Good day,

My name is Dr. Dionne Hart. I was a member of the Task Force on Priority Admissions to State-Operated Treatment Programs. For background purposes, I serve as the AMA Representative to the National Commission on Correctional Health Care Board of Representatives and hold elected leadership roles within the Minnesota Psychiatric Society, Minnesota Medical Association, and the American Psychiatric Association. As a member of the Board of Trustees of the Minnesota Medical Association, I co-chaired a task force focused on the issue of Emergency Department Boarding (see attachment). In addition to my participation in organized medicine, I have almost 17 years of work experience in corrections and 20 years of experience in both an emergency department and a state operated hospital. Based upon my wealth of professional experiences as both a patient advocate and treating patients in correctional facilities and community settings, I strongly support the recommendations of the House Public Safety Finance and Policy Committee HF 4366/SF4460 as written.

As a member of the task force, we grappled with inevitable tensions around incentives, payment, and authority, but unanimously agreed to the recommendations in the report. While all the recommendations have significant merit, I wish to highlight the most crucial steps to take ASAP.

1. Lack of access to Direct Care and Treatment (DCT) beds has resulted in an untenable position for the hospitals in our state. ED boarding and lengths of stay numbering in years has critically impacted access by all others who need it.

2. Increasing access to services operated by DCT in the community is key to future success in the area of mental health care for those who need it most. It is abundantly clear that Minnesota needs to do what it can NOW while simultaneously also planning the process to build and support more as circumstances allow.

3. We must change the priority admission law now to allow for better access and efficiency of DCT beds while more capacity, including physical beds and an adequately trained and supported

workforce, is built. This means authorizing psychiatric physicians to use their clinical criteria/judgment to determine which patients to transfer first for safety and which patients will not benefit from transfer and recommend more appropriate dispositions based upon their clinical judgment. This process is the standard of care for individuals with physical health concerns and individuals living with mental health disorders have a right to treatment using that same community standard of care.

4. Jails and prisons are the largest providers of psychiatric treatment in the United States and not an insignificant mental health provider in the state of Minnesota, it is imperative that we fulfill the constitutional obligation to provide mental health treatment to people living with mental health disorders confined to correctional facilities. Therefore, it is imperative that prescribed (oral or injectable) psychotropic medications are administered to these individuals living with mental health disorders as recommended by their physician or mental heath provider when they are confined to jails without delay, while simultaneously beginning the process of obtaining a waiver to allow Medicaid to pay for it. To achieve this objective, it is imperative that we also support educational opportunities for physicians in training and practicing physicians and mid-level providers to increase their capacity to provide this critical treatment.

Respectfully submitted,

Dr. Dionne Hart

Dionne Hart, MD, DFAPA, FASAM

Director Care From The Hart
AAPHP, Board Member
AMA. Liaison to the National Commission on Correctional Health Care
APA, Delegate to the AMA
APA, Area 4 Trustee 2024-2027
MMA Board of Trustees
MNAAP, President
MN Village, Founder
MPS, Assembly Representative
NMA, Region 4 Chairperson
ZVMS, Immediate Past Co-President
Jeremiah Program, Chair, Board of Community Directors
@lildocd

March 14, 2024

Chair Becker-Finn and Committee Members
House Judiciary Finance and Civil Law Committee
559 State Office Building
St. Paul, MN 55155

RE: Hospital boarding and discharge delays - proposed solutions

Thank you for your continued dedication to addressing boarding and discharge delays in Minnesota hospitals. The scenes that are playing out at health systems across the state are some of the most challenging situations our teams have faced in their careers. Patients are stuck in hospitals waiting for transfers to nursing homes, rehabilitation units, mental health treatment facilities, and other sub-acute care facilities, including state operated services.

In 2023, patients across the state spent nearly 195,000 avoidable days in hospitals, waiting for the right level of care to become available. This included almost 12,000 days of unnecessary stays for children alone. In most cases, these children don't have an emergent medical or psychiatric condition requiring hospitalization; they need long-term, stable support through community-based and residential services. For many, their mental health gets worse while they are stuck in the hospital. In short, patients across Minnesota are getting the wrong care in the wrong place, and often for too long a time. And, unfortunately, the problem isn't getting better, it is getting worse.

