

“ReThink Mental Health”

Welcome

Nancy McKenzie



Executive Director, PATH of North Dakota

North Dakota Behavioral Health Visioning: Introducing Change through Legislation

Senator Judy Lee
Representative Kathy Hogan
Representative Pete Silbernagel



ReThink Crisis

Kathy Lonski, FM Ambulance
Andrew Larson, Sanford Health



Crisis

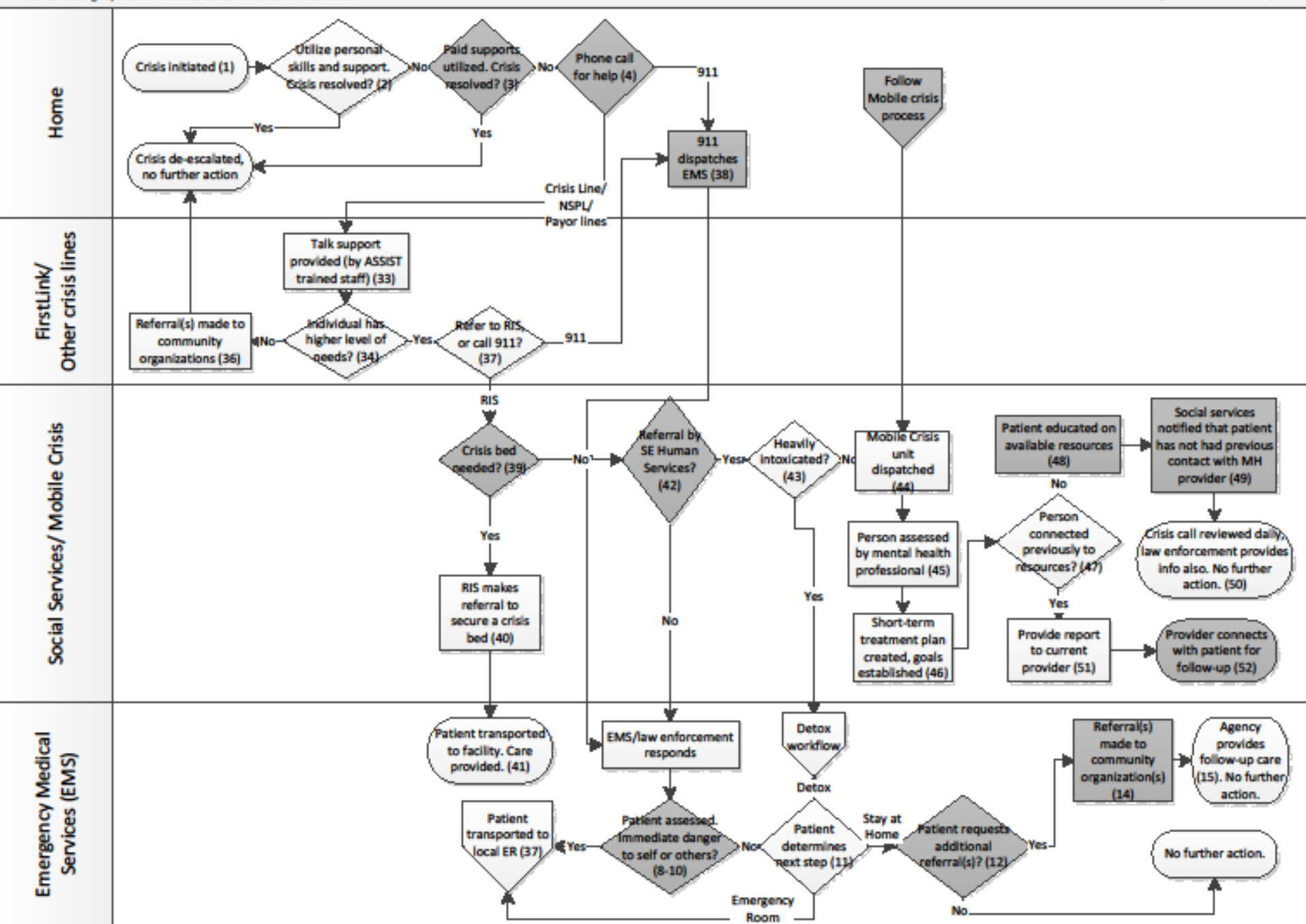
Workgroup

ANDREW LARSON, SANFORD HEALTH

&

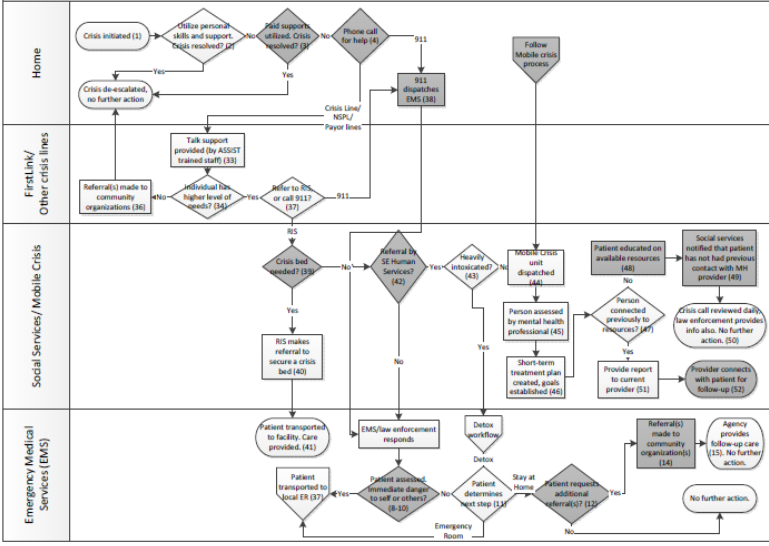
KATHY LONSKI, F-M AMBULANCE





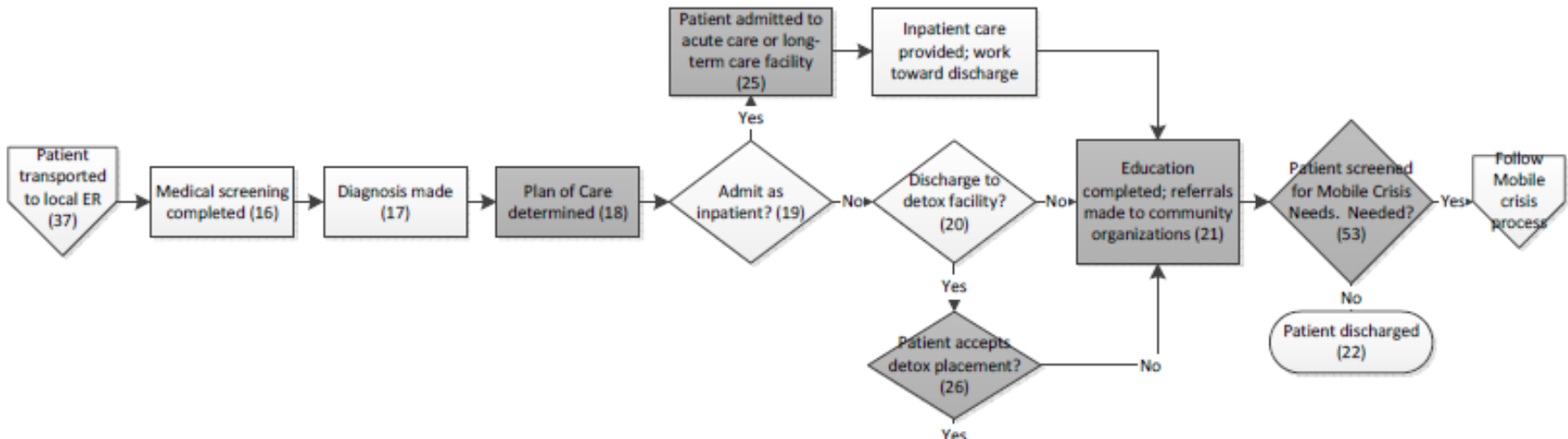
****NOTE: Dark grey boxes indicate areas with identified issues

