, including the potential creation of a clearinghouse model that will better utilize the time and talents of available providers.

• **Create Statewide Assessment Standards or Tools**
  Develop more standardized, evidence-based mental health assessment and transfer protocols so available public and private delivery system resources are better allocated based on individual patients’ particular acuity and needs.

• **Maximize Capacity of Unique Services Provided by the State**
  Collaborate with the Minnesota Department of Human Services, caregivers and advocates to optimize the use or expand capacity of unique services provided by the state, such as those delivered at the Anoka-Metro Regional Treatment Center, to their greatest capacity, including decreasing patients’ average lengths of stay in state facilities and developing additional placement options for patients who do not or no longer require acute inpatient care.

• **Improve Access to Care at Community Behavioral Health Hospitals**
  Encourage and support MHA members and the Minnesota Department of Human Services to investigate how public-private partnerships or collaborations could repurpose or expand capacity at Community Behavioral Health Hospitals (CBHHs).

• **Repurpose Unused Capacity in Rural Hospitals for Mental Health**
  Encourage and support MHA members operating critical access hospitals to explore whether converting existing portions of their existing facilities or expanding facilities to create distinct part units (DPUs) to provide greater access to mental or behavioral health services in rural communities.
Introduction and Overview of Previous Efforts

The Minnesota Hospital Association (MHA) Board of Directors has identified mental and behavioral health as a top priority for MHA. Nearly every hospital in Minnesota reported mental health, or some derivative of it, as a concern in their initial community health needs assessments; and every hospital and health system suffers the effects of system gaps and weaknesses.

MHA’s Board of Directors and Mental and Behavioral Health Task Force have a vision of a comprehensive and robust statewide mental and behavioral health system that serves all residents of Minnesota with appropriate, high-quality, accessible care. Some will continue to require inpatient hospitalization-level services; however, the needs of the vast majority would be met in a more convenient and efficient community setting, including in an individual’s home via telemedicine technology.

Accompanying this vision are several principles that have been generally agreed upon and frequently expressed by the task force and supported by the board:

- Hospitalization should be accessible but reserved for individuals who truly require acute care.

- Realizing this vision requires the engagement, cooperation and shared leadership of multiple stakeholders, including some that have not traditionally been considered full participants in the mental and behavioral health delivery system.

- The success of delivery system reforms will depend in part on overcoming the historical social stigma associated with mental and behavioral health issues.

These principles align with a number of previous initiatives intended to improve Minnesota’s mental and behavioral health system. Ten years ago, the Minnesota Mental Health Action Group (MMHAG), published its report entitled “Roadmap for Mental Health System Reform in Minnesota.” The following excerpts from the report articulated the vision, guiding principles and outcomes for Minnesota’s mental health system:

MMHAG’s vision for Minnesota’s mental health system.

Minnesota embraces a vision of a comprehensive mental health system that is accessible and responsive to consumers, guided by clear goals and outcomes and grounded in public/private partnerships.
MMHAG’s guiding principles for Minnesota’s mental health system.

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

Desired outcomes for Minnesota’s mental health system.

- Public/private partnerships to assure that all aspects of the mental health system are working to serve consumers and families
- A different fiscal framework for public and private mental health funding that creates rational incentives for the right care to be delivered in the right setting at the right time
- Quality of care for consumers and families, as measured by standardized assessment of performance and outcomes
- Innovative workforce solutions to assure an adequate supply of appropriately trained and qualified mental health professionals
- Earlier identification and intervention so that consumers and families are willing to seek and able to access help when needed
- Coordination of care and services so that the mental health system is easy for consumers and families to navigate and they receive the right
combination of services to achieve the desired health and social outcomes.

Other reports and efforts over the years reached similar conclusions, from 2005’s “Rural Health Advisory Committee’s Report on Mental Health and Primary Care” to 2014’s “Plan for the Anoka Metro Regional Treatment Center.”

Many of these reports led to legislative initiatives in MMHAG’s agenda in 2007 and 2015’s multi-stakeholder coalition, including MHA, seeking funding and reforms to increase mental and behavioral health access and capacity. Underlying almost every legislative push was the intention to build and expand a continuum of evidence-based practices, services and settings for treating mental health conditions. Work is underway for a similar effort related to substance use disorder treatment.

Even with all of the research, advocacy and care delivery that has occurred, more is needed. Minnesota’s hospitals and health systems are in a unique position to advance this work. As major providers of a broad array of services and access points; as large employers with a workforce more prone to anxiety, depression and addiction than the average population; as stewards of private sector financial resources held in charitable or public trust; as a unified group of stakeholders with statewide reach; and as the too-often providers-of-last-resort because of emergency department services and legal obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA), hospitals and health systems play major roles in today’s mental and behavioral health delivery system and in helping design the system of the future.

Another important factor weighing in favor of MHA’s ability to impact our state’s mental and behavioral health system is the significant role that Medicaid plays in financing these services. Across the country, Medicaid is the largest purchaser of mental health care. It represents half of all public spending on mental health and 25 percent of total spending on mental health. With expansion of Medicaid eligibility criteria and more than 100,000 additional Minnesotans covered through Medicaid since 2010, the program represents an even greater share of mental health spend in Minnesota.

Medicaid is a program largely controlled at the state level, with a wide range of federal approvals, waivers, demonstrations and other flexibility; therefore, Minnesota has extensive latitude to innovate how our Medicaid program covers mental health services. Examples of this latitude for states include Assertive Community Treatment (ACT) teams, medication management services, family psychoeducation and Minnesota’s Behavioral Health Homes initiative.
The Status of Mental and Behavioral Health in Minnesota

Mental illness impacts a large and growing portion of the population. Nationally, 18 percent of American adults face a mental illness, not including substance use disorders. Just over 4 percent are diagnosed with a serious mental illness, which includes major depression, schizophrenia and bipolar disorder. More than 20 percent of children have or have had a serious mental health disorder, including a mood, anxiety or behavior disorder. The magnitude of mental and behavioral health needs is compounded when one considers the larger number of people impacted because of their roles as family members, employers, neighbors or caregivers.

Additional data about the growth in demand for mental and behavioral health services put these statistics into a larger context. Both the number of cases and the costs associated with treating them increased more than those of heart disease, cancer or any of the other top five most costly physical health conditions. This growth translates directly into higher costs for individuals, too, because the percentage of out-of-pocket costs for insured individuals is higher than other conditions.

Minnesota’s statistics present a similar picture. On average, more than 500,000 adults in Minnesota have a mental illness, yet only 48 percent of them receive treatment. From 2009-13, 4 percent of adults over age 18 experienced a serious mental illness. Nearly 8 percent of Minnesota’s adolescents ages 12 to 17 – more than 26,000 young people – experienced a major depressive episode per year, and of those, only 54 percent received treatment. Forty-eight percent (about 338,000 people) of adults with any mental illness received treatment.

Nearly 8 percent of adolescents reported using illicit drugs, while almost twice as many reported binge alcohol use. For Minnesotans older than 21, nearly 8 percent reported heavy alcohol use.

At the end of 2014, Mental Health America issued a report ranking states’ performance on mental health care. Minnesota was one of only four states to rank in the top quartile in all three categories: overall performance, care for adults and care for youth. Our state’s relatively low rate of residents without health coverage is one of the primary reasons for Minnesota’s higher performance on Mental Health America’s metrics.

In short, while Minnesota’s health care delivery system struggles to meet the current demand for mental and behavioral health services, evidence shows that approximately half of those facing mental health issues receive treatment. Improving care, therefore, will require better processes to ensure that those who need treatment receive it, which in turn means that capacity needs to be increased dramatically and/or methods of
treatment need to be more streamlined or efficient to better utilize whatever capacity is available.

**MN Community Hospital Data**

**Snapshot**

On average, Minnesota hospitals care for 1,077 mental health inpatients each day.\(^{13}\) Individual hospitals with inpatient mental health units have an average occupancy rate of 80 percent, with a significant range between those with the highest and lowest occupancy rates. The average occupancy rate for hospitals in the Twin Cities area is 87.4 percent; for those elsewhere in the state it is 76.6 percent.\(^{14}\) In comparison, the average occupancy rate for all conditions at all hospitals is 40 percent. Anecdotal evidence suggests the occupancy rate may be higher for some hospitals because beds are occupied by long-term patients or have been removed from service due to inadequate staffing, the acuity needs of a particular patient or security concerns regarding a patient, meaning other patients cannot be safely treated on the unit.

The discrepancy between mental health admissions and all other admissions is highlighted in child and adolescent inpatient admissions. Mental health diagnoses were three of the top five reasons for admission for children and adolescents aged 10-17 from 2010-14. Mood disorders were the top reason for inpatient admissions for children and adolescents. The average length of stay for mood disorders was approximately six days.\(^{15}\)

Individuals with mental illnesses are 38 percent more likely to be readmitted for mental health treatment. Individuals with substance use disorders are 29 percent more likely to be readmitted for substance use disorder treatment. However, these rates may be underestimating readmissions because they are based on readmissions to the same hospital. Individuals with mental illnesses and substance use disorders are more likely to be readmitted to a different hospital for treatment than patients who are readmitted for physical health conditions.\(^{16}\)
2014 Volume of Inpatient Mental Health Visits by Zip Code, Includes ND

Source: Minnesota Hospital Association Administrative Claims Database and Nielsen Demographics Data, 2014
2014 Volume of Outpatient Mental Health Visits by Zip Code

Source: Minnesota Hospital Association Administrative Claims Database and Nielsen Demographics Data, 2014
Inpatient claims data for 2014 include Minnesota residents receiving inpatient treatment in North Dakota hospitals. Interestingly, claims data for 2013 (the latest year available) for Minnesota residents receiving inpatient treatment in other states do not change inpatient utilization patterns around the state. See Appendix B for the 2013 inpatient utilization map.

ZIP codes with the highest utilization rates of mental health services, both inpatient and outpatient, are scattered throughout the state. Outside of the Twin Cities, ZIP codes in the following regions are in the top 10 percent for utilization of mental health services: 17

- Northwestern Minnesota and along the Canadian border,
- Far western Minnesota,
- West central Minnesota in the Willmar area,
- Central Minnesota around St. Cloud and Little Falls,
- Winona,
- Parts of the Iron Range, and
- Grand Portage.