This patient gridlock not only reduces overall capacity for hospital care, it also cost Minnesota hospitals and health systems an estimated $487 million in unpaid care. A refreshed version of HF4106 (Carroll) / SF3989 (Morrison) would give hospitals some short-term financial relief, and we cannot wait any longer to systematically address this problem. Actions the legislature and state agencies can take include the following:

Legislative Proposals:

- Discharge policy bill (SF3989 Hoffman / HF4106 Noor) - Improves processes for MnCHOICES Assessments, SMRT Assessments and Medical Assistance eligibility determinations; establishes supplemental payment rate while counties and community providers determine long-term exception rate for an individual
- Medicaid Mental Health Reimbursement Rate increases (HFXXXX Her / SFXXXX Wiklund and HF4366 Edelson / SF4460 Mann) - Increases outpatient and inpatient reimbursement rates for mental health and substance use disorder services, building on the 2024 DHS Outpatient Services Rate Study

- Youth care transition program (HF4671 Fischer / SF4664 Mann) - Ensures sustained funding for the youth care transition program which supports youth with complex needs who need to transition from hospital and residential settings to a more appropriate level of services.
- Respite grants (HF4671 Fischer / SF4664 Mann) - Increases current county grant funding for respite care and invest resources in recruiting, licensing and compensating new respite family providers
- Emergency Medical Assistance (SF4024 Mann / HF3643 Noor) - Allows more flexibility in what Emergency Medical Assistance (EMA) will pay for, these bills broaden the settings available to a patient who qualifies for EMA by permitting certain services to be covered under EMA.
- Legislative recommendations from the Priority Admissions Task Force (HF4366 Edelson / SF4460 Mann) which includes expanded capacity at and access to Direct Care and Treatment facilities. These recommendations include an exception for 10 civilly committed individuals waiting in a hospital to be added to the admissions waitlist – this exception is a critical pressure release for hospitals who have been housing individuals in need of forensic or other intensive care in a state operated service, some for multiple years.

Administrative Actions:

- Determine a different way to prioritize complex patients for placement outside of the hospital including:
    - Prioritizing and expediting funding for in home and out of home placement, including MnCHOICES assessments, MA eligibility, and waivered services for kids in hospitals.
    - Ensuring counties prioritize the establishment and responsiveness of guardians, rate negotiations with group homes and the placement process for patients in acute care or hospital settings.
    - Prioritizing workforce crisis solutions to increase crisis and group home capacity.
- Strengthen enforcement of licensing standards to ensure group homes and other facilities cannot use "temporary suspension" of services as a mechanism to leave clients at hospitals and then refuse to take them back.
- Staff Willmar Child and Adolescent Behavioral Hospital to full capacity and accept "lateral" admissions.
- Counties all have a different "front door" to start the process of partnering to find patients an appropriate placement, and this information is challenging to find. Create one resource with this information to make navigating and outreach more streamlined for hospitals.

This is not a problem that any one part of the system can solve by itself. State agencies, counties, community providers, families and health systems all need to be responsible for their individual parts and work together to meet the needs patients, getting them the right level of care at the right time. The crisis of patients being stuck in hospitals needs immediate action.

Minnesota Psychiatric Society

Improving Minnesota's mental health care through education, advocacy, and sound psychiatric practice, and achieving health equity.

March 12, 2024

Dear Legislators:

The Minnesota Psychiatric Society strongly recommends the House Public Safety Finance and Policy Committee pass HF 4366/SF4460 as written. Members of the task force (which included significant county representation) grappled with inevitable tensions around incentives, payment, and authority, but, in a statesman-like manner, unanimously agreed to the recommendations in the report. While all the recommendations have significant merit, we want to highlight the most crucial steps to take ASAP.

1. Lack of access to Direct Care and Treatment (DCT) beds has resulted in an untenable position for the hospitals in our state. ED boarding and lengths of stay numbering in years has critically impacted access by all others who need it.

2. Increasing access to services operated by DCT in the community is key to future success in the area of mental health care for those who need it most. It is abundantly clear that MN needs to do what it can NOW while simultaneously also beginning the process to build and pay for more as circumstances allow.