Updated: October 31, 2014

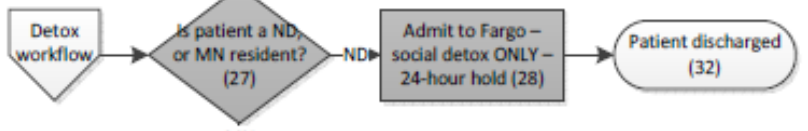


Continuation of process

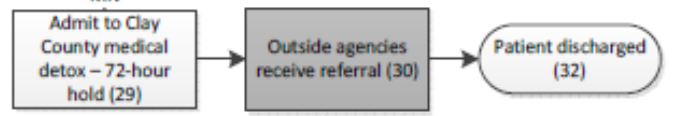
Emergency Department



Detox - North Dakota



Detox - MN



Issue List

- ▶ Multiple points of access
- ▶ No follow up
- ▶ Perceived HIPAA issues
- ▶ Laws & policies differ between ND & MN

31B – Need follow-up services for better success
31C – Detox releases at the point of withdrawal when individuals are more likely to relapse
28 – Limited mandatory hold time
33 – Appropriate training and continuing education training for staff manning crisis hotlines
22 – Lack of follow-up post-discharge from ED visit
21A – Level of navigation assistance determined by level of autonomy – consumer doesn't necessarily leave with appointments made
21E – Judicial process barriers for kids post-crisis treatment
21B – Release of Information has timebound limits (good for one year)
21C – Delay in release of information to outside agencies
25D – Short-term options become long-term treatments at the wrong level of care
18B – Repeat same pathway even for frequent callers; may not be needed
18C/3 – Limited night/weekend community services
* - Lack of funding/reimbursement for preventive care
25B – Limited resources for addressing needs at the community level

ISSUE LIST (by step):

1 – Lack of peer supports
4 – Response for kids (under 18) – needs different approach than adults
13 – Follow-up to engage in other services for patients that have refused transport
12 – “Pull” (vs. Push) for information to outside source – depends greatly on the knowledge level of the responder
14 – HIPAA issues in sharing information between agencies
10A – Mental health providers perceive individual needs differently than EMS/law enforcement
10B – Liability risk
6B – Mixed messages over where to call for help
18A – Limited case management during ED visit
25A – Long-term care hospitals function for acute care needs – leaves limited (or no) true long-term care options
36 – “Cold” handoffs between agencies – onus on consumer to reach out
21D – No two-way feedback loop on outside referrals – relies on “pushing” information

* - Can't share “Top 10” list between agencies to identify people with high needs
* - No statewide options for medical behavioral health patients (like Anoka)
* - Physical care needs are not addressed when there is a presence of a mental health issue
* - “Grey area” between protection of rights vs. long-term care needs
38 – Gap in mobile crisis services if no EMS/law enforcement are dispatched
43 – Subjective decision-making process
44 – Limited number of available mobile crisis units; multiple calls
48 – “Cold” handoff – consumer must reach out for services
49A – Mobile crisis doesn't know where person is receiving services; could have helped with consents for info sharing
49B – For substance abuse, misinformation about who can access mobile crisis – when referral is missed, it's a race against the clock to connect with resources, or wait until the next crisis
53 – Unsure whether this is consistently happening

What if...

- ▶ There was one place for people in a mental health crisis to go for help?
- ▶ They were connected with the services they need at the time of crisis?
- ▶ We could continue the intervention seamlessly between agencies until the crisis was over?
- ▶ There was follow up long after the crisis to provide long term mental health stability

An example of something working...

- ▶ West Fargo Police Department has embraced the Mobile Mental Health model.
- ▶ Officers activate Mental Health from the scene.
- ▶ Ambulance is usually cancelled.
- ▶ WFPD sends a report of all mental health encounters to SEHS each day so that follow up can occur.

The Numbers

WF Ambulance Calls

Count of Incident Number	
Incident Date	Total
2012	128
2013	149
2014	118
Grand Total	395

2014 =

31 fewer ambulance calls

36 WF mobile crisis calls

Mobile Crisis by City

Month	Fargo	West Fargo	Other
January 2014	36		
February 2014	21		
March 2014	47	1	1
April 2014	22		
May 2014	19		
June 2014	17	13	
July 2014	15	4	
August 2014	25	2	1
September 2014	18	3	1
October 2014	15	7	
November 2014	34	6	
Totals By City	269	36	3
Grand Total	308		

What if...

▶ We could expand this concept to Fargo and Moorhead.

- ▶ WF Chief Reitan to discuss idea with other Chiefs
- ▶ Re-focus on Mobile Mental Health availability by paramedics

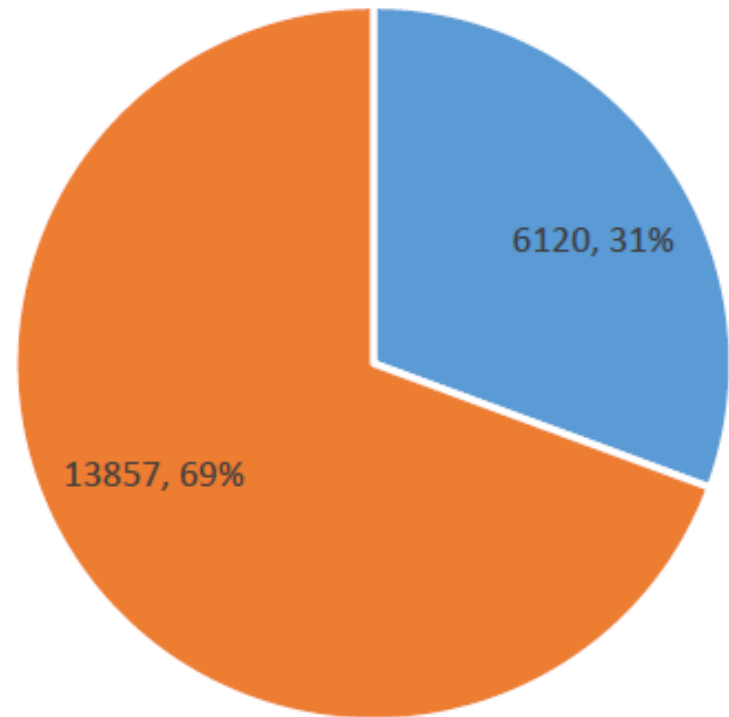
▶ The Facts

- ▶ Since January 2014, ND SE Region Mobile Crisis Team was **dispatched 308** times to assist individuals experiencing a mental health crisis.
- ▶ Out of the 308 crisis dispatches, only **9** of those calls ended with individual **going to hospital**.
- ▶ Out of the 308 crisis dispatches, **law enforcement** were involved in only **14** of those calls.
- ▶ 244 crisis dispatches were for adults and 64 crisis dispatches were for children.