ZIP codes with the lowest utilization rates of mental health services are clustered mainly in the southeastern part of the state, parts of the southwest and along the Iowa border, with others dispersed throughout the state. 18

When examining claims data by ZIP code and the percentage of the population consisting of people of color within each ZIP code, ZIP codes with the highest mental health utilization rates also had the highest levels of diversity. The average diversity of the top 10 percent ZIP codes is 17 percent compared with 5 percent in the lowest utilizing ZIP codes. 19

Emergency Department Utilization

From 2007-2014, Minnesota’s hospitals saw a 20 percent increase in all emergency department (ED) visits, for all ages. By comparison, over that same time period, hospitals experienced a 49 percent increase in all mental health ED visits, which included substance use, 20 for all ages. ED visits for substance use alone increased by nearly 70 percent. 21
An even more dramatic change is seen in the volume of inpatient admissions from the ED. While overall all-cause admissions from the ED have decreased 17 percent, they have increased 12.5 percent for all mental health-related conditions and nearly 25 percent for substance use.

Source: Minnesota Hospital Association Administrative Claims Data

From 2007-2014, Minnesota’s hospitals saw a 20 percent increase in all emergency department (ED) visits, for all ages. By comparison, over that same time period, hospitals experienced a 49 percent increase in all mental health ED visits, which included substance use, for all ages.
Hospitals in Greater Minnesota experienced a 40 percent increase in all mental health ED visits, while those in the Twin Cities metropolitan area saw a 34 percent increase.

Source: Minnesota Hospital Association Administrative Claims Data

For substance use ED visits, Greater Minnesota hospitals saw utilization nearly double and hospitals in the Twin Cities had a 56 percent increase.

Source: Minnesota Hospital Association Administrative Claims Data
Statewide, all age groups showed increases in all mental health ED visits from 2007-14.

<table>
<thead>
<tr>
<th>Age</th>
<th>Greater MN % increase</th>
<th>Metro % increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-17</td>
<td>56</td>
<td>39</td>
</tr>
<tr>
<td>18-64</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td>65+</td>
<td>24</td>
<td>23</td>
</tr>
</tbody>
</table>

*Source: Minnesota Hospital Association Administrative Claims Data*

**Payer Mix**

The payer mix for inpatient and ED visits is fairly evenly distributed between commercial and public payers. The Medicaid and commercial payer populations were a slightly higher percentage of inpatient admissions than individuals covered through Medicare.

*Source: Minnesota Hospital Association Administrative Claims Data*
Individuals covered through Medicaid represent the largest percentage of all ER visits, 35 percent. Six percent were uninsured.

*Source: Minnesota Hospital Association Administrative Claims Data*
However, a greater percentage of outpatient mental health visits were covered by commercial insurance than by public programs.

*Source: Minnesota Hospital Association Administrative Claims Data*
Uninsured patients were most likely to use the ED for outpatient services and were also more likely to be admitted from the ED than other patients with health coverage. Eighty percent of outpatient mental health visits by people who were uninsured were to the ED. Individuals without insurance were also more likely to use the ED for alcohol and substance use disorder treatment.22

Source: Minnesota Hospital Association Administrative Claims Data

Source: Minnesota Hospital Association Administrative Claims Data
Workforce

The mental health workforce shortage is a national, even international, problem with ramifications in Minnesota. According to the definition used by the Health Resources Services Administration (HRSA), a mental health provider shortage area is one that has 30,000 or more residents per psychiatrist. Currently, there are 4,000 designated mental health professional shortage areas in the United States.

Nine of the Minnesota’s 11 geographic regions have been designated as mental health professional shortage areas by HRSA. The shortage of psychiatrists in Minnesota, especially child and adolescent psychiatrists, is the most acute of all the mental health professions. The Substance Abuse and Mental Health Services Administration (SAMHS) reports Minnesota had only 1.8 child and adolescent psychiatrists per 100,000 people in 2009. The seven-county metro area and the southeast corner of the state are the only two regions not classified as mental health professional shortage areas.

In addition to psychiatrists, Minnesota suffers from a shortage of other mental health professionals, mental health practitioners and direct service workers. The following table illustrates the ongoing need for more mental health professionals:
### Total Projected Openings and Projected Growth Rate, Statewide

<table>
<thead>
<tr>
<th>Current Employment</th>
<th>Total Projected Openings,(e) 2010-2020</th>
<th>Projected Growth Rate, 2010-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists (a)</td>
<td>290</td>
<td>180</td>
</tr>
<tr>
<td>Psychologists (a)</td>
<td>2,420</td>
<td>1,900</td>
</tr>
<tr>
<td>Social Workers, Mental Health and Substance Abuse (b)</td>
<td>2180</td>
<td>1,200</td>
</tr>
<tr>
<td>Social Workers, Child, Family, &amp; School (b)</td>
<td>5,660</td>
<td>2,000</td>
</tr>
<tr>
<td>Social Workers, Healthcare (b)</td>
<td>2,580</td>
<td>1,040</td>
</tr>
<tr>
<td>Social Workers, Other (b)</td>
<td>390</td>
<td>120</td>
</tr>
<tr>
<td>Marriage &amp; Family Therapists (c)</td>
<td>820</td>
<td>640</td>
</tr>
<tr>
<td>Mental Health Counselors (c)</td>
<td>2180</td>
<td>1,130</td>
</tr>
<tr>
<td>Advanced Practice Psychiatric Nurses (d)</td>
<td>303</td>
<td>No data*</td>
</tr>
<tr>
<td>Statewide, All Occupations</td>
<td>1,041,750</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Minnesota Department of Employment and Economic Development (DEED)

(a) Data does not reflect those who are self-employed.
(b) Data is collected according to federal standard occupation codes identifying type of work being done which may not correlate to employer terminology. Data does not distinguish between licensed and un-licensed. Data is reliant on employer nomenclature.
(c) Data does not distinguish between licensed and unlicensed.
(d) Data does not distinguish between licensed and unlicensed.
(e) Includes new and replacement openings.

When accounting for the need for culturally appropriate mental and behavioral health care, these workforce shortages are even starker. Although state demographics show a growth in the diversity of our population, Minnesota’s mental health workforce does not reflect even current levels of diversity.

<table>
<thead>
<tr>
<th>Race and Ethnicity, select professions</th>
<th>Psychiatrist</th>
<th>Social Worker</th>
<th>Marriage/Family Therapist</th>
<th>Psychiatric APRN</th>
<th>Percent diversity in MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensees</td>
<td>670</td>
<td>12,125</td>
<td>1578</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td>Number responding to survey</td>
<td>406</td>
<td>6788</td>
<td>853</td>
<td>187</td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>0.3%</td>
<td>0.0%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Asian</td>
<td>6.0%</td>
<td>1.0%</td>
<td>2.0%</td>
<td>0.0%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Black</td>
<td>2.3%</td>
<td>2.0%</td>
<td>2.2%</td>
<td>0.5%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Other (a)</td>
<td>2.3%</td>
<td>3.0%</td>
<td>3.4%</td>
<td>1.1%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Unknown—did not respond to race question</td>
<td>10.3%</td>
<td>4.0%</td>
<td>5.4%</td>
<td>1.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Hispanic/Latino (b)</td>
<td>3.2%</td>
<td>1.0%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>5.0%</td>
</tr>
<tr>
<td>Unknown—did not respond to ethnicity question</td>
<td>8.1%</td>
<td>5.0%</td>
<td>7.3%</td>
<td>3.7%</td>
<td></td>
</tr>
</tbody>
</table>

(a) Includes Native Hawaiian, multiples races, and "Other"
(b) Ethnicity was a separate question from race on this survey

Source: “Gearing Up for Action: Mental Health Workforce Plan for Minnesota,” p. 16.32
Another challenge facing the mental and behavioral health workforce is the aging of today’s caregivers. Nationally, almost half of all practicing psychiatrists are older than 60 and expect to retire in less than five years.\textsuperscript{33}

A number of efforts have sought to address the mental and behavioral health workforce shortage concerns. Most recently, MHA supported the Minnesota Legislature’s decision to fund several loan forgiveness and residency grant programs that are designed to increase the size of the state’s health care workforce, including mental health professionals who are prescribers (psychiatrists and psychiatric nurse practitioners), as well as psychologists and licensed independent clinical social workers. Over the next four years, $10.6 million will be invested in loan forgiveness, with preference given to applicants who document diverse cultural competencies.

The Legislature appropriated another $6 million over four years to expand primary care residencies, including psychiatry.

An additional $4 million over four years is set aside to assist immigrant international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. A $200,000 grant program designed to encourage state licensure of foreign-trained health care professionals, including mental health professionals, also passed.\textsuperscript{34}

There is also $4 million added to the Medical Education and Research Costs (MERC) program over the next four years.\textsuperscript{35}

Another piece of legislation that MHA successfully advocated for in 2015 is the Minnesota Telemedicine Act. Although the legislation is not limited to mental and behavioral health services, the bill will help ease the mental health workforce strain and expand access to mental health care by better leveraging the available workforce. The legislation will provide coverage and payment parity for services delivered via telemedicine that are also covered when delivered face-to-face. The act also expands the list of providers who are eligible for reimbursement for telemedicine services under Minnesota’s Medicaid and MinnesotaCare programs. Therapy, assessments and other mental health services delivered via telemedicine by mental health professionals will be covered services for non-self-Insured insurance plans.\textsuperscript{36} Telemedicine is particularly helpful for delivering services in underserved rural areas, where the greatest workforce shortages exist.
Gaps Analysis

Development of the Community Mental Health System

More than 50 years ago, the United States began shifting from an institutionalization-based system of care for individuals living with mental illnesses to a community-based system. The Community Mental Health Act, signed by President Kennedy in 1963, created the nation’s system of community mental health centers. The community mental health centers and new psychotropic drugs were a welcome alternative to long-term or even lifetime care in an institution. 37

Following this philosophical shift, the federal Medicaid program excluded coverage for “institutes of mental disease” (IMDs), defined as stand-alone mental health hospitals and residential treatment facilities with more than 16 beds, or hospitals or nursing homes in which a majority of the patients are admitted for mental health treatment. The IMD exclusion applies to adults aged 21-64 covered under Medicaid; there is an exemption for inpatient and residential psychiatric services for children, often referred to as “psych under 21,” that includes coverage of Psychiatric Residential Treatment Facilities (PRTFs). 38 Consequently, federal Medicaid funds will pay for a portion of the beneficiary’s treatment and services, but not room and board costs for care in settings such as foster care (group homes), crisis residential services, Intensive Residential Treatment Services (IRTS), substance use residential treatment or assisted living. As a result, states must cover these services in their Medicaid programs with state and local funding, as well as through their housing assistance programs.