3. We must change the priority admission law now to allow for better access and efficiency of DCT beds while more capacity is built. This means empowering psychiatrists to use clinical criteria/judgment to decide which patients to transfer first for safety and which patients won't benefit from transfer and instead recommend more appropriate dispositions. Currently the 48 hour law does not allow DCT to match the needs of patients with a medically appropriate bed. **We cannot afford this inefficiency now!** Every DCT bed is precious and needs to be optimally utilized.

4. We must begin to administer necessary psychotropic medications to people incarcerated in jails ASAP while simultaneously begin the process of obtaining a waiver to allow Medicaid to pay for it.

If you have any questions please contact Linda Vukelich, Executive Director, Minnesota Psychiatric Society (l.vukelich@comcast.net) or Bill Amberg, Government Relations Counsel, Minnesota Psychiatric Society (Bill@amberglawoffice.com).

Thank you for your consideration.

Sincerely yours,

Michael Trangle, MD, DLFAPA
MPS Legislative Committee Chair

Association *of* Minnesota Counties

MACSSA Minnesota Association of County Social Service Administrators

To: Chair Jamie Becker-Finn and House Judiciary Finance and Civil Law Committee
Re: House File 4366
Date: March 13, 2024

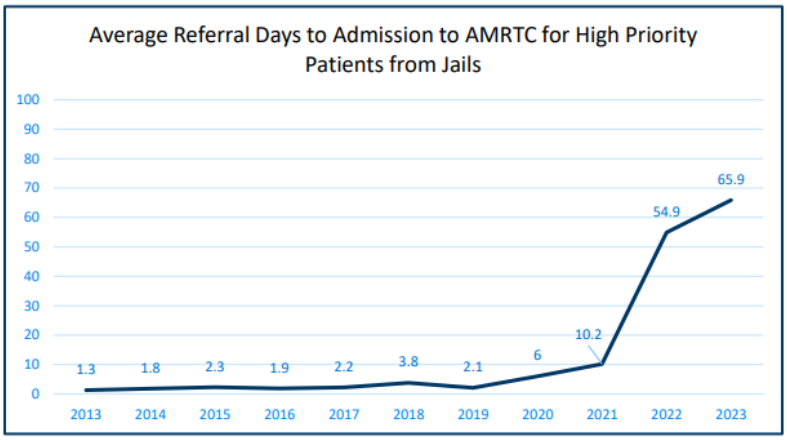
Chair Becker-Finn and Judiciary Finance and Civil Law Committee members:

Thank you for the opportunity to share comments on behalf of AMC, MACSSA, MSA, and MCAA and as members of the Priority Admissions Task Force. We support the final task force report recommendations which will become House File 4366. We thank author Rep. Edelson for working with the Task Force members to quickly to codify the report recommendations. We look forward to our continued work together to ensure these urgent and critical needs are met this session.

Urgent action by the legislature is needed to expand capacity in our state operated system and within our communities to meet the acute mental health needs of individuals in jails, hospitals and in the community. We believe all people living with mental health disorders are entitled to have care when and where they need it. Specifically, people who are civilly committed should have access to the court-ordered treatment they require to achieve recovery.

The county associations represented on the task force emphasized the principle that jails are not a replacement for mental health hospitals or secure treatment facilities. A key county objective was to ensure that any steps to mitigate the problems hospitals face does not come at the expense of people in jails, where people have no chance to access inpatient mental health services. We know the Priority Admissions Statute was a response to the lack of access and inpatient capacity at DCT that persists today.

The 48-hour rule was enacted to protect the constitutional rights of people in jail that were court ordered to receive the treatment they needed –and it worked – for about 10 years until the demand for forensic services exceeded capacity, among other factors influencing . With the significant and increased demand for services, and in civil commitments overall, it is not surprising that DCT does not have adequate capacity for even the most acutely ill people. A key principle of the Task Force Recommendations is that ANY changes to the priority admissions statute must be accompanied by immediate expansion of DCT's hospital capacity.



The first listed recommendation was to immediately increase DCT capacity and access. This means a 10-20% immediate increase in Forensics beds and a 20% immediate overall increase in AMRTC/CBHH beds. This would total 37-74 additional beds at Forensics and an additional 38 beds between AMRTC/CBHH. Amending the 48-rule and how placements are prioritized is a significant change that requires a real commitment to addressing our system capacity issues.