What if...

- ▶ **Continue to improve upon the process as it grows**
 - ▶ SEHS, Solutions and Lakeland to watch for ways to create more openings and staffing.
 - ▶ Address issues promptly so it continues to improve

2013 F-M Ambulance Overall Calls



- Substance or Mental Health Involvement
- No Substance or Mental Health Involvement

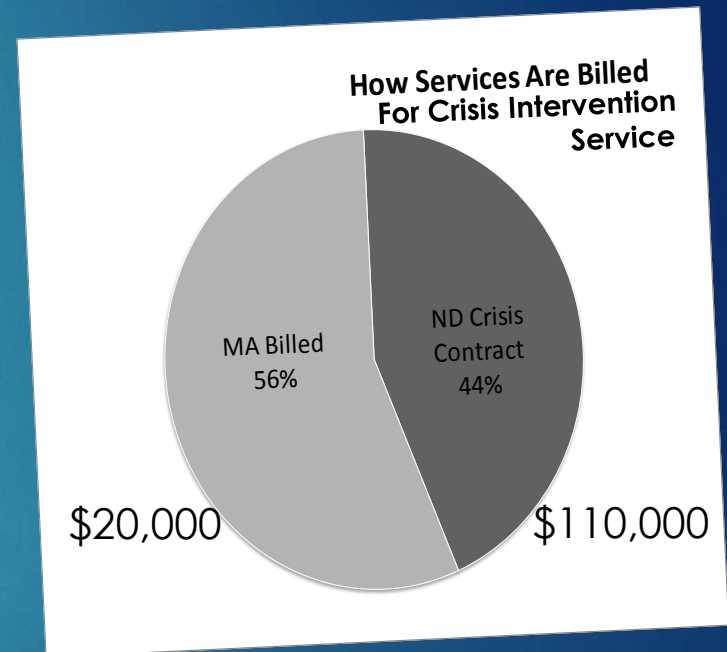
The Money

- ▶ **ND SE Region Mobile Crisis Services are available 5pm-8am weekdays and 24 hrs on weekends and holidays.**


Financial Impact:

Total cost for ND SE Region Mobile Crisis Services: January – November, about **\$130,000 for 308** crisis dispatches and on-call services.

Cost of being hospitalized: About \$1200/day. Without ND SE Region Mobile Crisis Services as an option, there was a high probability of the 299 crisis calls that did not end in **hospitalization** may have resulted in hospitalization and could have **cost \$358,800 just for one day** in hospital. Average length of stay in hospital can be between 5-10 days which could have cost between 1.79 million and 3.59 million dollars.



- ▶ **Potential Savings: 1.49 million – 3.29 million dollars. This estimate does not include the potential cost of law enforcement or EMT services.**



The best crisis response
still means nothing if we
don't address the
treatment, rehabilitation
and aftercare.

HIPAA and Other Regulations Affecting Cross Agency Collaborations: Challenges and Opportunities for Improved Care

Michael J. Mullen
Special Assistant Attorney General



HIPAA and Mental Health ReThink Mental Health Initiative

HIPAA and Other Regulations Affecting Cross Agency Collaboration: Challenges and Opportunities for Improved Care

Michael J. Mullen, J.D.
Moorhead, MN
Dec. 10, 2014

Disclaimer

This is educational information, **not** legal advice. You must seek legal advice from your own attorney.

The views set forth in this presentation do not reflect the views of any government agency.

What is HIPAA?

- It is **HIPAA**, not “HIPPA,” or “HIPPO” [or “hippos” from the greek]
- **HIPPA** is short for the Health Insurance Portability and Accountability Act. “HIPAA” refers to the federal rule establishing minimum requirements [a floor] for the privacy of health information

Who Does HIPAA Apply To?

- HIPAA applies to any health care provider who submits electronic claims for reimbursement. So, except for a dinosaur provider who operate solely with paper records, or a cash only boutique dermatology practice that does not submit electronic claims to insurance companies—**HIPAA applies!**
- HIPAA also applies to all health plans both government [Medicare and Medicaid, DOD, VA, IHS, etc.] and private health insurance companies & HMOs

Who Does HIPAA Apply To?

- HIPAA also applies to a “business associate” of a covered entity, such as a law firm, accounting firm, or information technology company that receives “protected health information” in connection with services it provides “for or on behalf of” the covered provider or health plan.
- A Business Associate generally must comply with the HIPAA Privacy & Security Rules the same as a “covered” Health Care Provider.

HIPAA Does NOT Apply To

- HIPAA Does NOT Apply To:
 - Law Enforcement Officials
 - Schools [except maybe a medical school]
 - Employers [but HIPAA does apply to an employer's health plan]

HIPAA Sets a Floor on Privacy

- HIPAA does not supersede (“preempt”) a State law that provides more protection to health information than the privacy rule [45 C.F.R. § 160.203]
- Minnesota law provides more protection than the HIPAA privacy rule because, except in certain important situations, a patient must “consent” to the disclosure of their health information [See Minn. Stat. § 144.293 subd. 2]
- North Dakota Law was harmonized to match the HIPAA privacy rule— So, protected health information may be disclosed w/o consent for the treatment or payment for health care

HIPAA Keeps Information “Locked In”

- HIPAA [and more “stringent” MN laws] keep information “locked in”—i.e., PHI may be disclosed only as required or permitted by law
- In contrast, “Henry Veryfit” may send daily reports on his pulse, blood pressure, & blood oxygen level to his MD—and post this information on Facebook
- But his doctor may disclose Henry’s reports on his vital signs **only as permitted by law**

ND Health Information Network

- The North Dakota Health Information Network, known as “NDHIN,” “makes medical record sharing faster and easier for authorized doctors, [nurses, other providers,] and patients.” <http://www.ndhin.org>
- NDHIN is a closed system; **only** “participants” & authorized users may access health information through NDHIN. Others are “locked out.”
- NDHIN is an “opt out” health information exchange (HIE). If an individual opts out, their information cannot be accessed. (There is also an option under which an individual can opt out, except for an emergency.)
- Minnesota has an HIE known as the Community Health Information Collaborative (CHIC). Essentia Health is a member of CHIC.

Terminology I

- PHI - “protected [individually identifiable] health information [A defined HIPAA term]
- “Health data” - Data that relates to the past, present, or future treatment, or payment for treatment for health care. Virtually the same meaning as PHI. Minn. Stat. § 144.291 subd. 2(c)
- “Private data on individuals” is data that is “(a) not public; and (b) accessible to the individual subject of those data.” Minn. Stat. § 13.02 subd. 12

Terminology II

- “Release of Information”- **ROI** [used by Soc. Serv.]
- “Consent to Disclose Information” [Minn. Law]
- “Authorization” to disclose PHI - [HIPAA term]
- All are roughly the same - a signed form permitting disclosure of specific “PHI” to specific persons, for specific purposes, for a specific time period, etc.

Minnesota: General Exception to “Consent”

- When an individual is treated at a MN facility, consent to disclose a “health record” is not required in a medical emergency. Minn. Stat. § 144.293 subd. 5(1). [Minn. Health Records Act.]
- “Medical emergency” means “medically necessary care which is immediately needed to preserve life, prevent serious impairment to bodily functions, organs, or parts, or prevent placing the physical or **mental health** of the patient in serious jeopardy.” Minn. Stat. § 144.291 subd. 2(f).