Medicare, on the other hand, covers IMD stays, but imposes a lifetime limit on coverage for all inpatient mental health treatment. Medicare Part B covers screenings; medication management; outpatient services, like psychotherapy; 39 and some partial hospitalizations, but does not cover many mental health or substance use community-based services. 40

Community mental health and substance use disorder services are paid for by the Community Mental Health Services Block Grant, which is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services. 41

In Minnesota, these funds are combined with the Substance Abuse Block Grant and channeled from the Minnesota Department of Human Services (DHS) to local entities called Adult Mental Health Initiatives and Children’s Mental Health Regions. These local entities are authorized to determine which services are needed in that particular initiative or region of the state. 42 State Medicaid funds are also directed to these entities
to deliver community-based services. Finally, counties are under Maintenance of Effort requirements to provide and fund services.\textsuperscript{43}

In the late 1990s-early 2000s, Minnesota closed all of the state’s regional treatment centers except the Anoka Metro Regional Treatment Center (AMRTC) in order to secure additional available federal funds to support needed services for Medicaid enrollees and shift away from institutionalization as Minnesota’s previous default service for individuals under nonforensic state care. Instead, ten 16-bed community behavioral health hospitals (CBHHs) built and operated by the state and a plan for more robust community-based services were intended to fulfill the role previously played by the RTCs.

Today, only seven of the 10 CBHHs remain open in that capacity, and those that continue to operate are not staffed to reach their full occupancy capacity. CBHHs are unable to accept or care for patients with very aggressive or violent behavior.

Another service model in Minnesota is the Child and Adolescent Behavioral Health Services (CABHS) hospital in Willmar, which serves as the state’s inpatient treatment option for children and adolescents with the most complex and challenging needs. Because of its limited capacity, it takes a very low number of patients.

In addition, with respect to substance abuse treatment, a recent change in direction from the state has been to downsize most of its dual-diagnosis substance use treatment programs in order to secure more federal Medicaid funds.

Altogether, the closure of so many state-operated inpatient hospital beds with insufficient replacement services or options for care has put additional pressure on community hospitals and community-based services to meet the demand for care and treatment from individuals needing acute and intensive treatment.

Another driver of the shift to addressing more and more mental and behavioral health needs through community-based mental health services is Minnesota’s unique hospital construction moratorium statute. In order to add licenses for inpatient beds of any kind to the state system, hospitals must undergo a public interest review process conducted by the Minnesota Department of Health and receive legislative approval for an exception to the moratorium.

Currently, two more general and permanent exemptions to the moratorium law exist. First, there is a permanent exemption for critical access hospitals to add up to 10 inpatient psychiatric beds above their 25 general inpatient bed limit, as allowed under federal law, if they reduced their bed capacity after the federal Balanced Budget Act of
1997. Second, Mayo Clinic has a permanent exemption to add beds in Olmsted County.44

Current Gaps

In 2014, DHS conducted a statewide analysis of mental health services gaps around the state. The results confirmed what many people knew anecdotally: Minnesota’s community mental health infrastructure for adults and children is not meeting the demand.45 The following charts from the report indicate that a majority of adult and children’s mental health services are only limitedly available in most of the state (indicated by yellow triangles).

Source: “Minnesota’s Mental Health System Gaps,” p.2
Many areas of the state do not have access to important services such as crisis residential or ACT teams for adults or children (indicated by red hexagons). Children’s inpatient hospitalization capacity is also scarce throughout the state, with limited availability even in the Twin Cities (Region 11).

Overall, there are very few areas in the state in which services are sufficient to meet demand (green circles). In order to address these gaps, the Minnesota Legislature passed a comprehensive package of funding and services in 2015 (see next section).

The following maps show hospitals with inpatient mental health services by Adult Mental Health Initiative and Children’s Mental Health Region.
Hospitals with Children and Adolescent Inpatient Services
by Children’s Mental Health Region

Children’s Mental Health Initiatives

[Map of Minnesota showing regions and hospitals]
There is a large gap in services for individuals with mental illness and/or substance use disorders who also have violent and aggressive symptoms, as well as for complex patients who have additional medical conditions. The gap is found across the continuum of services, with limited inpatient beds in community hospitals, a lack of access to state-operated facilities and few community providers willing or able to accept clients with these symptoms.

AMRTC is the only nonforensic state hospital able to accept adult patients with this level of acuity. Its capacity, however, is further restricted due to ramifications from the 48-hour rule (see further discussion below) that have made a difficult situation worse by further limiting access to AMRTC for patients other than those being transferred from a jail. CBHHs are unable to accept individuals with violent and aggressive behavior. Children and adolescents have one state-operated option, CABHS in Willmar, which admits very few patients. Community mental health providers, like IRTS or group homes, are often unwilling to accept clients with histories of violent and aggressive behavior.

Therefore, by default, community hospitals are left to treat individuals with these symptoms unless they are arrested and incarcerated. Consequently, hospitals have reported instances of closing beds to additional admissions because of security concerns stemming from one patient on the unit. This means that other individuals cannot be served and staff may be at higher risk of injury.

Most often, the community hospital fulfills this default role through services provided in its ED. If a patient is unable to be stabilized, discharged or transferred, s/he may be admitted to an inpatient bed to free up capacity in the ED pending such a transfer. However, many mental health patients spend an inordinate amount of time in hospitals’ EDs waiting to receive care and to be transferred.

In a high-profile case last year, the Washington State Supreme Court ruled that the state’s Medicaid program did not authorize “psychiatric boarding” or recognize it as appropriate treatment for Medicaid enrollees. As a result, the court’s ruling essentially says that ED boarding of mental health patients enrolled in Medicaid deprives them of the covered benefits of the Medicaid program and violates their civil rights. The state’s argument that ED boarding is necessary to avoid overcrowding in certified evaluation and treatment facilities was rejected by the court.
Although the Washington State Supreme Court’s decision does not govern Minnesota’s Medicaid program or define the rights of its enrollees, the case demonstrates that there are limits to the level of fragmentation, delays and suboptimal outcomes that can exist before courts will step in to protect individuals’ rights under state public programs.

Services for Older Adults

There are growing concerns regarding the lack of appropriate mental and behavioral health services available for older adults. Individuals with mental illnesses and substance use disorders are aging along with the rest of our population and they require community-based and acute care specific to their needs. There are also increases in the populations of older adults living with dementia and experiencing delirium, both of which require specialized care. Some older adults live with a co-occurring mental illness and dementia. In addition, depression and anxiety can often manifest in older adults.

As with other mental and behavioral health crises, community hospitals are often viewed as the best place for older adults in a crisis. Although an alternative to an ED visit or inpatient stay may be more appropriate, too often that alternative is unlikely to exist or be readily available in many communities. Hospitals, therefore, report experiencing difficulties finding appropriate care for older adults who are well enough to be discharged, particularly when an assisted living facility or nursing home is unable to provide the level of care needed.

Furthermore, because of their increased vulnerability and unique needs, it is difficult for hospitals with inpatient psychiatric units to meet the needs of both older adult patients and the rest of the patient population. Often, this results in hospitals being unable to accept other patients because of the care being received by an older adult already admitted to the unit – or, vice versa, being unable to admit an older patient because of the level of risk posed by younger or more aggressive patients currently being served.

Other Community Stakeholders

Individuals with mental illness and/or substance use disorders also enter services through other community doors. Law enforcement, county social services, education and tribal entities are the other most common entry points for people in need of mental health services. Each entry point offers challenges and opportunities for improving services for these residents.

Law Enforcement

Law enforcement is often contacted to intervene when someone is having a mental health crisis. Interventions used vary by location and often by the officer responding.
Although many law enforcement officers have received crisis intervention training, many have not or do not have access to continuing education. In addition, many law enforcement officers are unfamiliar or uncomfortable with contacting crisis teams to intervene initially.

As a result, individuals may be arrested, taken to jail or brought to the nearest emergency room for stabilization. Officers may wait hours with an individual in the ED or spend even more time transporting someone hundreds of miles away to a hospital with an available inpatient mental health bed. This takes limited resources away from community safety. In totality, it also increases costs for law enforcement and the hospital that might be responsible for paying the transportation costs.

Hospitals have reported law enforcement dropping people off at the ED, regardless of the level of care needed by the individual or the level of care the particular hospital can provide safely. Law enforcement may not understand why someone brought to the hospital does not meet the criteria for admission and, therefore, is released.

For most individuals who are arrested and incarcerated, robust mental health treatment is not provided while they are in custody and it can be difficult for those individuals to access psychotropic medications. This lack of treatment being provided in jail is one reason county sheriffs brought forth legislation in 2013 to require the state to admit to a state facility any individual who is incarcerated and under commitment within 48 hours of the commitment. The so-called “48-hour rule” means that individuals waiting to be transferred from a community hospital or simply within the community are pushed further down the list each time someone from jail is admitted, even though those waiting to be admitted might have deeply acute conditions.

Due to a lack of capacity and the increasing level of violent behavior demonstrated by patients, in the spring of 2015 DHS notified law enforcement that it would stop admitting individuals from jail to AMRTC for a period of time due to low staffing, a lack of beds and the acuity of the individuals currently at AMRTC. Community hospitals have seen their lengths of stay increase for patients waiting for care at AMRTC, which has further decreased the availability of community hospital inpatient beds.

**County Social Services**

County social services are another stakeholder group deeply involved in delivering services and supports for individuals living with mental illness and/or substance use disorders. Anecdotal evidence suggests growing frustration from multiple parties with what is perceived as a lack of clear roles and responsibilities around treatment for individuals with mental illnesses and substance use disorders; a lack of transparency about the availability of services; and the variability and inconsistency of services and responses between counties. These frustrations are particularly evident during the
hospital discharge process, when it can be difficult to find available, appropriate services, such as children’s residential treatment, IRTS or supportive housing, for someone about to leave the hospital.

Recent legislation may ease some of these frustrations. Counties, health care providers and mental health providers may now share welfare data to assist with service coordination for individuals receiving public services. Welfare data do not include medical data that are protected under the state’s Health Records Act. The purpose of this new authority is to give providers and counties the opportunity to share relevant information to better coordinate services. For example, this information would help someone get stable housing when being discharged from a hospital, or allow the county to inform a hospital when one of its patients has had a commitment order started before the hospital discharges the person.

Child welfare within county social services will also be involved in some cases, particularly if a child or adolescent requires out-of-home placement. This can add another complicating layer to finding appropriate services for children, particularly upon hospital discharge.

