Acute Care Transitions Advisory Council: Report and Recommendations

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DEPARTMENT OF
HUMAN SERVICES

The Vision

VISION	Minnesota has a responsive, accessible and timely response to ensure each person can live in their community with the services they need to support them.
GOAL	People in Minnesota access acute care services when needed and have timely and high-quality transitions back to their communities
NEEDS	• Collaborative view of data across the spectrum of services • Focus on building a sustainable, statewide system while supporting individual transitions • Funding to support regional collaborative efforts, rolling up to a statewide leadership team

Vision

Purpose of the Council: Create Action Plan

- Improve regional capacity for acute care transitions, including examining the roles and experience of counties and Tribes in delivering services and identifying any conflicting and duplicative roles and responsibilities among health and human services agencies, counties, and Tribes
- Create a measurement and evaluation system as part of an overall statewide implementation science approach; and
- Design statewide strategies that focus on addressing geographic, racial, and ethnic disparities.

Hospital Decompression vs Complex/Acute Care Transitions

Hospital Decompression

COVID related initiative to assist long-stay patients transition to more appropriate services out of hospital

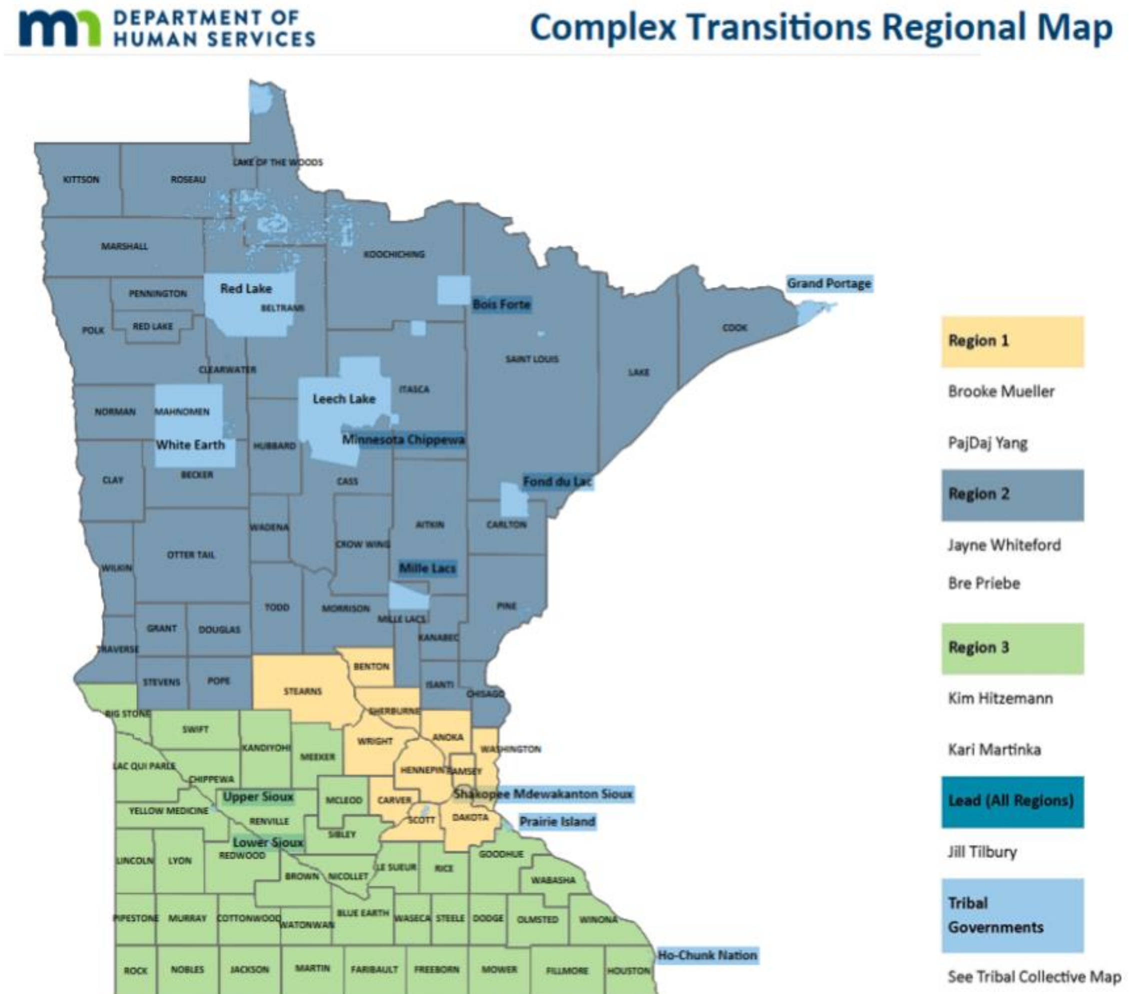
Goal: To make room in hospitals for people in need of access to acute care