MN: Emergency Exception to Consent: Mental Health II

- Minnesota Statutes 13.46 Subd. 2(a)(10) provides: Data on individuals collected, maintained, used, or disseminated by the welfare system are private data on individuals, and **shall not be disclosed except [i.e., may be disclosed]**: “(10) to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the individual or other individuals or persons. . . .”
- Minn. Stat. § 13.46 Subd. 2(d) provides: “Mental health data. . . are not subject to the access provisions of. . . [Minn. Stat. § 13.46 subd. 10(b)].” So, another responsible authority in the welfare system **may not** access private data data “when access is necessary for the *administration and management of programs.*” Minn. Stat. § 13.46 subd. 10(b).

MN Welfare System: Defined

- “Welfare system” includes the Department of Human Services, **local social services agencies, county welfare agencies**, private licensing agencies, the public authority responsible for child support enforcement, **human services boards, community mental health center boards**, state hospitals, state nursing homes, the ombudsman for mental health and developmental disabilities, and persons, agencies, institutions, organizations, **and other entities under contract to any of the above agencies to the extent specified in the contract** .
Minn. Stat. § 13.46 Subd. 1(c). [Section 13.46 is part of ch. 13 known as the “Minnesota Government Data Practices Act.”]

MN: Exception to Consent: Mental Health III

- Minn. Stat. § 13.46 Subd. 7(a). Mental health data are private data on individuals and [may] not be disclosed, except:
 - (1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;
 - (2) pursuant to court order;
 - (3) pursuant to a statute specifically authorizing access to or disclosure of mental health data [e.g., MN law: duty to warn, Minn. Stat. § 148.975 [psychologist & psychological practitioner] or as otherwise provided by this subdivision [disclosure to police]; or
 - (4) with the **consent** of the client or patient.

Minn Standard Consent to Disclose PHI Form

- If a situation does NOT come within an exception (permitting disclosure without consent), a MN provider should use the—
- Minnesota “Standard Consent to Disclose PHI Form”

<http://www.health.state.mn.us/divs/hpsc/dap/consent.pdf>

Minn. Consent to Disclose Form “Must” be Accepted as Valid

- **Minn. Stat. § 144.292 Subd. 8. *Form.*** By January 1, 2008, the Department of Health must develop a form that may be used by a patient to request access to health records under this section. **A form developed by the commissioner must be accepted by a provider as a legally enforceable request under this section.**
- Note: the instructions to the form have the logo of the Minnesota Department of Health, “MDH” & the official seal of the state of Minnesota; its “OFFICIAL”

North Dakota Standard Authorization Forms

- In North Dakota, if the disclosure is NOT for treatment or payment (or otherwise required [e.g., “reportable conditions”], or permitted by law), use a HIPPA-valid “authorization”
- Sanford Authorization —
<http://www.sanfordhealth.org/content/pdfs/patientsvisitors/patientinformation/releaseofinformation.pdf>
- Essentia Health—
<http://www.essentiahealth.org/Uploads/Public/Documents/Essentia-Release-of-Medical-Information.pdf>

Continuity of Care Document

- The Continuity of Care Document (CCD) is an electronic document exchange standard for sharing patient summary information.
- The Continuity of Care Document (CCD) specification is an XML-based markup standard intended to specify the encoding, structure, and semantics of a patient summary clinical document for exchange.

CCD: Data Included

- A “CCD” includes the following sections, each of which contains several data elements: Advance directives; Alerts; Encounters; Family history; Functional status; Immunizations; Medical equipment; Medications; Payers; Plan of care; Problem; Procedures; Purpose; Results; Social history; Vital signs. [Plus name, address, DOB. . .]

CCD: Technical Background

- "The CCD owes its existence to CCR and CDA," he said. "The CCR started out as a three-page paper document, which was used in patient care referrals." Additionally, the CCR was created by the Massachusetts Department of Public Health and included information necessary for providers to effectively continue care. "Since it was a very successful document in the transfer of care scenario, the Massachusetts Department of Public Health teamed up with ASTM and the Massachusetts Medical Society to create an electronic version of CCR," said Brull. Eventually, he continued, ASTM combined efforts with HL7 to construct the CCD document, which includes all the same content of the CCR, but under the architecture of the CDA [clinical document architecture].
- The CCD has 17 fields or categories of information.

Disclosure to Person Assisting With an Individual's Care

- A provider covered by HIPAA may disclose [“IAW” next slide requirements] to a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, the protected health information [PHI] directly relevant to:
 - A. Such person's involvement with the individual's care;
or
 - B. Payment related to the individual's health care.
- 42 C.F.R. § 164.510(b)(1), (2) and (3).

Disclosure to Person Assisting With an Individual's Care [II]

- A provider may disclose PHI directly relevant to a patient's care to: a family member, other relative, or a close personal friend of the individual, or any other person identified by the individual, if the Provider:
 - (i) Obtains the individual's agreement;
 - (ii) Provides the individual with the opportunity to object to the disclosure, and the individual does not express an objection; or
 - (iii) Reasonably infers from the circumstances, based the exercise of professional judgment, that the individual does not object to the disclosure.
- Or if the individual is not available or consent:cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, **in the exercise of professional judgment**, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care

Disclosure to Person Assisting With an Individual's Care [Minn.]

- MN law may be more stringent than HIPAA, and require the provider to obtain a signed Minnesota “consent” form from the patient before disclosing PHI to an individual “assisting with an individual’s care.”

Tarasoff Warning

- Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 354 (Cal. 1976)
- “When a therapist determines . . . that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.”
- MN law duty to warn Minn. Stat. § 148.975 [psychologist & psychological practitioner]; Minn. Stat. § 148B.1715 [Marriage & Family Counselors]; Minn. Stat. § 148E.240 subd. 6 [social workers] ~~ maybe other providers?
- North Dakota has no statute or Supreme Court opinion on Tarasoff, but as 46 states have a statute or judicial decision on the duty to warn— prudence suggests providers should act “as if” the duty may apply in North Dakota [NOTE: *The prior sentence is NOT legal advice, but purely general guidance a provider might consider in consultation with their legal counsel*]

HIPAA: disclosures to avert a serious threat to health or safety

- Under HIPAA, A provider may, [1] consistent with applicable law and [2] standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure:
 - (i)(A) Is necessary to prevent or lessen a **serious and imminent threat** to the health or safety of a person or the public; and
 - (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
- 45 C.F.R. § 164.512(j). This is the “HIPAA” *Tarasoff* Rule

42 C.F.R. Pt. 2: Emergency

- “Patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of **treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.**” 42 C.F.R. § 2.51(a).
- “Immediately following disclosure, the drug treatment program [must] document the disclosure in the patient's records, setting forth in writing: (1) The name of the medical personnel to whom disclosure was made and their affiliation with any health care facility; (2) The name of the individual making the disclosure; [and] (3) The date and time of the disclosure.” 42 C.F.R. § 2.51(c).