Education

The K-12 education system is a key entry point for children and adolescents, particularly for students receiving services through an Individualized Education Plan (IEP). Recognizing the need for more mental health services in schools, Minnesota established school-linked mental health grants to allow schools to host a mental health professional on-site. DHS found this program has been the first point of contact for services for children with serious emotional disturbance, as well as for students of color.

At the national level, Minnesota’s U.S. Senator Al Franken has called for more counselors in schools. Franken cites the low ratio of school counselors to students in Minnesota – one for 792 students, one of the lowest in the nation – as evidence more support is needed.

Likewise, higher education institutions provide counseling and other services that often act as the initial point of entry for an individual with more serious or acute mental or behavioral health conditions. For example, colleges and universities are often called upon to address initial signs or symptoms of schizophrenia, which often does not present in men until early adulthood.
Tribes

Members of American Indian tribes may receive services through federal Indian Health Services or tribal facilities operating under the Indian Self-Determination and Education Assistance Act. Like counties, there is variability in the services and responsiveness of different tribes. There is often a lack of coordination between hospitals and community health providers serving American Indians and their respective tribes. In addition, a lack of culturally competent providers and services for American Indians contributes to lower levels of treatment across the state.

Summary of 2015 Legislation: The Year of Mental Health

The 2015 legislation session resulted in a historic public investment in Minnesota’s mental health infrastructure. A summary of the key mental and behavioral health outcomes from the session is included in Appendix C.

The Legislature allocated more than $50 million of additional resources for the 2016-17 biennium. In particular, this funding is directed toward increasing capacity in the community, with some funding for state-operated programs. The package reflects a policy of moving more services to private providers, while increasing staffing at AMRTC in order to return capacity to 110 beds from the approximately 90 recently in use.

The legislative package implements behavioral health homes, which integrate primary health and mental and behavioral health care services; expands and improves crisis services for children and adults; implements PRTFs for children and adolescents, to be run by private providers; allows for 20 new extended-stay beds for children and adolescents to be created by a private community provider; covers protected non-law enforcement and non-ambulance transportation services under Medicaid; expands and improves ACT teams; increases provider rates for community providers; and many other items that are intended to strengthen Minnesota’s mental health infrastructure.\(^5\)

Legislation also downsizes state services for substance use services provided through the Community Addiction Recovery Enterprise (CARE) program and increases payments to private community providers to treat individuals under commitment with complex needs, for a total appropriation of $15 million. The legislation calls for moving Minnesota to a medical-based detoxification service, called withdrawal management, the costs of which will be eligible for matching federal Medicaid dollars, although no state funding was attached to the proposal.\(^6\)
The Legislature also invested $2 million for inpatient mental health hospital rates that otherwise would have been cut as a result of a new budget-neutral Medicaid rebasing formula. In addition, the new disproportionate share formula prioritizes hospitals that contract with DHS to provide extended-stay inpatient mental health treatment.\(^\text{57}\)

Minnesota’s hospitals and health systems will greatly benefit from this legislative package – and not just from the additional funding for inpatient psychiatric beds. Investing in community services will mean more individuals will receive services before their condition deteriorates enough that they need an acute level of care.

More services will be available to intervene before an ED visit. According to DHS, 85 percent of adults who received crisis services for a particular crisis in fiscal year (FY) 2013 did not need hospitalization. Eighty-nine percent of children who received crisis service interventions during the state’s FY 2013 did not need hospitalization for that crisis, according to DHS.\(^\text{58}\)

More options will also be available to patients when they are discharged from a hospital, particularly for individuals needing supportive housing services.

These investments in community mental health services will take time before they can be fully implemented.

**Federal Activity**

As in Minnesota, there has been no shortage of mental and behavioral health proposals at the federal level.

**Legislation**

**Comprehensive Justice and Mental Health Act**

Sen. Al Franken has advanced legislation focused on the intersection of criminal justice and mental health. He introduced the Comprehensive Justice and Mental Health Act (S. 993),\(^\text{59}\) which would reauthorize the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) and expand it to include more investments and training in evidence-based practices. Co-sponsored by Sen. Amy Klobuchar, S. 993 would expand grant programs to states and local authorities to include: veterans’ treatment court and other services; efforts to improve conditions in correctional facilities; crisis intervention services for jail and hospital diversion; education to improve law enforcement responses to people with mental illnesses; sequential intercept mapping, which would help identify
individuals with mental illness at each point in the criminal justice system in order to intervene and redirect them to more appropriate mental health services; and mental health courts.

The legislation also would require mental health crisis intervention training for federal first responders and federal criminal justice agencies.

Helping Families in Mental Health Crisis Act

The most comprehensive mental health legislation in many years, the Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646), was introduced by Rep. Tim Murphy of Pennsylvania and is co-sponsored by Minnesota representatives Rick Nolan, Erik Paulsen, Collin Peterson and Tim Walz. The changes directed by the legislation would seek to reduce rates of suicide and suicide attempts, substance abuse, overdoses, emergency hospitalizations, ED boarding, incarceration, crime, arrests, victimization, homelessness and joblessness among individuals living with serious mental illness and substance use disorders.

The legislation would make a number of changes to the oversight structure for mental and behavioral health services. Most notably, these would include eliminating the authority of the SAMHSA for most programs and creating a new assistant secretary for mental health and substance abuse to oversee mental health and substance use programs, as well as restructuring grant programs that fund a number of community-based services.

The proposal also contains a number of changes to mental health coverage provided through Medicaid and Medicare. In particular, it would provide Medicaid coverage for IMD stays of up to 30 days for adults under age 65 and eliminate the 190-day lifetime limit on inpatient psychiatric hospital coverage under Medicare. New Medicare hospital discharge requirements would apply when patients leave inpatient psychiatric treatment.

Another provision would change federal privacy laws regarding caregiver access to medical and education records and allow sharing of substance use disorder information within a patient’s accountable care organization.

The legislation proposes to expand alternative outpatient treatment (community civil commitment) grants and target other grants toward crisis services and crisis intervention by law enforcement and first responders.

A number of these provisions are controversial among advocates for individual rights, particularly the civil commitment and privacy changes. However, the legislation has garnered broad support from organizations like National Alliance for Mental Illness (NAMI), the national mental health professional associations and law enforcement.
Although the American Hospital Association has not yet taken a formal position with respect to the bill as a whole, many of its individual provisions represent changes that hospitals and health systems have sought from Congress.

Mental Health Access Improvement Act of 2015

MHA’s Mental and Behavioral Health Task Force has sought changes in Medicare policy to recognize licensed marriage and family therapists and licensed counselors as eligible providers of mental health services for Medicare enrollees. A bill recently introduced in the U.S. House, the Mental Health Access Improvement Act of 2015 (H.R. 2759), would address this concern, thereby expanding the number of mental health providers that already exist in Minnesota communities for Medicare enrollees.

Regulation

Proposed Medicaid Managed Care Organization Rule/15-Day Allowance for IMD Treatment

As noted above, the federal Medicaid program will not authorize matching fund expenditures for inpatient mental health treatment provided in stand-alone hospitals with more than 16 beds or many residential treatment options. However, the Centers for Medicare and Medicaid Services (CMS) recently issued a proposed rule containing provisions that would relax this barrier and allow coverage for up to 15 days per calendar month for inpatient mental health treatment in stand-alone settings. In Minnesota, this regulatory change would mean that up to 15 days of care delivered to a Medicaid enrollee in a single calendar month at AMRTC would be eligible for federal matching funds, as well as detox and substance use treatment provided in residential settings. Depending on when a patient is admitted, the proposed rule would appear to allow up to 30 days of care, so long as the care equally spanned two calendar months. Although MHA has long sought to eliminate the IMD exclusion altogether, the association expressed strong support for this provision of the proposed rule.

Beyond the outcome of this rule-making process, several states have federal waivers that allow their Medicaid managed care organizations to cover inpatient psychiatric stays without imposing a 16-bed limit on the facility or a 15-day stay limit.

Behavioral Health Homes

Behavioral health homes (BHHs) are Minnesota’s version of the health homes demonstration project, authorized by the Affordable Care Act and overseen by CMS. Health homes are a service package under Medicaid that must include the following
components: comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and improved exchange of health information.

One of MHA’s top priorities in mental and behavioral health policy has been advancing integration of physical and behavioral health. To that end, MHA’s Mental and Behavioral Task Force identified Minnesota’s adoption of BHHs as a goal early in the task force’s existence. MHA advocated for BHH funding and enabling legislation during the 2015 legislative session. The outcome: BHH received more than $5 million in state funding for FY 2017 and over $28 million for the 2018-19 biennium.

The BHH model relies on a team-based approach to deliver services and requires specific roles be included in the team. One provider will be designated for BHH certification and can contract with other providers to ensure the required roles are fulfilled.

Minnesota chose adults with serious mental illness, adults with a serious and persistent mental illness, and children and youth experiencing a severe emotional disturbance as the eligible populations for BHH.

While CMS must still approve Minnesota’s State Plan Amendment for BHH, there are already a number of providers participating in the demonstration project. Known as First Implementers, these 37 providers – including six MHA members – created coordinated care service packages that integrate behavioral and physical health care services, along with social supports and services, and are sharing best practices under this model. Pending approval of Minnesota’s State Plan Amendment, initial BHH certification will begin in January 2016.

Excellence in Mental Health Act

Another opportunity for integrated care that requires partnerships between community mental health centers and hospitals is the Excellence in Mental Health Act. This federal demonstration creates a new payment and delivery model for community mental health clinics.

Community mental health clinics can become Certified Community Behavioral Health Clinics (CCBHCs), which is “a new designation for community-based behavioral health organizations that will deliver intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention and wellness services. This includes 24/7 crisis response and peer support services.” CCBHCs must have partnerships with hospitals that include “care coordination expectations with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient
facilities and ambulatory detoxification centers” to ensure these needs are met for CCBHC clients. CCBHCs are also required to “maintain a working relationship with local EDs” and establish protocols for CCBHC staff to address the needs of their clients who come to those EDs.

Minnesota has received a planning grant for this demonstration.

Other Models

Every state and community around the country is facing the challenge of providing appropriate, accessible treatment and services to individuals living with mental illness and/or substance use disorders. Below is a small sampling of models from other states, as well as here in Minnesota.