Complex/Acute Care Transitions

Goals: Support people of all ages (including children) to access the appropriate services in the community to facilitate a safe discharge and transition from an acute care setting. Connect with the appropriate support to return home or a to a community-based setting when possible. Ensure access to the appropriate level of care to meet the person's needs Prevent possible readmission through continued transition planning and coordination post-discharge.

DHS Efforts: Current Regional Approach

- Referrals are open statewide to institutional providers and lead agencies
- Regional approach
- Regional and statewide data and opportunities



Complex/Acute Care Transitions

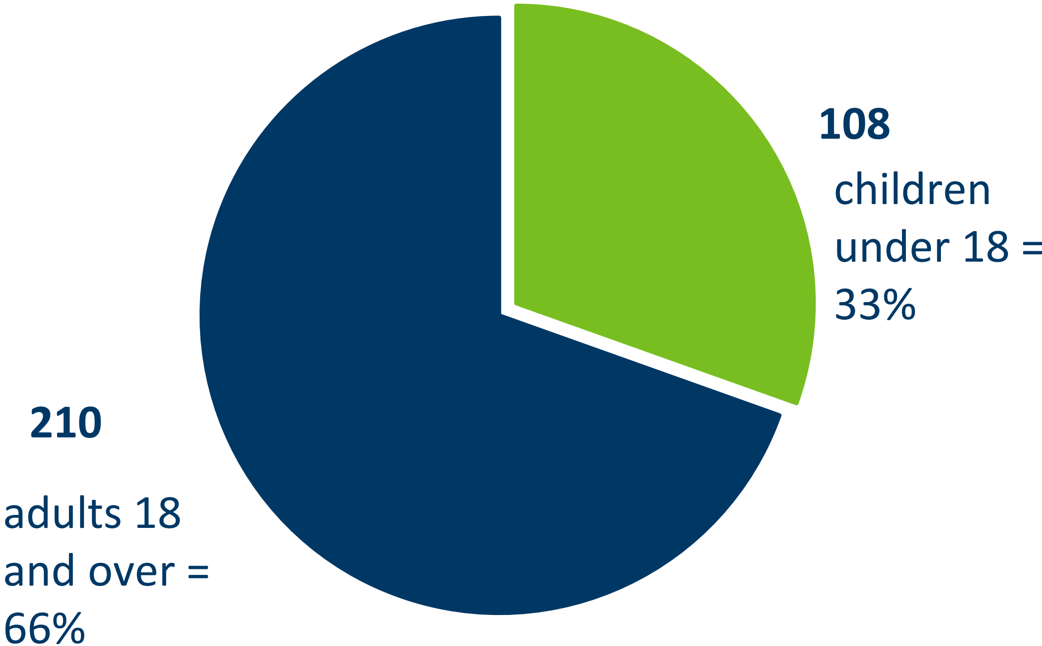
To be eligible for Complex Transitions, a person:

- Must be in receipt of MA or in the process of application for MA
- Must have been receiving care in an institution for more than one week
- Must have met their treatment objectives and no longer need the institutional level of care
- Must have had Lead Agency involvement working toward a plan for transition back to community and all options have been exhausted

Complex Transitions can:

- Connect to clinical consultation and enhanced training for staff supporting the person in community
- Provide referral options from DHS provider network for potential placement
- Connections to person-centered planning
- Support through the use of flexible grant funding
- Provide support related to rate exceptions and waiver challenges