HF4366 features another key county priority. Counties currently pick up 100 percent of the costs for individuals when an individual is determined to not meet the medical criteria of their current placement (DNMC), but for whom the next appropriate placement is a state operated bed, when there is no available bed due to lack of capacity in our state system. Counties have no control over how or when an individual is moved by the state between these facilities and counties shouldn't have to deplete local property tax funded behavioral health budgets to cover this cost. The taskforce also recommends any DNMC costs paid by counties should be redirected from their current pathway - the state's general fund - and instead be returned to counties to expand the scope of mental health services and facilities to successfully support individuals in community settings.

There are several areas still to be addressed in this bill's language to align it with the Task Force Recommendations. We appreciate that Rep. Edelson is committed to ensure the language reflects a consensus on the task force recommendation. Issues to address include:

The bill currently lacks language ensuring there are no changes in the 48 rule or placement priority without increased capacity. Any change to the Priority Admissions law must occur simultaneously to or following the immediate increase in capacity at DCT as referenced in the Taskforce Recommendations.

- To clarify: The task force did not take a position to eliminate the 48-hour rule – Counties continue to support the urgency to get individuals to an appropriate placement, reflected in the origins of the 48-hour rule. Thus, we continue to support policy that reflects urgency of admission after commitment, not just "when a medically appropriate bed is available".
- Urgency is needed to expand our state operated system capacity and our community capacity, to meet the need of individuals in jail and with the highest acuity. Otherwise changes in prioritization will only expand the wait for those with the highest needs.
- The bill includes a one-time exception to the priority admissions rule, but counties can only support this when accompanied simultaneously to or following a commitment to an immediate increase in capacity at DCT. Urgency is needed to expand our state operated system capacity and our community capacity, to meet the need of individuals in jail and with the highest acuity. Otherwise changes in prioritization will only expand the wait for all those with the highest needs.
- We strongly support the Medicaid 1115 waiver for jail reentry, however, language should also reference seeking a waiver for the Pre-Trial status individuals. Two states have already submitted Pre-Trial 1115 waivers to the federal government - Oregon and Arkansas.
- Counties appreciate the language calls out specific goals for increased DCT capacity, we suggest requiring regular reports back to the legislature about capacity levels at DCT and the progress towards meeting the capacity goals that accompany their appropriation.

Overall, counties are committed to finding the best ways to address the current lack of high acuity placement options, appropriately place and treat individuals who are civilly committed, and to build out our entire continuum of mental health care.

Signed:

Association of Minnesota Counties:
Tarryl Clark, Stearns County Commissioner

Minnesota Association of County Social Service Administrators:
Angela Youngerberg, Blue Earth County Human Services Director of Business Operations

Minnesota County Attorneys Association:
Kevin Magnuson, Washington County Attorney

Minnesota Sheriffs Association:
Bryan Welk, Cass County Sheriff

Priority Admissions in Washington: A Case Study

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The Case: In 2014, a class action lawsuit was filed against the state of Washington's Department of Social and Health Services (DSHS), informally known as *Trueblood*. Federal courts found that the DSHS was violating the constitutional rights of people by holding them in jail for too long while awaiting competency evaluations and services. The court ordered DSHS to offer competency evaluation and restoration services within seven or fourteen days.[i] Since the 2015 ruling, Washington's DSHS has been found in contempt three times and fined hundreds of millions of dollars. In 2018, an agreement was reached to settle the contempt orders by requiring the state to make changes in five substantive areas: competency evaluations; competency restoration services; crisis triage and diversion support; education and training; and workforce development.[ii]

The Result: *Since the beginning of the case, Washington State has been fined at least $400 million*.[iii] For a decade now, the state has worked to comply with the settlement and implement changes through a phased approach, including developing forensic navigator positions, outpatient competency restoration programs, and expanding capacity for inpatient care. However, the central point of the case has always been complying with timelines set by an external authority. How has Washington faired? According to the January 2024 mandated monthly report published by DSHS "Restoration admission wait times at WSH (western state hospital) were 30.2 days in November (2023), a moderate decrease from 33.0 days in October (2023). The ESH (eastern state hospital) average admission wait-time decreased moderately to 43.0 days in November (2023) from 47.2 days in October (2023)… At both hospitals and the RTF's (residential treatment facilities) combined, overall timeliness for inpatient restoration admissions for November increased to a *nine percent completion rate within 7-days*." In other words, after 10 years and $400 million, the state still fails to meet the settlement timeline 93% of the time.[iv]