Pick an Existing Model or Program

In researching potential models or care delivery reforms to highlight, it became apparent that hundreds of innovations and pilot projects are underway throughout the country. Specifically with respect to mental and behavioral health, SAMHSA’s National Registry of Evidence-based Programs and Practices contains 355 examples of individual, evidence-based programs aimed at addressing one or more challenges. While some of these are community-specific, all of them contain evidence for evaluation and offer examples of potential initiatives for Minnesota’s hospitals and health systems to explore based on the needs of their local communities. This library of resources can be searched by topic, program name, care setting where the intervention occurs, geographic area of the program and more.

The SAMHSA website also features an online course and road map to guide individuals and organizations through the implementation process, from selecting a program to modifying it for the unique needs or circumstances in the particular community to measuring its impacts and results.

The Alameda Model: Psychiatric Emergency Department

Alameda Health System (AHS) in Oakland, California, is a public hospital system that created a dedicated psychiatric ED at its John George Psychiatric Hospital. By 2013, this ED provided care for 99 percent of all psychiatric emergencies in Alameda County. In 2014, the California chapter of the National Alliance on Mental Illness (NAMI) honored the hospital with its Outstanding Treatment Provider and its Zero Tolerance for Seclusion and Restraints awards.
More than 100 dedicated psychiatric emergency rooms now exist throughout the country. These programs serve to evaluate and care for all the acute mental health crises for a given region, accepting patients via ambulance or police delivery, transfer from medical hospitals or self-presentations. As a result, these dedicated services benefit patients by caring for them in a setting specifically designed for mental health care, with providers experienced and trained in mental health care, and under evidence-based protocols to avoid unnecessary commitments or inpatient hospitalizations. These specialized emergency rooms also benefit other hospitals and emergency rooms that are able to free up their capacity that is too often taxed by boarding mental health patients awaiting treatment or transfers to other settings.

Dedicated psychiatric EDs generally treat and observe patients for up to 24 hours, which is often sufficient to resolve crisis symptoms and avoid involuntary commitments or hospitalizations. A study of AHS’ program at John George Psychiatric Hospital showed that it reduced ED boarding across 11 hospitals in its region by more than 80 percent compared to statewide averages and avoided inpatient admission for more than 75 percent of patients already placed on involuntary psychiatric holds.

Alameda’s model is built on a regional basis in which John George Hospital accepts transfers from any other hospital in the region, takes patients brought in via ambulance or law enforcement and accepts walk-in patients. The hospital works closely with local law enforcement and EMS services to train them in de-escalation techniques, as well as how to identify the signs of mental health crisis. As a result, when law enforcement arrives at a scene at which an individual is in a mental health crisis, an ambulance is called and the individual is treated as a medical patient rather than being handcuffed or put in a squad car.

Another key element of the Alameda model is the utilization of an existing crisis stabilization billing code recognized and covered by California’s Medicaid and state employee insurance programs. This emergency stabilization code provides for a four-hour bundled service payment and the Medicaid program will reimburse an ED for up to five such bundles in a 24-hour period. Other states, including Oregon, have adopted the billing code as well.

Some hospitals in Minnesota have created separate behavioral health EDs or areas in their existing facilities to offer an environment more appropriate for people having a mental health or substance use disorder crisis. Unlike the Alameda model, they are not stand-alone facilities. Hennepin County Medical Center’s Acute Psychiatric Services, Fairview University of Minnesota Medical Center’s behavioral emergency service and Regions Hospital’s Gamma Pod, or Pod G, are some examples of these models in Minnesota.
Mental and Behavioral Health Integration beyond Primary Care

While many health care delivery systems across the country, including here in Minnesota, focus on integrating mental and behavioral health services with primary care services, Atlantic Health System in New Jersey is taking this concept to another level. Atlantic is working on incorporating mental and behavioral health services and providers in many other departments in its hospitals and outpatient clinics.

So far, the system has moved to integrate psychologists in its diabetes, pain management, oncology, cardiology and bariatrics departments. In addition to addressing mental health conditions or anxiety that play important roles in achieving the best outcomes possible for these patients, these efforts also decrease the stigma of discussing mental health concerns in the context of physical health care. Early data show that these efforts also increase patients’ adherence to their care plans.74

Criminal Justice System

Law enforcement is often the first to respond to someone in a mental health crisis. Some criminal justice systems have developed new ways to intervene in a mental health crisis.

One model that recently received attention from the Minnesota Legislature is a mental health “hub” in Orange County, Florida.75 The Orange County Central Receiving Center was developed to offer a diversion from jail to individuals in mental health crisis who are at risk of arrest or are under arrest. It is funded by the county, state and a local hospital.

Law enforcement officers can bring individuals to the receiving center to be assessed for treatment and offered services.76 While individuals can also access services without law enforcement involvement, the Central Receiving Center is primarily used by law enforcement. In 2015, the Minnesota Legislature authorized a grant to Beltrami County to develop a comprehensive mental health program modeled after the Central Receiving Center approach.

In the meantime, some Minnesota communities have developed partnerships with law enforcement that benefit hospitals, law enforcement and the person in crisis. One example is the regional crisis center in Mankato. Although operated as a crisis center for all individuals needing assistance, law enforcement can bring people in and have a mental health assessment for needed treatment completed within five minutes.

Not only does this save time for the officer, but it has diverted people from jail and the hospital ED, while ensuring that those who are in crisis get the right care. An estimated
500 people received services through the crisis center who would otherwise have gone to the hospital ED.\(^{77}\)

Another approach to reduce the number of people with mental illness taken to jails instead of more appropriate care settings is a “mental health evaluation unit” within a police department.\(^{78}\) The Los Angeles Police Department uses this kind of unit to provide a resource for officers who encounter situations that might involve a mental health, rather than criminal, issue. The unit is staffed by specially trained officers and social workers who talk through and triage the situation with the officer on the scene to help determine whether the individual needs mental health care or, instead, should be arrested and brought to the jail.

Last year, the mental health evaluation unit fielded 14,000 calls from its officers on the street. In 4,700 of those calls, members of the mental health evaluation unit conducted in-person visits either in immediate response to the event that led to the call or within 48 hours to provide follow-up services or evaluations.

Less than 9 percent of the calls received by the mental health evaluation unit resulted in the arrest of the individual, thereby significantly reducing the overall costs to the police department, local jail and court system.

Offering treatment in jail is another model; Cook County, Illinois, is an example. The jail now has a mental health dormitory and offers treatment for mental illnesses and substance use disorders. Upon discharge, individuals may enter residential treatment programs and continue receiving additional services, including housing. This program can save about $50,000 per person. According to the Cook County sheriff, it costs nearly $70,000 a year to jail someone for “crimes of survival” (theft of basic necessities or trespassing in an attempt to find shelter), whereas it costs $10,243 to provide community-based treatment and an additional $9,200 for housing.\(^{79}\)

**Violence and Aggression**

Behavioral Emergency Response Teams (BERTs) are a national model used by some Minnesota hospitals, including CentraCare’s St. Cloud Hospital and the Mayo Clinic Rochester Hospital, St. Marys Campus. BERTs consist of nurses, social workers and other staff with expertise in behavioral health and violence de-escalation. They are available to provide interventions with patients with mental illness in any unit of the hospital, including the ED. Some BERTs also conduct regular rounds of the hospital to increase their accessibility and ability to intervene quickly to de-escalate a situation. BERTs are designed to provide a safer environment for staff, patients and visitors.\(^{80}\)
Community Initiatives

Intensive community outreach to individuals with complex needs is another model for addressing mental health and substance abuse. Accessing safe, stable housing is a major barrier for individuals who experience homelessness and mental illnesses and/or substance use disorders. A lack of safe, stable housing also contributes to increased physical and mental illness.

New York City has undertaken a $45 million citywide initiative to address homelessness. A portion of these resources, $9.5 million, is targeted to help individuals who are unsheltered and often have mental illness and substance use disorders.

The initiative is an intensive outreach program to meet people who are unsheltered and fund 667 beds in “safe havens,” expanded drop-in centers and additional beds in nontraditional shelter settings. Safe havens are transitional housing centers with social services, showers, meals and counseling for individuals who are not sleeping in shelters. They provide a stable housing environment for people as they transition to more permanent housing.

An additional 300 beds have been opened in churches and other community centers to serve as alternatives to traditional shelters. The city hired additional outreach workers to locate individuals in subways and connect them with beds in shelters, safe havens or other settings.81

Community Hospitals and Community Behavioral Health Hospitals

Minnesota currently has seven operating CBHHs; an additional facility in Cold Spring closed. Those remaining open are licensed for 16 beds; however, due to lack of staff, they are capping admissions at 8-12 patients per setting.

One possible solution is for nearby community hospitals to take a more active role in the operation of the CBHHs, either by managing them on behalf of the state or by assuming full ownership and management of the facilities. Another option would be for community hospitals to partner with community mental health centers to operate CBHHs. Either approach would provide an intensive service to the community and for people discharging from inpatient treatment.

School-based Clinics

Recognizing the importance of both early intervention in physical and mental health needs and the challenges families face getting their children to caregivers, Park Nicollet is partnering with school districts to embed a free health clinic on schools’ campuses.
The proposed clinic to be located at Richfield High School, for example, will be free for children from birth through high school graduation, regardless of the students’ insurance status or carrier. In addition to sports physicals and treatment for minor physical conditions, the clinic will feature access to mental health care.

By making mental health care services and screenings free and easily accessible to students and their families, the clinics are able to identify and intervene in mental health issues earlier and more effectively. In addition, because the clinic offers both physical and mental health services, seeking care from its professionals has less stigma for students than waiting for an appointment outside the traditional school counselor’s office.

Park Nicollet has three school-based clinics so far and, if approved by the school board, the clinic in Richfield will open in 2016.

**In-reach**

Owatonna Hospital partnered with South Central Human Relations Center, the local community mental health center; Steele County Human Services; and South Country Health Alliance, the region’s Prepaid Medical Assistance Plan providing managed care to enrollees in the state’s Medicaid program, to develop and pilot an emergency department in-reach service. The in-reach “program is designed to coordinate multiple service providers to improve health care outcomes of patients who frequent the Allina Health Owatonna Hospital Emergency Department. The program employs one full-time social worker.”

In this model, the social worker works directly with the individual in the community as well as in the hospital. A functional assessment is conducted to look at all aspects of an individual’s life and why s/he might be frequenting the ED.