Adult vs Children's Referrals

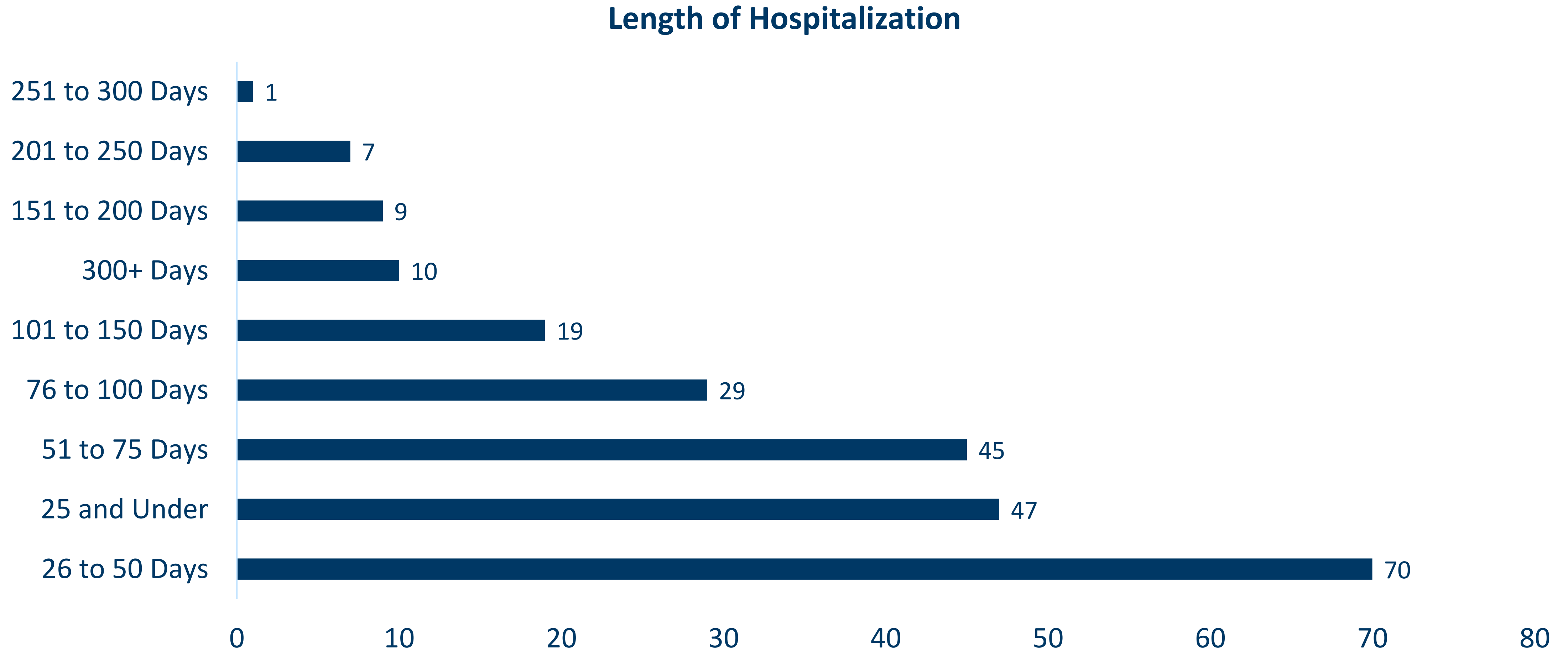


All children's referrals are forwarded to DCYF to identify intersections with child protection or welfare.

Of the 108 children's cases, **approximately a third remained with DCYF due to child protection or welfare intersections.**