FERPA: Consent or w/o Consent in Emergency

- FERPA is the Family Educational Rights and Privacy Act of 1974
- FERPA generally requires a signed and dated written consent before a school discloses personally identifiable information from an education record. 34 C.F.R. § 99.30.
- FERPA permits disclosure of educational records w/o consent in an emergency “if knowledge of the information is necessary to protect the health or safety of the student or other individuals.” See 34 C.F.R. §§ 99.31(a)(10) and 99.36. [Similar to *Tarasoff*]

Imminent is not Necessarily Immediate

- “The synonyms used to define imminent: near, coming, close, approaching, gathering, on the way, forthcoming, looming, menacing, brewing, impending, upcoming, on the horizon, in the pipeline, near at hand. In summary: An imminent danger is an anticipated danger that is likely to happen, is impending, and is separated by space or time. This impending danger could be one hour, one day, or an unknown time away but is still imminent.”
- JH Rick Massimino MD, Recovery Model: Mental Health Recovery Model Applied to Severely Mentally Ill, “Imminent vs Immediate Danger” [found at: <http://recoverymodel.com/id14.html>]
- REMEMBER: This is one expert’s view, **not legal advice.**

Disclosure to Law Enforcement: MN

- “Notwithstanding. . . any other law. . . , a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:
 - (1) client or patient is currently involved in **an emergency** interaction with the law enforcement agency; **and**
 - (2) data is **necessary to protect the health or safety** of the client or patient or of another person.”
- Minn. Stat. § 13.46 Subd. 7(c) [~ like *Tarasoff*].
- The scope of disclosure under paragraph (c) “is limited to the minimum necessary for law enforcement to respond to the emergency.” Minn. Stat. § 13.46 Subd. 7(c).

Disclosure by Law Enforcement: MN

- Data created or collected by a MN law enforcement agency which document the agency's response to a request for service. . . shall be **public government data** [including]:
 - (a) date, time and place of the action; (f) a brief factual reconstruction of events associated with the action; (h) names and addresses of any victims or casualties unless the identities of those individuals qualify for protection under subdivision 17; (i) the name and location of the health care facility to which victims or casualties were taken. . . Minn. Stat. § 13.82 Subd. 6.
- A law enforcement agency must withhold the victim's ID if "the object of the call is to receive help in a mental health emergency." Minn. Stat. § 13.82 Subd. 17(f)(2).

In ND Police May Disclose 911 Information to EMS

- An audio recording of a request for emergency services or of a report of an emergency, or a written transcript of such an audio recording, is an exempt record as defined in section 44-04-17.1 and **may be used only for public safety purposes and for the delivery of law enforcement, fire, medical, or other emergency services.** N.D.C.C. § 57-40.6-07(4).
- So, in ND—911 call information may be disclosed to EMS, the hospital ED, etc.

Takeaway # 1

- If the individual is treated in ND [at Sanford, Essential, or Prairie St. Johns], then HIPAA & **North Dakota law apply**, AND the provider can disclose PHI to:
 - A family member, other relative, or a close personal friend of the individual, or any other person identified by the individual as permitted by 45 C.F.R. § 164.510(b)— w/o any “formal” signed “consent to disclose” [*But in MN may need signed consent*]; or
 - Another provider for treatment of the individual [ND]

Takeaway # 2

- If the individual is treated at a Minnesota health care facility, get the individual to sign the Standard MN consent to release health information form

QUESTIONS

- Since disclosure of mental health information is **ALL CLEAR NOW**, and because of time limitations, no questions may be asked at this time!
- **LOL !!!**

42 C.F.R. Pt. 2 Programs

- The Sanford ER is not a designated drug & alcohol abuse treatment “program” subject to the 42 C.F.R. Part 2 restrictions on disclosing PHI. Also, it appears Essentia does not have a designated “program” subject to the 42 C.F.R. Part 2.
- Prairie St. John’s has a designated “program” subject to the 42 C.F.R. Part 2.
- Prairie St. Johns is not a “Participant” in the ND health information network [at this time].

Minors: Mental Illness

- In MN, a minor 16 years of age or older may consent to hospitalization, routine diagnostic evaluation, and emergency or short-term acute care to treat mental illness. Minn. Stat. § 253B.03 Subd. 6(d).
- In ND, except for a “life-threatening” emergency situation [when a minor of any age may be treated without the consent of the minor's parents, N.D.C.C. § 14-10-17.1], a minor (<18 years of age) may not be treated for mental illness w/o parental consent. See N.D.C.C. § 14-10-17.

Minors: Drug Abuse

- In MN, a minor of any age may receive treatment for drug and alcohol abuse without parental consent. Minn. Stat. § 144.341 Subd. 1.
- In North Dakota, a minor age 14 and over may receive treatment for drug and alcohol abuse without parental consent. N.D.C.C. § 14-10-17.

Pareto 80/20 Rule

- The Pareto principle is named after Vilfredo Pareto. It is built on his observation (among others) that 80% of the land in Italy was owned by 20% of the population. and thus, more generally things like:
 - 20% of the input creates 80% of the results
 - 20% of the workers produce 80% of the results
- So, while you need to respond to 100% of the calls for assistance, if you focus on the 20% of the clients who need help most often, you will likely take care of 80% of the **effort needed** for crisis assistance!

Prairie St. John's

- Prairie St. John's is able to accept medically stable patients (with no active legal involvement) on a MN Emergency or Peace/Health Officer Hold and also able to initiate MN Holds and Commitment. This is the result of a MN Civil Commitment Contract between Prairie St. John's and Clay County, and is valid throughout the state of MN. Clay County acts as a "host county" for all of Minnesota. See - <http://prairie-stjohns.com/referrals/holds-and-commitments/>
- For additional information, download the Prairie St. John's MN "Hold Card." Found at: http://prairie-stjohns.com/pdf/MN-Hold-Card_2010-01-20.pdf

MN Case Managers

- Persons with serious and persistent mental illness may have a case manager either because the client has requested one or because the court has appointed one. Unless the court has specifically ordered the release of information or if the assessment is done by the case manager's agency, the client must consent in order for the case manager to obtain a copy of the client's diagnostic assessment. **However, once the case manager obtains a copy of the assessment**, the assessment and other client data may be shared with the client's family, the advocate, service providers, and significant others in order to develop and implement the individual community support plan. Minn. Stat. § 245.4711, subd. 4 and 5. The consent of the client is not necessary to disseminate the information to these people if the client has been provided a **Notice of Privacy Practices** in which these people have been identified as potential recipients of the data. *Data Practices Manual*, MENTAL HEALTH DATA [MN DHS]

Pre-Commitment Screening Team [MN]

- In Minnesota, a **Pre-Commitment Screening Team** “[i]n conducting the investigation required by. . . subdivision [1], . . . shall have access to all relevant medical records of proposed patients currently in treatment facilities. Minn. Stat. § 253B.07 Subd. 1(b).
- “Prior to filing a petition for commitment of or early intervention for a proposed patient. . . [t]he designated agency shall appoint a screening team to conduct an investigation.” Minn. Stat. § 253B.07 Subd. 1(a).