From July 2009 through December 2013, patients who were one year removed from the intervention achieved a 48 percent decrease in ED visits and a 51 percent decrease in admissions, with a total decrease in charges of nearly $4 million. There were similar results for patients two, three and four years out from the intervention.82

In-reach is now a covered benefit in Minnesota’s Medicaid program.
Detox and Withdrawal Management

County-based detoxification services are dwindling across Minnesota, which has resulted in hospitals and their EDs serving as the defaults for detox services and has sometimes forced individuals to be transferred long distances for care. Legislation passed in 2015 creates a medical-based, Medicaid-funded model called withdrawal management that includes coverage for transportation costs.

Withdrawal management is a national model. Once this service is funded and approved by CMS, hospitals and certain residential treatment programs will be eligible for reimbursement for delivering this service.

Certified Peer Specialists

Certified peer specialists are individuals living with mental illnesses and in recovery who are trained to provide support and recovery services to other people living with a serious and persistent mental illness. In Minnesota, certified peer specialist services are covered under Medicaid as a rehabilitative service for adults. “Certified Peer Specialists provide non-clinical, person-centered recovery-focused support while helping to ensure the treatment plan reflects the needs and preferences of the person being served to achieve their measurable and individualized goals. The level of services provided must be determined on an individual basis taking into account the intensity of the situation for the person receiving services, the experience of the Certified Peer Specialist and the acuity of the beneficiary’s condition.” Certified peer specialists may work in a community mental health center, hospital or other health care setting, as well as through help lines or other environments providing rehabilitative services.

A similar service for children with emotional disturbance or severe emotional disturbance and their families, family peer specialists, is also a covered benefit in Minnesota but is in the process of being implemented.

Using Consultation Services to Address Mental Health Provider Shortages

There are a number of examples of Minnesota-based consultation services available to hospitals and other providers.

Behavioral Health Providers, for example, provides teleassessments, therapy and appointment scheduling for mental health and substance use treatment services. A number of Minnesota hospitals and health systems, including rural hospitals, use the service in their emergency departments.
PrairieCare operates the Psychiatric Assistance Line, [www.mnpsychconsult.com](http://www.mnpsychconsult.com), which provides free child and adolescent psychiatric consultations to primary care providers. This program is funded by a DHS grant.

Fast-Tracker, [www.fast-trackermn.org](http://www.fast-trackermn.org), is a free, searchable resource for nonhospital mental health and substance use treatment services. It includes services for adults and children. The resource is available to providers, as well as individual patients and their families. Fast-Tracker is operated by the Minnesota Mental Health Community Foundation.

In addition to these Minnesota models, a new state program in South Carolina provides psychiatric consults to EDs via telemedicine 16 hours a day, seven days a week. The program has reduced per patient costs by approximately $1,400 and resulted in state savings of more than $28 million.88

**Trauma System or “Air Traffic Control” Model for Mental Health**

Interest is growing in creating a streamlined system for delivering acute care for patients with the most acute mental health needs. Two possible approaches are one based on Minnesota’s trauma system and one based on a centralized system for locating and directing patients to hospitals, much like an air traffic controller.

Both models call for hospitals to be designated to deliver certain levels of care, much like a trauma level, and then be available to accept patients requiring that level of care. This kind of system would add predictability and accountability into acute care for mental health by ensuring patients are sent to the most appropriate level of treatment. Hospitals will have greater certainty of the types of patients they will receive and law enforcement will have clear guidance on where to take patients in an acute crisis if hospital treatment is needed.

**Conclusion**

Minnesota has one of the most comprehensive, community-based mental health systems in the country. However, the capacity of and access to our services present the greatest challenges to meeting the needs of our residents, improving the outcomes of care provided and increasing the patient flow or efficiency of the system as a whole.

Clearly, there are opportunities for improvement as MHA members, state and local governments, advocates, community-based providers, social service providers and other stakeholders continue to strive to create a more collaborative, efficient and evidence-based mental and behavioral health delivery system.
Appendix A: Glossary of Common Mental and Behavioral Health Services and Terms in Minnesota

A

- **Adult Foster Care**
  Licensed, sheltered living arrangement for up to four functionally impaired adults in a family-like environment. Adult foster care is available to persons age 18 years or older. Adult foster homes provide food, lodging, protection, supervision and household services. They may also provide living skills assistance or training, medication assistance and assistance safeguarding cash resources.

- **Adult Rehabilitative Mental Health Services (ARMHS)**
  Also known as the MA Rehab Option and Adult Mental Health Crisis Response Services, ARMHS are Medical Assistance (MA) State Plan Mental Health Services.

- **Advanced Psychiatric Directive**
  A written tool used to make mental health care decisions when an individual is unable to do so because of incapacity.

- **Assertive Community Treatment (ACT) Team**
  An intensive, non-residential rehabilitative mental health service that is an identified evidence-based practice. ACT services are provided by multidisciplinary staff using a team approach and are directed to adults with a serious mental illness who require intensive services.

- **Assessment (Adult)**
  Process of identifying: a) a person’s strengths, preferences, functional skills and need for support and services; b) the extent to which natural supports are able to meet the person's need for support and services; and c) the extent to which human services agencies and providers are able to provide or develop needed support or services.

- **Assessment (Child and Family)**
  A professional review of child and family needs that is done when services are first sought from a caregiver. The assessment of the child includes a review of physical and mental health, intelligence, school performance, family situation and behavior in the community. The assessment identifies the strengths of the child and family. Together, the professional caregiver and family decide what kind of treatment and supports, if any, are needed.
• **Behavioral Health Home**
  Minnesota’s version of the federal “health home” benefit for Medical Assistance (MA) enrollees. Adults with serious mental illnesses (SMI) or serious and persistent mental illnesses (SPMI) and children with serious emotional disturbance (SED) diagnoses will be eligible. In a behavioral health home, providers will address MA enrollees’ comprehensive physical and behavioral health needs in a coordinated manner. Services include: comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and improved exchange of health information.

• **Brain Injury (BI) Waiver**
  Funding stream for home and community-based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of an eligible person and who would otherwise require the level of care provided in a specialized or neurobehavioral hospital.

• **Care Coordination**
  Brokering services for an individual to ensure that his/her needs are met and his/her services are not duplicated by the organizations involved in providing care.

• **Case Management**
  A service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social, educational, health, vocational, transportation, advocacy, respite care and recreational services, as needed. The case manager makes sure that the changing needs are met.

• **Case Manager**
  An individual who organizes and coordinates services and supports for adult individuals and/or children with mental health problems and their families. (Alternate terms: service coordinator, advocate and facilitator)

• **Civil Commitment**
  Involuntary treatment for people with mental illnesses meeting certain criteria. Minnesota offers inpatient and outpatient options for civil commitment. Inpatient treatment is available for individuals meeting the following criteria:
  • be a clear danger to others, or
likely to be in danger to self/others as demonstrated by failure to obtain necessary food, clothing, shelter or medical care as a result of impairment; or probability of suffering substantial harm, significant psychiatric deterioration or debilitation, or serious illness; or a recent attempt or threat to harm self/others; or a recent, volitional conduct involving significant damage to property.

Community-based, outpatient civil commitment is also an option for individuals meeting one of the above criteria for inpatient treatment as well as one of the following:

- show manifestations that interfere with the ability to care for self and, when competent, would choose substantially similar treatment; or
- have had at least two court-ordered hospitalizations in past three years, exhibit symptoms/behavior substantially similar to those precipitating one or more of those hospitalizations, and
- reasonably to be expected to deteriorate to inpatient standard unless treated.

**Children’s Therapeutic Supports and Services (CTSS)**
A package of rehabilitation mental health services offered to children under Medical Assistance and MinnesotaCare. The spectrum of services available under CTSS allows providers to address the conditions of emotional disturbance that impair and interfere with children’s abilities to function. These rehabilitative services offer a broad range of medical and remedial services and skills to restore a child’s functional abilities as much as possible.

**Child Welfare**
Child service sector that focuses on child protection, foster care and the overall care of children’s health and living conditions (i.e. Department of Social Services).

**Community Alternatives for Disabled Individuals (CADI) Waiver**
Funding stream for home and community-based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of a person who would otherwise require the level of care provided in a nursing facility.

**Community Support Plan**
Person-centered plan that reflects a person's needs and preferences.

**Community Support Program (CSP)**
Services designed to help adults with serious and persistent mental illness function and remain in the community. These services may include medication monitoring, assistance in independent living skills, crisis, psychological rehabilitation and help in applying for government benefits.
• **Crisis Residential Treatment Services**
  Short-term, round-the-clock help provided in a nonhospital setting during a crisis. The purposes of this care are to avoid inpatient hospitalization, help stabilize and determine the next appropriate step.

• **Crisis Services**
  A group of services that is available 24 hours a day, seven days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams and crisis respite care.

• **Day Treatment (Adult)**
  A short-term structured program consisting of group psychotherapy and other intensive therapeutic services provided by a multidisciplinary team. Day treatment services are provided to stabilize a recipient's mental health status while developing and improving his/her independent living and socialization skills. The goal of day treatment is to reduce or relieve the effects of mental illness and provide training to enable the recipient to live in the community. The treatment must be provided to a group of recipients by a multidisciplinary team under the clinical supervision of a mental health professional.

• **Day Treatment (Child)**
  Includes special education, counseling, parent training, vocational training, skill building, crisis intervention and recreational therapy. It lasts at least four hours a day. Day treatment programs work in conjunction with mental health, recreation and education organizations and may even be provided by them.

• **Functional Assessment**
  Evaluation of how a child "functions" at school, home and in the community.
• **Group Residential Housing (GRH)**
  A state-funded program that provides an income supplement to approximately 20,000 recipients each month to pay for rent and food. All of those supported by the program are at risk of institutional placement or homelessness. The amount of a GRH payment is based on a federal and state standard of what an individual would need, at a minimum, to live in the community. In some cases, GRH may pay a supplemental amount to the basic rate. Effective July 1, 2015, this base rate is $891 per month.

• **Independent Living Services**
  Support for a person living on his or her own. These services include therapeutic group homes, supervised apartment living and job placement. Services teach skills needed to handle financial, medical, housing, transportation and other daily living needs, as well as how to get along with others.

• **Independent Living Skills (ILS)**
  Services that develop and maintain the community living skills and community integration of a person. ILS is provided in the home of a person or in the community.

• **Individual Education Program (IEP)**
  A plan that guides the delivery of special education supports and services for a student with a disability.

• **Individual Education Program (IEP) Case Manager**
  Special education teacher who is a member of the student's IEP team and coordinates instruction for the student.

• **Individual Interagency Intervention Plan (IIIP)**
  A multidisciplinary, interagency intervention plan for children that coordinates the delivery of special education and other community support services for a student with a disability.