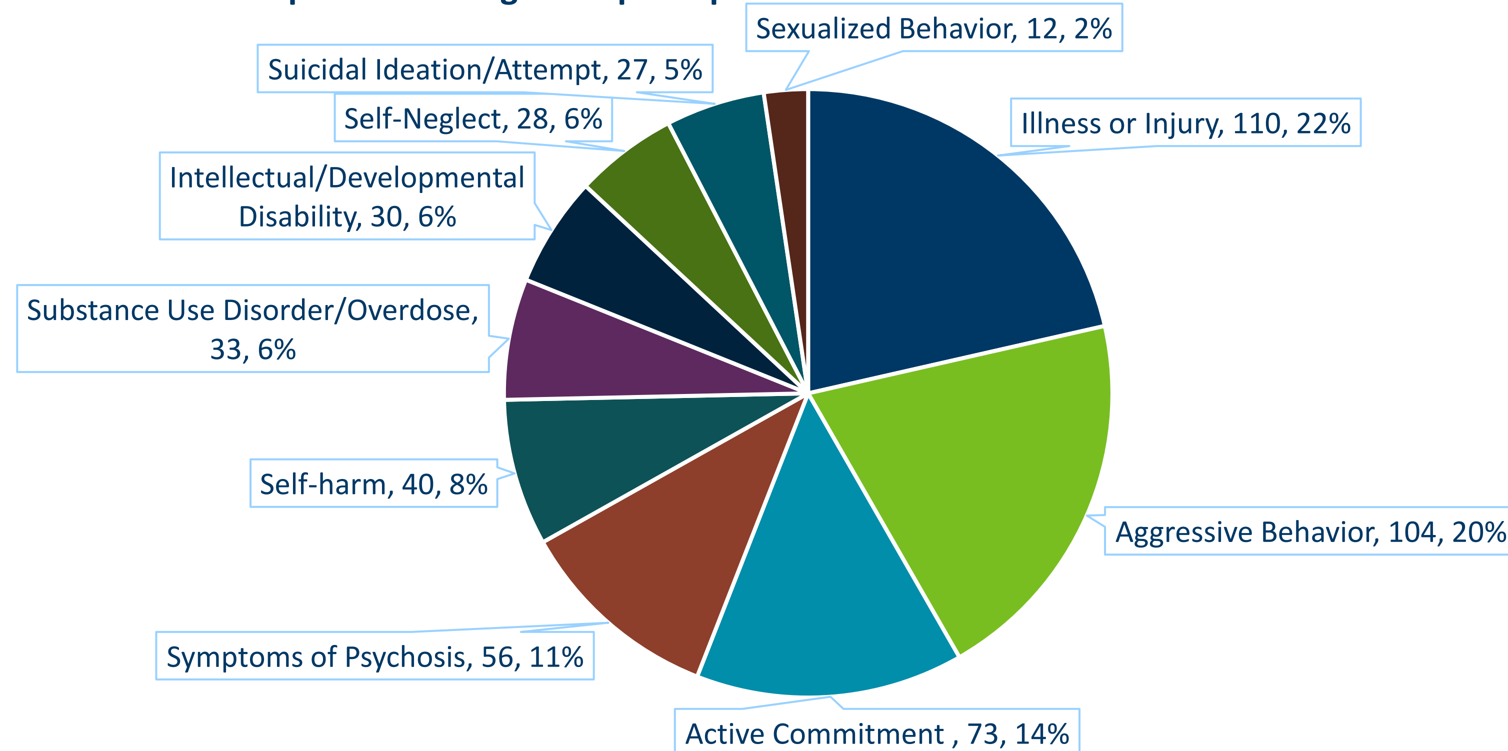
Reason for Referral to Complex Transitions (Hospitalization)

Complex Transitions Length of Hospitalization



Support Needs People Experience

- Illness or Injury
- Aggressive Behavior
- Active Commitment
- Symptoms of Psychosis
- Self-harm
- Substance Use Disorder/Overdose
- Intellectual/Developmental Disability
- Self-Neglect
- Suicidal Ideation/Attempt
- Sexualized Behavior



Recommendation 1 of 5: Expanding Regional Capacity and a Statewide System

Continuation of the Acute Care Transitions Advisory Council as a standing unit with specific directions to:

a. Continue to provide guidance to DHS while expanding the representation of diversity of the council and

b. Establish bi-directional communication systems between the council and current regions

c. Recommend statewide data collection and analysis tool that protects privacy and creates better opportunities for collaboration

Recommendation 2 of 5
Expanding Regional Capacity and a Statewide System

- Build on the Complex Transitions Team to develop three regional teams to support children and adults across the lifespan experiencing barriers to transitions from the Emergency Department and/or hospital.
- Establish funding for regions to flexibly and creatively fill support gaps in their region

Measurement and Evaluation System
ACTAC Recommendation 3 of 5

- Establish a state-wide data infrastructure that will improve communication systems, provide coordination/support to regions and monitor the development of a unified measurement system.

- Data sharing agreements need to be considered to protect person-level protected information

- Utilize Continuous Improvement models for analyzing data and adjusting approaches

Measurement and Evaluation System Recommendation 4 of 5

- Integrate measurement systems that monitor and evaluate geographic, racial, and ethnic disparities in acute care transitions while coordinating with existing statewide health equity systems change efforts in Minnesota.

Community Provider Capacity: Recommendation 5 of 5

Build short and long-term incentives for direct support staff, providers of existing waiver services and/or organizations that support children and adults while in hospital to assist with transition planning.

Questions

References

- Acute Care Transitions Advisory Council
  - Search internet: DHS Acute Care Transitions
- Acute Care Transitions Advisory Council Report and Recommendations
  - Search internet: Acute Care Transitions Advisory Council Report
- DHS Complex Transitions Team
  - Search internet: DHS Complex Transitions

DEPARTMENT OF HUMAN SERVICES

Thank You!

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