People with Lived Experience at the Core

Robyn Priest
PeerLink 



RETHINK MENTAL HEALTH

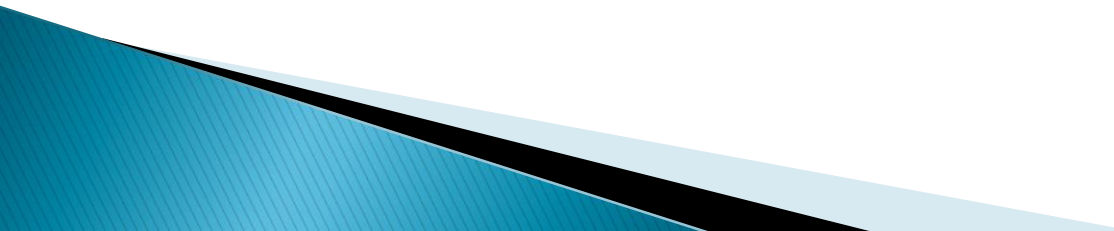
People with Lived Experience at the Core

This presentation is made possible by grant funding from the Substance Abuse
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SAMHSA Strategic Initiatives

Six strategic directions:

- ▶ Prevention of Substance Abuse and Mental Illness
 - ▶ Health Care and Health Systems Integration
 - ▶ Trauma and Justice
 - ▶ **Recovery Support**
 - ▶ Health Information Technology
 - ▶ Workforce Development
- 

SAMSHA Recovery Definition

A process of change through which individuals improve their **health and wellness**, live a **self-directed life**, and strive to reach **their full potential**

Four major dimensions that support a life in recovery:

- ▶ *Health*
 - ▶ *Home*
 - ▶ *Purpose*
 - ▶ *Community*
- 

Leading Change 2: A Plan for SAMHSA's Roles and Actions 2015–2018

Goal 4: Recovery Support

Goal 4.4: Promote peer support and social inclusion of individuals with or in recovery from mental and substance use disorders in the community

Peer Support

Peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain.

Mead, Hilton, & Curtis, 2001



Peer Support

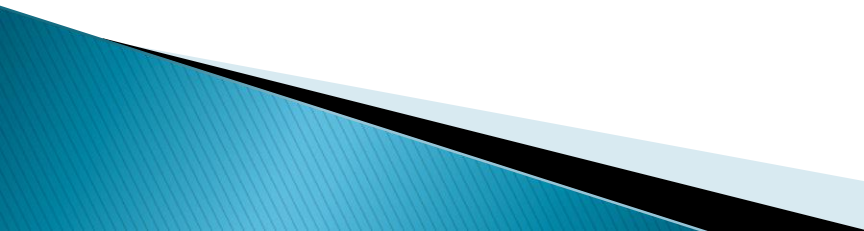
Peer support is rooted in the knowledge that “hope is the starting point from which a journey of recovery must begin.” Peer support workers can inspire hope and demonstrate the possibility of recovery. They are valued for their authenticity because they can relate to the challenge and have found their way to recovery.

Peer Support is NOT

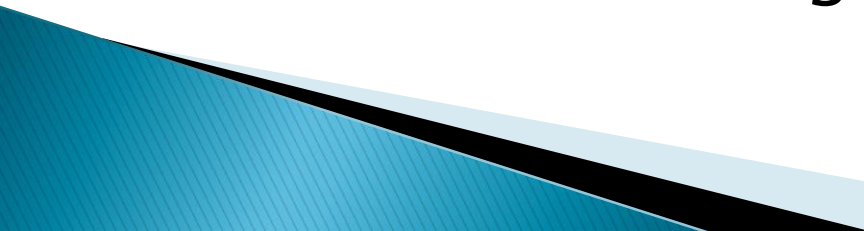
Grabbing someone off the street and saying
“ you have a lived experience/you’re a family
member, so your it”

or

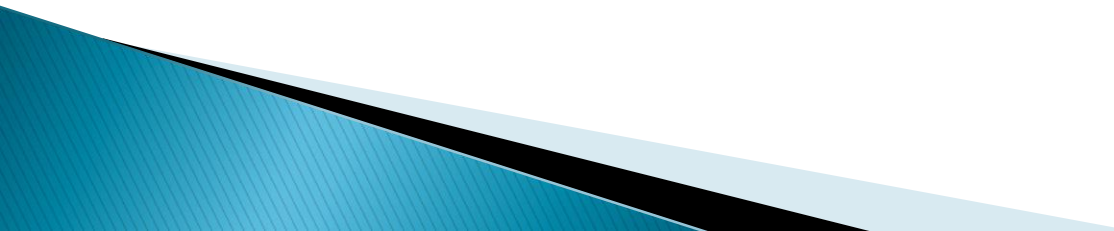
Saying
“ you work at our service and have a lived
experience/you’re a family member so you
must be doing peer support”



Peer Support is NOT

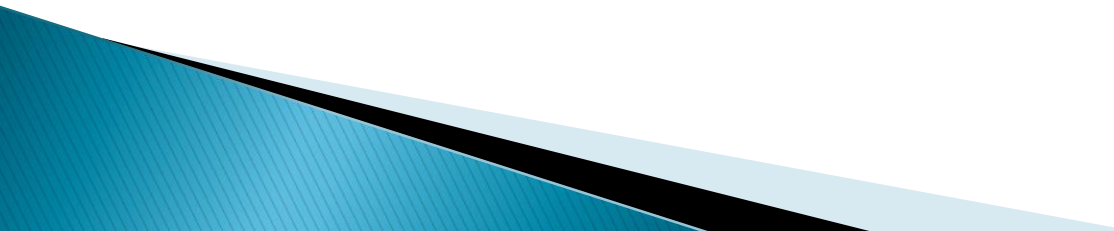
- Helping
 - Friendship
 - Enabling
 - Therapy/counselling
 - Pushing an agenda
 - Forever
 - Casual
 - Fixed
 - About PSWs superior recovery
 - About PSWs having the power
- 

So What IS Peer Support

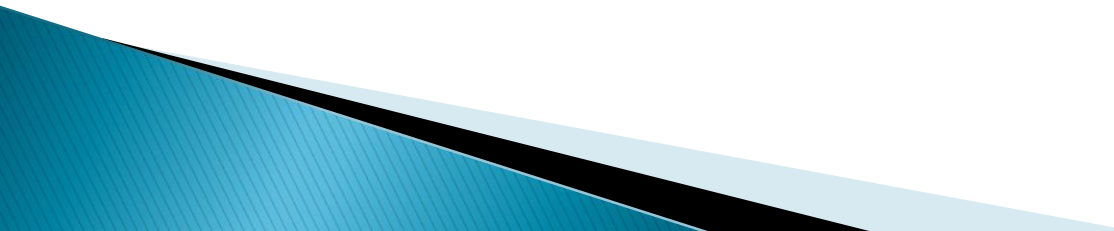
- ▶ A supportive relationship between people who have a common lived experience of a mental health challenge and/or addictions
 - ▶ It provides emotional and social support in the individual's recovery process
 - ▶ It is founded on key principles of respect, shared responsibility and mutual agreement of what is helpful
- 

What is The Difference?