Why is this important for Minnesota? Neither Washington nor Minnesota are unique in the United States. Minnesota's "48-hour law" was passed in 2013, a year before the *Trueblood* case, and for many years it worked. Both states, along with the rest of the country, have seen the drastic increase of people being held in jail, found incompetent, and awaiting services over the last decade. In 2018, the same year the *Trueblood* contempt settlement was reached, Minnesota's DHS shifted policy to prioritize treatment of all Minnesotans, over the specific competency needs of the court system in order to meet demand. This strategy has also worked, as admissions at Anoka Metro Regional Treatment Center (AMRTC) rose significantly after the policy change. More people were able to get the care they need, even while DHS was still prioritizing people in jail according to the priority admissions law. However, admissions of people into state operated hospitals from non-jail settings have dropped substantially, leading to critical gaps in care and further criminalization of those with mental illnesses.

Minnesota has the opportunity to continue to model collaboration and collective accountability. Washington has been forced to build its mental health system from the outside in, and in a risky and

unsustainable way.[v] Over the last decade in Minnesota, the Mental Health Legislative Network has made significant gains in building our mental health system in all the critical areas mentioned in the *Trueblood* settlement, including crisis response, diversion programs, education, and workforce development.

In regard to the court system, Minnesota's efforts culminated in the 2019 Community Competency Restoration Task Force and the comprehensive legislation passed in 2022 to create and implement an actual competency attainment system. NAMI Minnesota has led this charge since 2019, and we have been in many national conversations with many experts dealing with the very same issue. Minnesota is truly a nation leader in competency attainment. System designs across the country are quite similar, but Minnesota is unique in that the 2022 legislation was a successful compromise between county attorneys, public defenders, DHS, counties, sheriffs, law enforcement, and community providers. And these partners continue to collaborate to implement the law through the Minnesota Competency Attainment Board.

The legislature has the opportunity to make practical decisions to invest in what actually works. Simply put, arbitrary timelines do not decriminalize mental illnesses. Arbitrary timelines do not build beds, grow the workforce, or build the community mental health system. That is up to us as collaborators committed to improving the lives of all Minnesotans.

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[i] This is a parallel example of Minnesota's priority admissions, or "48-hour" law. Presently, nearly every person under the priority admissions law has been found incompetent. So "inpatient competency restoration services" in Washington are akin to civil commitment following a finding of incompetence in Minnesota.

[ii] A.B. by and through Trueblood v. DSHS. Disability Rights Washington. (n.d.). https://disabilityrightswa.org/cases/trueblood/#below

[iii] Deng, G. (2023, December 6). Washington pays $100m fine for neglecting mental health services months earlier than expected. Oregon Capital Chronicle. https://oregoncapitalchronicle.com/2023/12/05/washington-pays-100m-fine-for-neglecting-mental-health-services-months-earlier-than-expected/

[iv] Washington State Department of Social and Health Services. (2024, January 31). Cassie Cordell Trueblood, et al., v. Washington State Department of Social and Health Services, et al. Monthly Report to the Court Appointed Monitor. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2024Trueblood/Trueblood-Report-2024-01.pdf

[v] In a document to the public, Washington's DSHS noted, "Separate from the Trueblood grant funding decisions that are approved through the Federal District Court as described above, funding to support the Settlement Agreement would be provided through the Washington state budget process. This process requires that DSHS seek funding from the legislature and the Governor's Office to support the strategies within the Trueblood Settlement Agreement." Monthly court monitor reports also detail budget appropriations for the settlement agreement, in addition to the fines paid to the federal government. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Trueblood/2020Trueblood/19-0125%20BHA%20Trueblood%20Diversion%20Grants%20and%20Settlement%20Funding%20Overview%20v2.pdf