• **Individuals with Disabilities Act (IDEA)**
  Federal law requiring schools to provide services to children with disabilities through age 21.
• **Institute of Mental Disease (IMD)**  
A stand-alone inpatient psychiatric hospital or psychiatric residential treatment facility. The federal government currently prohibits Medicaid coverage for adults 22-64 receiving treatment in these settings, which is commonly known as the IMD exclusion. The federal government has also raised concerns about Medicaid coverage for residential treatment programs for children and adolescents.

• **Intensive Residential Treatment (IRT)**  
A short-term (usually up to 90 days) service provided in a 24-hour, seven-day-a-week residential setting to individuals who are in need of a more restrictive setting and are at risk of significant functional deterioration. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.

• **Jarvis**  
Law allowing the involuntary use of psychotropic medications without judicial review when individuals refuse treatment and are in an emergency situation or are unable to consent to treatment but have previously been prescribed the medications or have requested their use in a health care directive. Substitute decision-makers are also allowed to consent to treatment on behalf of the individual.

• **Least Restrictive Environment**  
An educational, treatment or living situation that provides appropriate services or programs for persons with disabilities while imposing as few limitations or constraints as possible.

• **Local Advisory Council (LAC) on Mental Health**  
The Mental Health Act of 1987 and the Children's Mental Health Act of 1989 require counties to establish local mental health advisory councils. Both acts give LACs a broad role in the review, evaluation and planning of local mental health systems and reporting to the county board. See Minnesota Statute 245.466.
• **Mental Health**
  Refers to how a person thinks, feels and acts when faced with life’s situations. It is how people look at themselves, their lives and the other people in their lives; evaluate the challenges and the problems; and explore choices. This includes handling stress, relating to other people and making decisions. Mental health is impacted by genetics, brain chemistry, trauma and environment.

• **Mental Health Practitioner – Defined in MN Statute 245.4871 Subd26**
  A person who provides services in the treatment of mental illness, under the supervision of a mental health professional.

• **Mental Health Professional – Defined in MN Statute 245.4871 Subd27**
  A qualified and licensed professional providing clinical services in the diagnosis and treatment of mental illness. These licensed professionals are able to complete diagnostic assessments to determine appropriate diagnoses and treatment plans.

• **Mental Illness**
  (1) General term applied to severe emotional problems or psychiatric disorders. (2) Organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior.

• **Mobile Crisis Team**
  Mobile crisis teams, made up of mental health professionals, can travel to an individual’s location and assess a crisis situation. They help the individual through the crisis by providing stabilization services, intervention services, crisis prevention planning, referral to other professionals (including in some areas rapid access to psychiatrists) and follow-up services. Located throughout the state, services can be available 24/7 in some areas. Recent legislation increased funding to crisis services to expand the number and availability of teams statewide.

• **Olmstead Decision**
  *Olmstead v. L.C.*, a 1999 U.S. Supreme Court decision requiring states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs.
• **Olmstead Plan**
  Created in response to a U.S. District Court decision requiring Minnesota to develop an Olmstead Plan for Minnesotans living with disabilities. The plan encompasses a broad series of key activities the state must accomplish to ensure people with disabilities are living, learning, working and enjoying life in the most integrated setting. The most recent version of the plan has been rejected by the judge imposing the requirement.

• **Plan of Care**
  A treatment plan especially designed for each individual, based on strengths and needs. The caregiver(s) develop(s) the plan with input from the family or individual. The plan establishes goals and details appropriate treatment and services to meet the individual's needs.

• **Residential Treatment Centers**
  Licensed facilities that provide treatment 24 hours a day and can usually serve more than 12 young people at a time. Children with serious emotional disturbance (SED) receive constant supervision and care. Treatment may include individual, group and family therapy; behavior therapy; special education; recreation therapy; and medical services. Residential treatment is usually more long-term than inpatient hospitalization.

• **Respite Care**
  A planned break for a child who has a severe emotional disorder and his/her parents. Respite can last from a couple of hours to a few days and can be provided in the child's home or in another setting. Respite care can be provided by a family member, friend or an outside person.

• **Screening**
  An assessment or evaluation for the purpose of determining the appropriate services for a client.

• **Screening Instruments**
  A measure to determine one's level of need for treatment.

• **Serious and Persistent Mental Illness (SPMI) (defined by legislation)**
  Person age 18 years or older who has a mental illness diagnosis and meets one of the following conditions: a) has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months; b) has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months duration within
the preceding 12 months; c) has been treated by a crisis team two or more times within
the preceding 24 months; d) has a diagnosis of schizophrenia, bipolar disorder, major
depression or borderline personality disorder; evidences a significant impairment in
functioning; and has a written opinion from a mental health professional stating he/she
is likely to have future episodes requiring inpatient or residential treatment, unless
community support program services are provided; e) has, in the last three years, been
committed by a court as a mentally ill person under Minnesota statutes, or the adult's
commitment as a mentally ill person has stayed or continued; f) was eligible under one
of the above criteria but the specified time period has expired or the person was eligible
as a child with severe emotional disturbance and the person has a written opinion from
a mental health professional, in the last three years, stating that he/she is reasonably
likely to have future episodes.

- **Severe Emotional Disturbance (defined by legislation)**
  For purposes of eligibility for case management and family community support services,
"child with severe emotional disturbance" means a child who has an emotional
disturbance and who meets one of the following criteria: (1) the child has been admitted
within the last three years or is at risk of being admitted to inpatient treatment or
residential treatment for an emotional disturbance; or (2) the child is a Minnesota
resident and is receiving inpatient treatment or residential treatment for an emotional
disturbance through the interstate compact; or (3) the child has one of the following as
determined by a mental health professional: (i) psychosis or a clinical depression; or (ii)
risk of harming self or others as a result of an emotional disturbance; or (iii)
psychopathological symptoms as a result of being a victim of physical or sexual abuse
or of psychic trauma within the past year; or (4) the child, as a result of an emotional
disturbance, has significantly impaired home, school or community functioning that has
lasted at least one year or that, in the written opinion of a mental health professional,
presents substantial risk of lasting at least one year.

- **Supported Employment**
  Community jobs that any person can apply for, in integrated settings (and in regular
contact with nondisabled workers) that pay at least minimum wage. Supported
employment is a well-defined approach to helping people with disabilities participate in
the competitive labor market, helping them find meaningful jobs and providing ongoing
support from a team of professionals. First introduced in the psychiatric rehabilitation
field in the 1980s, supported employment programs are now found in a variety of
service contexts, including community mental health centers (CMHCs) and
psychosocial rehabilitation agencies.

- **Supportive Housing**
  Combines affordable housing with services that help people who face the most complex
challenges live with more stability.
• **Transition-Age Youth**
  Youth between the ages of 16-21 who are in the process of aging out of the systems designated for children.

• **Withdrawal Management**
  Medical model of detoxification services. Although the model passed in the 2015 legislative session, no funding was attached to the proposal.

• **Wraparound Services**
  A collaborative team-based approach to offering services for children with complex needs, including emotional and behavioral problems, and their families. Team members who are identified by the child and family and other service providers meet regularly to create goals, implement treatment and monitor the outcome of individualized treatment plans.

• **Youth ACT**
  Assertive Community Treatment (ACT) services adapted to youth aged 16-20. See ACT definition above.

**Sources**
Minnesota Mental Health: [http://mnmentalhealth.org/glossary](http://mnmentalhealth.org/glossary)
Department of Human Services: [http://mn.gov/dhs/](http://mn.gov/dhs/)
Corporation for Supportive Housing (CSH): [http://www.csh.org/](http://www.csh.org/)
Appendix B: Additional Hospital Utilization Data

Top 10 percent ZIP codes

Source: Minnesota Hospital Association Administrative Claims Database and Nielsen Demographics Data, 2014
Bottom 10 percent ZIP codes

Source: Minnesota Hospital Association Administrative Claims Database and Nielsen Demographics Data, 2014
2013 volume of inpatient mental health visits by ZIP code; includes admissions to hospitals in ND, SD, IA, KS, MT, MO, NE, GA, VA, TN, MI, WY and one in WI.
Average occupancy rates by facility

Source: Minnesota Hospital Association Administrative Claims Database and Nielsen Demographics Data, 2013
## Appendix C: Components of 2015 Mental Health Legislation

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
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<tbody>
<tr>
<td>Rebasing and new funding for inpatient mental health services</td>
<td>$2 million to offset lower rates for inpatient mental health services resulting from the Medical Assistance inpatient fee-for-service rate rebasing process.</td>
</tr>
<tr>
<td>Disproportionate Share Hospital (DSH) payment formula</td>
<td>Establishes a new DHS distribution formula that prioritizes payments to Prospective Payment System (PPS) hospitals that provide mental health contract beds.</td>
</tr>
<tr>
<td>Behavioral health homes</td>
<td>$5.3 million (2016-17) and $23.8 million (2018-19) to implement behavioral health homes (BHH), which will coordinate primary and behavioral health care for children and adults with serious emotional disturbance (SED), serious mental illnesses, and serious and persistent mental illnesses. Effective July 1, 2017.</td>
</tr>
<tr>
<td>Child and adult crisis services</td>
<td>$8.6 million (2016-17) and $9.5 million (2018-19) to expand and improve child and adult crisis services statewide: establishes a single telephone line for mobile crisis services; requires at least 50% of funds to go to rural Minnesota; funding priority for areas currently without crisis residential or an inpatient unit within 90 miles, or demonstrated need; start-up grants to establish new adult crisis residential services.</td>
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</tbody>
</table>
| Psychiatric residential treatment facilities                             | $6.6 million (2016-17) and $23.7 million (2018-19) to develop psychiatric residential treatment facilities (PRTFs) for children and adolescents needing intensive residential services. Up to 150 beds will be built in up to six locations around the state. These beds will draw federal matching dollars. 