Peer's said the difference between clinicians and peer support was:

- ▶ Power Relationships – reciprocal, egalitarian, self-determination, voluntary, choice, social justice, empowerment
 - ▶ Identification with Each Other – comradery, community, non discrimination, acceptance, understanding of issues, recovery, hope
- 

Fundamentals of Peer Support

- Lived experience
 - Power of hope and recovery
 - Self Determination
 - Mutuality/Equality – empathetic and equal relationships
 - Dignity, Respect and Social Inclusion
 - Personal growth and Learning
 - Health and Wellness
- 

Peer Jobs

Peer Navigators

Peer Bridgers

Emergency/Crisis Workers

Forensic Workers

Recovery Coaches, Peer Mentors, Peer Recovery Specialists
(*addiction field terminology*)

Harm Reduction Workers (*addiction or co-occurring
field terminology*)

Court Liaison Workers

Community Support Workers

Peer Jobs

Emergency Room Workers

ACT Peer Support Workers

Drop in centre workers

Employment Workers

Warmline Workers

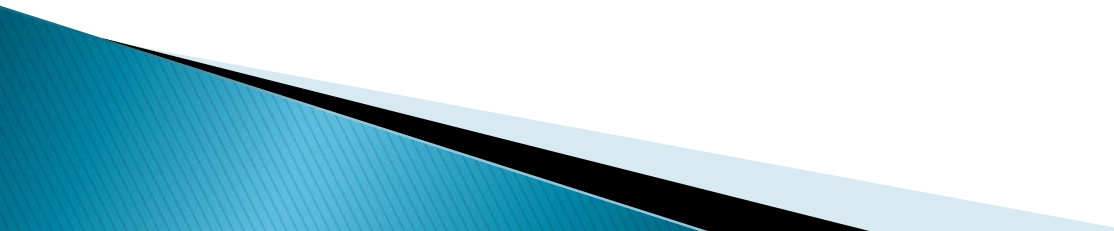
Inpatient Unit Workers

Housing Workers

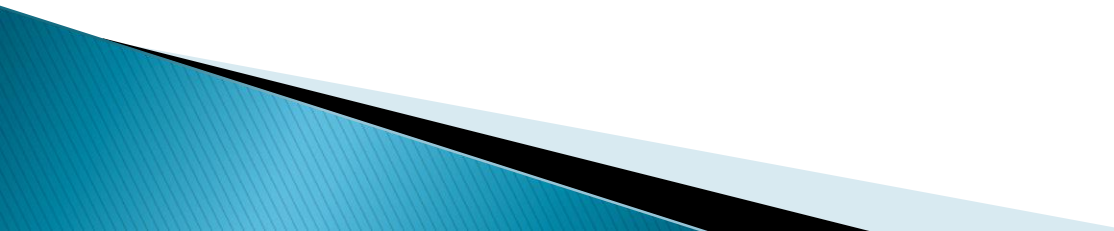
Crisis Respite Workers



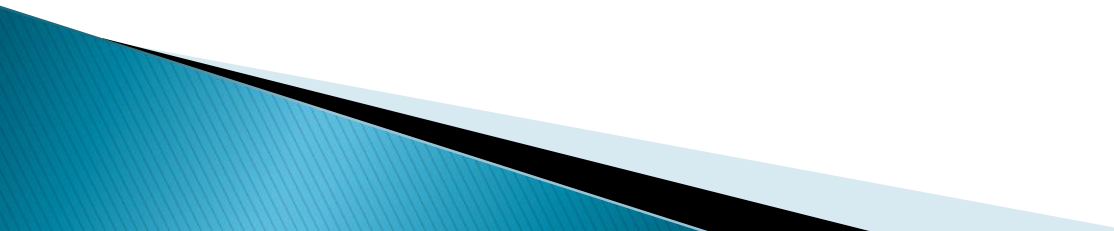
Common Issues Worldwide – Peers in Mainstream Services

- ▶ Support only from upper management and no buy in throughout the organization
 - ▶ Clash of values/policies/etc
 - ▶ Isolation from other peers
 - ▶ Limited/no peer training opportunities
 - ▶ Limited/no peer supervision
- 

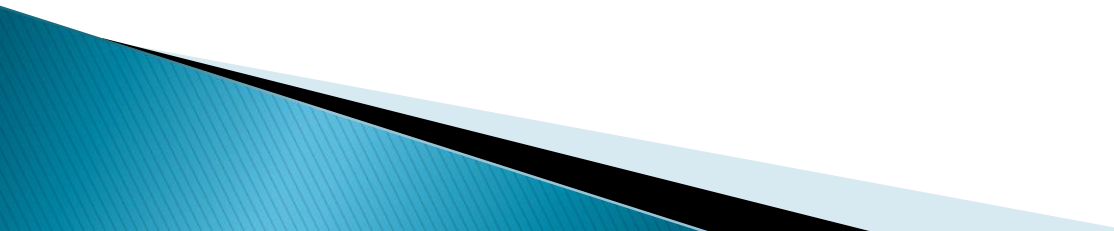
Elements of Success

- ▶ Designated peer jobs with more than one peer worker employed – non tokenistic
 - ▶ Peer advisory committees
 - ▶ Specified peer training for peer workers and joint training opportunities with other staff
- 

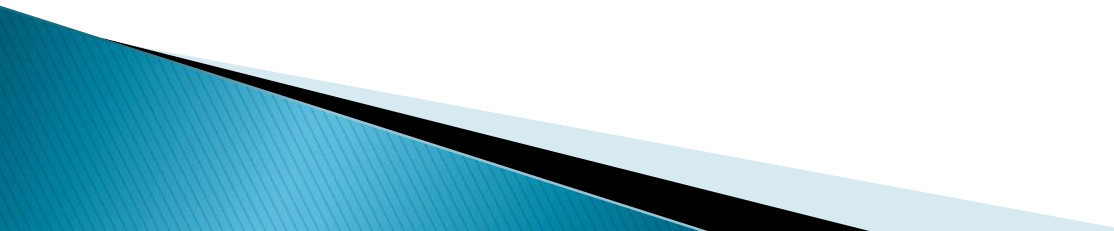
Elements of Success

- ▶ Specified peer supervision
 - ▶ All employees receive training on peer support and its added value – peer presenters
 - ▶ Peer developed and led evaluation activities
 - ▶ Commitment by all
- 

Why Peer Support?

- ▶ With workforce shortage – untapped workforce
 - ▶ Cost effective
 - ▶ People trust in peer support and can work through issues in different way with each other
 - ▶ Can be in every community no matter how isolated
 - ▶ We know what we need
- 

Why Peer Support?

- ▶ “It saved my life”
 - ▶ “I am less isolated”
 - ▶ “Gave me a sense of being normal”
 - ▶ “I wasn’t just my diagnosis”
 - ▶ “I can just be who I am and not pretend”
- 



Robyn Priest
Lead Project Coordinator
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This presentation is made possible by grant funding from the Substance Abuse
and Mental Health Services Administration (SAMHSA).
Grant # SMSM059955



Lunch

Sponsored by UCare and
Solutions Behavioral Healthcare
Professionals



12:30
Dessert Walk



CARES: ReThink Housing: A Model for Local Innovation, Integration and Governance

Carla Solum, Coordinator West Central & Northwest MN Continuum of Care
Laurie Baker, Executive Director FM Coalition for Homeless Persons
Colleen Murray, Director of Family & Community Svc. at Lakes & Prairies



CARES

Coordinated Assessment Referral and Evaluation System

HOW CARES STARTED

1. Foundation in place:

- Partnership: Strong Community Partnerships already existed (FMCHP & others).
- Plan: Ending Long Term Homeless Plan identified need for change.

2. Common purpose & focus:

- Developed initial goals & vision
- Developed guiding principals
- Adapted to fit reality

3. Started with willing, with goal to expand.

- Informed & invited everyone, but needed starting point.
- Aware that we needed to gain additional input and support for success

KEY POINTS TO STARTING THE PROCESS

1. Identify all areas of project

- Desired Purpose & Outcomes
- Potential Challenges
- Process and Steps

2. List all stakeholders and prioritize engagement

- Essential Partners
- Desired/Helpful Partners
- Bonus Partners

3. Keep goals and vision visible

- People come in and out of process so need to continually inform
- Remind us of why we are here
- Helps Communication in complex system
- Keeps project in scope & avoids mission creep

SYSTEMS CHANGE



“What if we don’t change at all ...
and something magical just happens?”

