March 19th, 2024

Professional Distinction

Personal Dignity

Patient Advocacy

Chair Liebling
MN House Commerce Finance and Policy
Minnesota State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
Saint Paul, MN 55155

Chair Liebling and committee members,

With 22,000 members, the Minnesota Nurses Association (MNA) is the leading voice for professional nursing in the State of Minnesota. As leaders in labor and health care, we are a voice for frontline hospital nurses around the state who strongly work to ensure that patients in hospitals are not languishing without with receiving appropriate access to care and services at facilities best able to provide that support. Thus, we write in support of the priority admission bill, HF 4366

Healthcare in Minnesota used to be about taking care of each other. Our system of nation-leading care was built by passionate providers and community members working together to build up and sustain community hospitals across our state. But in recent years, we've seen the focus drift away from the bedside to the bottom line.

These misplaced priorities result in fewer critical care staff levels at the bedside, with serious consequences for care and working conditions in our hospitals. Healthcare workers face moral distress and leave the bedside in increasing numbers; patients wait longer for medicine or care, and experience more adverse outcomes; and the risk of violence goes up for patients and workers in our hospitals.

Hospitals are now one of the most dangerous places to work in Minnesota. In 2021, 97 percent of surveyed Minnesota nurses had observed violence in the workplace, including verbal and physical intimidation and assaults, and 62 percent reported that they consider patient safety to be at risk at their hospital due to management inaction.

Without the proper support, patients with increased needs are not able to transfer to facilities where they are able to receive the care they need within the structure of support meant for their needs. It's vital that we properly invest in our state healthcare facilities to help alleviate patient boarding in our acute-care hospitals. Removing the 48-hour rule and creating better systems to receive patient needs and open bed opportunities will also help with patient boarding issues and decrease repeated violence against direct care staff.

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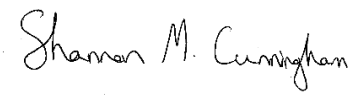
AFL-CIO

We thank Rep. Edelson for taking on this challenging issue and working to find productive solutions. We ask that you please pass HF 4366 and look forward to seeing the continued work on this important legislative to meet patient needs and worker safety.

Thank you,



Shannon M. Cunningham
Director of Governmental and Community Relations
Minnesota Nurses Association

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 19, 2024

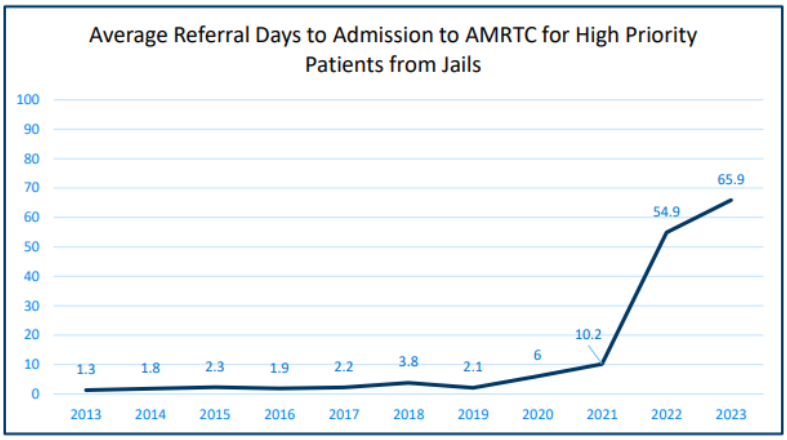
Chair Liebling and Health Finance and Policy Committee members:

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.

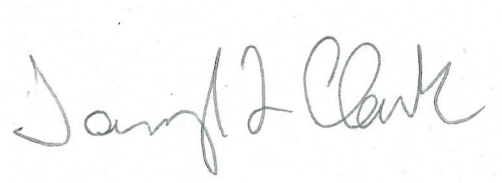
There are several areas still to be addressed in this bill's language to align it with the Task Force Recommendations. We appreciate that Rep. Edelson is committed to ensure the language reflects a consensus on the task force recommendation. Issues to address include:

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

March 19, 2024

Chair Liebling and Committee Members
House Health Finance and Policy Committee
477 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.