A related provision calls for a moratorium exemption process for 20 inpatient psychiatric child/adolescent contract beds in Maple Grove. These beds, anticipated to be available by the end of 2015, will offer longer-term, extended-stay treatment under a contract arrangement with DHS. The beds will help fill some gaps in service while PRTFs are developed and initiated. |
<p>| Anoka Metro Regional Treatment Center                                   | $6.4 million (2016-17) and $6.2 million (2018-19) to increase Anoka Metro Regional Treatment Center’s (AMRTC) census from 95 to 110 beds by fully staffing up to 15 additional beds.   |</p>
<table>
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<tr>
<th>Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>Saves $1.75 million (2016-17) and $1 million (2018-19) from increasing the county share to 100% for days patients are in AMRTC but no longer meet level of care criteria.</td>
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<tr>
<td>Protected transportation</td>
<td>$3.7 million (2017) and $14.6 million (2018-19) for nonemergency medical transportation funding, including protected transportation. Originally passed in 2013, protected transportation provides an alternative method for transporting patients experiencing a mental health crisis rather than relying on ambulance or law enforcement.</td>
</tr>
<tr>
<td>Mental health provider rate increases</td>
<td>$5.5 million (2016-17) and $6 million (2018-19) to stabilize mental health intensive services. Provides grant funding to protect current infrastructure like intensive residential treatment services (IRTS), residential crisis stabilization and assertive community treatment (ACT) while the payment structure for these services is analyzed and reforms proposed for the 2017 session. Also includes payment parity for mobile crisis services to align with in-person psychotherapy visits. $3.6 million (2016-17) and $4.6 million (2018-19) for a 2% rate increase for chemical dependency providers.</td>
</tr>
<tr>
<td>Assertive Community Treatment teams</td>
<td>$1.3 million (2016-17) and $1.5 million (2018-19) to expand the number of Assertive Community Treatment (ACT) teams and increase quality of services provided. Also creates a forensic ACT team for people involved with the criminal justice system.</td>
</tr>
<tr>
<td>Supportive housing</td>
<td>$4.7 million (2016-17) and $6.1 million (2018-19) to expand housing with supports grants over four years to serve 840 adults with serious mental illnesses in permanent supportive housing.</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>$1 million (2016-17) and $1 million (2018-19) for Text 4 Life texting suicide prevention and crisis service. $449,000 for suicide prevention (2016-17) and $416,000 (2018-19) to the Minnesota Department of Health (MDH) for suicide prevention and intervention training programs. Improvement of collection and reporting of suicide data.</td>
</tr>
<tr>
<td>First episode of psychosis treatment</td>
<td>$260,000 (2017) and $685,000 (2018-19) for first episode programs to support and treat individuals experiencing their first psychotic episode.</td>
</tr>
<tr>
<td>Initiative</td>
<td>Funding Details</td>
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<tr>
<td>Clubhouse model</td>
<td>$134,000 (2016-17) to plan for clubhouse model coverage in Medical Assistance.</td>
</tr>
<tr>
<td>Beltrami County comprehensive mental health program</td>
<td>$2 million (2017-18) grant for Beltrami County to develop a jail diversion and comprehensive mental health program for individuals experiencing a mental health crisis.</td>
</tr>
<tr>
<td>Community Addiction Recovery Enterprise (CARE) programs</td>
<td>$15.3 million (2016-17) and $11 million (2018-19) to keep all CARE programs open, reduce each program (except AMRTC) to 16 beds to capture federal matching funds, and increase rates to CARE programs and private community providers servicing individuals under commitment with complex needs.</td>
</tr>
<tr>
<td>Psychiatric consultation</td>
<td>$285,000 (2016-17) and $679,000 (2018-19) for Licensed Independent Clinical Social Workers (LICSWs) and Licensed Marriage and Family Therapists (LMFT) to provide mental health consultation to primary care doctors under Medical Assistance.</td>
</tr>
<tr>
<td>Withdrawal management</td>
<td>Withdrawal management program, payment methodology to be developed.</td>
</tr>
<tr>
<td>Children and adult mental health initiatives</td>
<td>Clarification of services eligible for grants under the children and adult mental health initiatives and biennial reports on the use of grant funds. The first reports are due to members of the legislative committees having jurisdiction over mental health funding and policy issues by Nov. 1, 2016.</td>
</tr>
<tr>
<td>Excellence in Mental Health</td>
<td>$398,000 (2016-17) to certify behavioral health clinics to prepare for federal Excellence in Mental Health demonstration project.</td>
</tr>
<tr>
<td>Coverage for physician assistant mental health services provided in outpatient setting</td>
<td>Physician assistant mental health services provided in outpatient setting covered under Medical Assistance, after the physician assistant has completed 2,000 hours of clinical experience in the evaluation and treatment of mental health.</td>
</tr>
<tr>
<td>Adverse childhood experiences</td>
<td>$726,000 (2018-19) for adverse childhood experiences (ACEs) training.</td>
</tr>
<tr>
<td>Supported employment</td>
<td>$5 million (2016-17) for supported employment grants for people with mental illnesses.</td>
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Effective July 1, 2016.
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>Rental assistance</td>
<td>$8 million (2016-17) for rental assistance for people with mental illnesses or families with an adult member with a mental illness.</td>
</tr>
<tr>
<td>Foreign-trained health care workers</td>
<td>$200,000 (2016) for a workforce grant program designed to encourage state licensure of foreign-trained health care professionals, including: physicians, with preference given to primary care physicians who commit to practicing for at least five years after licensure in underserved areas of the state; nurses; dentists; pharmacists; mental health professionals; and other allied health care professionals. The commissioner must collaborate with health-related licensing boards and Minnesota workforce centers to award grants to foreign-trained health care professionals sufficient to cover the actual costs of taking a course to prepare health care professionals for required licensing examinations and the fee for the state licensing examinations.</td>
</tr>
</tbody>
</table>

3 “Roadmap for Mental Health System Reform in Minnesota,” p. 5.
9 “Behavioral Health: Mental Disorders Outgrow Other Costly Conditions,” Trustee, p. 3, Vol. 68, no. 7 (July/August 2015) (citing http://meps.ahrq.gov/mepsweb).


11 Ibid.

12 “Parity or Disparity: The State of Mental Health in America,” Mental Health America, p. 12 (December 2014).

13 Average occupancy data includes occupancy data from the state-operated hospitals in Anoka, Alexandria, Annandale, Baxter, Berndji, Fergus Falls, Rochester, and St. Peter. These hospitals are not included in the claims data used to calculate volume or rates of inpatient and outpatient mental health visits.

14 Minnesota Hospital Association Hospital Annual Report and Nurse Staffing data.

15 Minnesota Hospital Association Administrative Claims Database. Claims data does not include claims from state-operated facilities.

16 Minnesota Hospital Association 2014 potentially preventable readmission rate data.

17 Minnesota Hospital Association Administrative Claims Database. Claims data does not include claims from state-operated facilities.

18 Ibid.

19 Ibid.

20 “All mental health” is defined as all Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Clinical Classification Software (CCS) for Principle Diagnosis categories for mental health diagnoses and includes developmental disabilities, substance use disorders, and alcohol use disorders. Alcohol use is not included in the category for substance use disorder.

21 Ibid.

22 Ibid.


24 U.S. Department of Health and Human Services Health Resources and Services Administration, Shortage Designation: Health Professional Shortage Areas and Medically Underserved Areas/Populations http://www.hrsa.gov/shortage/.

25 “Growing Need, Declining Capacity,” Trustee, p. 14, Vol. 68, no. 7 (July/August 2015).


28 “Mental health professional” is defined in statute and includes psychiatrists, psychologists, clinical social workers, advanced practice psychiatric nurses, marriage and family therapists and certain licensed clinical counselors (2014 MN Statutes 245.462 subd. 18).

29 “Mental health practitioner” is defined in statute and includes individuals with necessary credentials who practice under the supervision of a mental health professional (2014 MN Statutes 245.462 subd. 17).


31 Ibid.

32 Ibid. p. 16.


34 2015 Minnesota Laws 1st Special Session, Chapter 1, Article 1, section 2, subd. 3 https://www.revisor.mn.gov/laws/?year=2015&type=1&doctype=Chapter&id=1.
Minnesota currently has coverage under the Medicaid State Plan Amendment for children's residential services that are not PRTFs.

Medicare does not cover services delivered by licensed marriage and family therapists or licensed mental health counselors. Federal legislation has been introduced to include these providers under Medicare Part B. See H.R. 2739 (Gibson – R-NY-19) https://www.congress.gov/bill/114th-congress/house-bill/2759/.


Substance Use and Mental Health Services Administration, Community Mental Health Services Block Grant http://www.samhsa.gov/grants/block-grants/mhbg and Substance Use and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant http://www.samhsa.gov/grants/block-grants/sabg.


Minnesota Department of Human Services, “Minnesota’s Mental Health System Gaps,” 2015. Provider adequacy was determined by the number of available providers divided by the number of individuals with serious mental illness and multiplied by 10,000.

Psychiatric Residential Treatment Services (PRTFs) for children and adolescents are not yet implemented in Minnesota, hence the lack of availability anywhere in the state. Family peer specialists are coming online but not yet available.

See In re Detention of DW v. Dept. of Soc. & Health Servs., 181 Wash. 2d 201; 332 P 3d 423 (2014).

DHS has established a pilot project, Whatever It Takes, to help patients with barriers to service transition out of AMRTC. The pilot is being expanded to include individuals meeting certain criteria who are on the waiting list.
62 The bill’s text is available at https://www.congress.gov/114/bills/hr2759/BILLS-114hr2759ih.pdf.
64 Colorado, Massachusetts, North Carolina, Oregon, Tennessee and Wisconsin. "New CMS rule could reshape Medicaid Managed Care," Modern Healthcare, p. 7 (June 1, 2015).
68 Ibid p. 21.
69 Available at http://www.nrepp.samhsa.gov/ViewAll.aspx.
75 A 2015 legislative effort to create this model in Minnesota was defeated due to lack of support from mental health advocates and providers, who wish to see a health and social services-directed solution rather than one driven by law enforcement. However, Beltrami Co. received a grant to develop a comprehensive mental health program for individuals brought in by law enforcement that would also be accessible by all individuals in crisis. See SF 141 (Goodwin) https://www.revisor.mn.gov/bills/text.php?number=SF0141&session=ls89&version=latest&session_number=0&session_year=2015 and 2015 Minnesota Laws Chapter 71, Article 2, section 41 https://www.revisor.mn.gov/laws/?year=2015&type=0&doctype=Chapter&id=71.
76 Orange County Government, Florida, Adult Mental Health http://www.orangecountyfl.net/FamiliesHealthSocialSvcs/AdultMentalHealth.aspx#Va_qPfViko and CRC: Central Receiving Center https://www.osco.com/LinkClick.aspx?fileticket=bzKvLrRV3Qs%3D&tabid=147&mid=641.
77 Conversation with Angela Youngerberg, Assistant Human Services Director, Blue Earth County, July 8, 2015


87 http://www.bhpcare.com/.