STEPS TO SYSTEM CHANGE

1. Accept that change is hard!
 - Some will continue to see change as threatening, scary or unneeded.
 - Continually need to re-embrace and reinforce change and shared vision.
 - Having tough discussion and attacking tough issues collectively
2. Focus on best practices
 - Don't recreate the wheel - research and examine evidence based tools available.
 - Be willing to adapt to community needs, but try EBP first.
 - Evidence based practices can save time, improve outcomes and support reason for change
 - Tested and uniform tools help provide better service (no assumptions, same language) and outcomes.
3. Focus on collaborative process & data driven outcomes and planning
 - Helps hold everyone accountable .
 - Identifies to better reach and serve persons who were slipping through the cracks.
 - Together we can do more. Share best practices and shared responsibility.
3. Just Try! Embrace that system will evolve and change – not creating perfect system first.
 - Reality of change & chain reaction
 - Unexpected chain reaction.
 - Vision and reality are not always in sync
 - Balance comprehensive evaluation with need to move forward.

CARES LEADERSHIP & PLANNING

1. INITIAL Leadership and Planning Process

- Ending Long-term Homeless Sub-committee in FM Area
- BUSH grant to fund FM Collaborative with expansion to WC and ND CoC regions.

2. CURRENT Leadership and Planning Process

a. Collaborative Effort

- a. Mandate that cover entire CoC region caused fast expansion.
- b. MOU between Continuums of Care, FMCHP, and White Earth Nation
- c. Continuums still responsible to adherence to federal mandate, but effort beyond mandate.

b. Joint Governance Board

- a. Elected & Advisory members
- b. Bylaws

c. Staff Support

d. CARES Partners

- a. Formal Partnership Agreement & Data Sharing Agreement
- b. Policy Manual

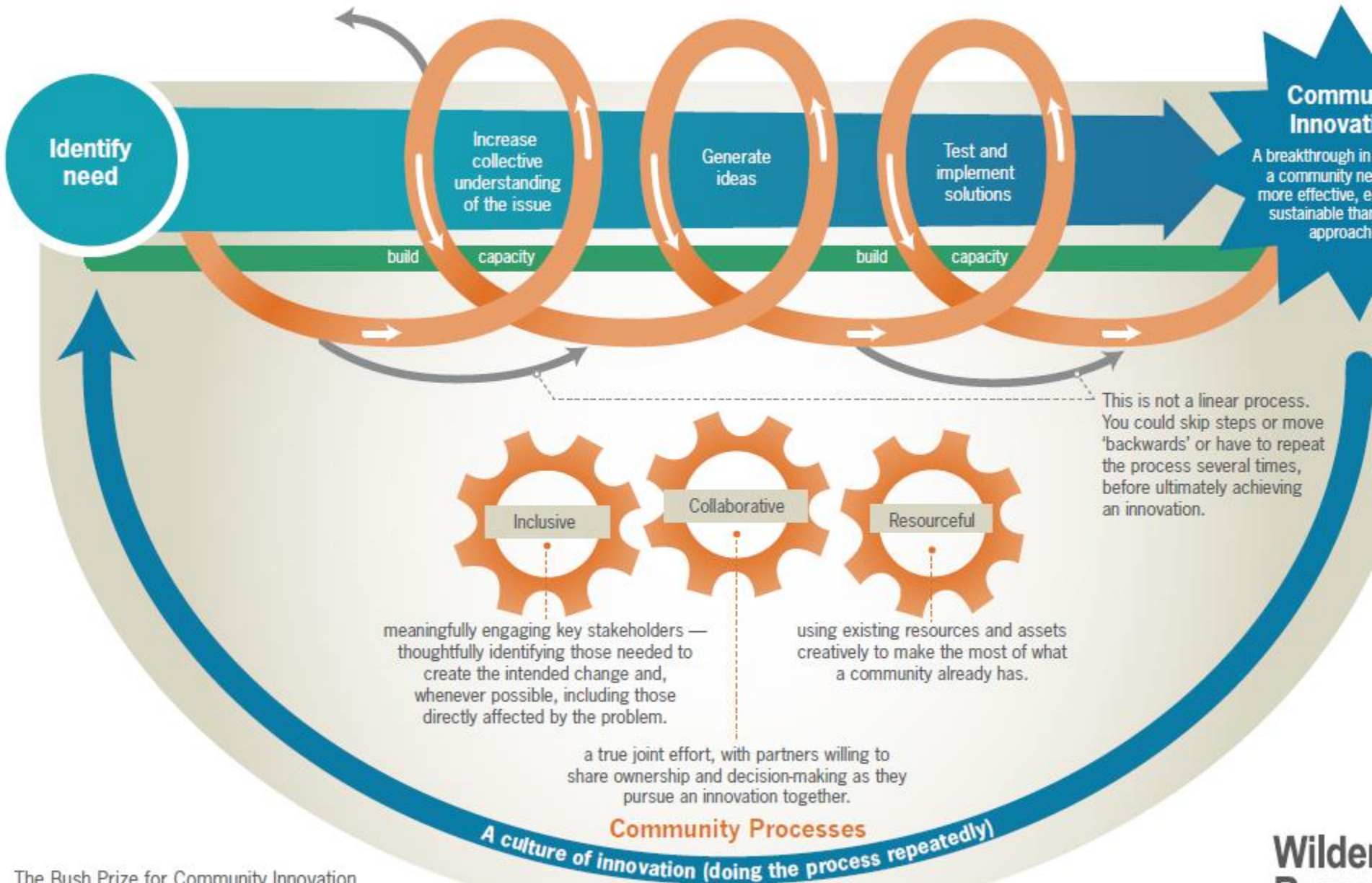
e. Committees: Protocols, Implementation, Data and Evaluation

f. Local provider – Prioritization meetings & Local decisions on Access/Assessment sites.

LESSONS LEARNED

1. Collaborative data helped identify and quantify gaps (unified diversion, housing case management)
2. Need to have defined start & end dates despite ambiguity of technology.
3. Technology is essential!
4. Macro vs. Micro - Connecting reality of day-to-day work with big picture
5. Communication requires variety and consistency (more visual learning, simplified, repetitive)
6. Growing need has kept it a priority – money is more competitive, economy, outcome based, non-profit change (feel good helpers vs. professional, data drive practices).
7. Silo vs. community approach –
 - Collective response and shared data allows us to do more things than we can do individually (resource sharing, big task seems more doable, better understanding of need).
8. **It's a continual process!!!!!!!!!!!!!!**
9. **Already seeing results –**
 - **People are being housed – especially hardest to house.**
 - **People need to be assessed once**
 - **Common Language**
 - **Others replicating effort**

The Community Innovation Process



Questions & Comments



Minnesota's Vision for Mental Health

Thomas J. Ruter
Director of Operations for Chemical and Mental Health Services
Minnesota Department of Human Services





Minnesota Department of **Human Services**

Mental Health 2015 to 2018

Thomas J. Ruter

Director of Operations

Chemical & Mental Health Services



Our mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our vision

Healthy People

Stable Families

Strong Communities



THE PROBLEM:

The mental health infrastructure is insufficient with too many gaps, structurally and financially fragile, limited service availability, and inconsistent measurement.

Olmstead

Olmstead is a key component of achieving a better state for all Minnesotans, and strives to ensure that Minnesotans with disabilities will have the opportunity, both now and in the future, to live close to their families and friends, to live more independently, to engage in productive employment and to participate in community life.



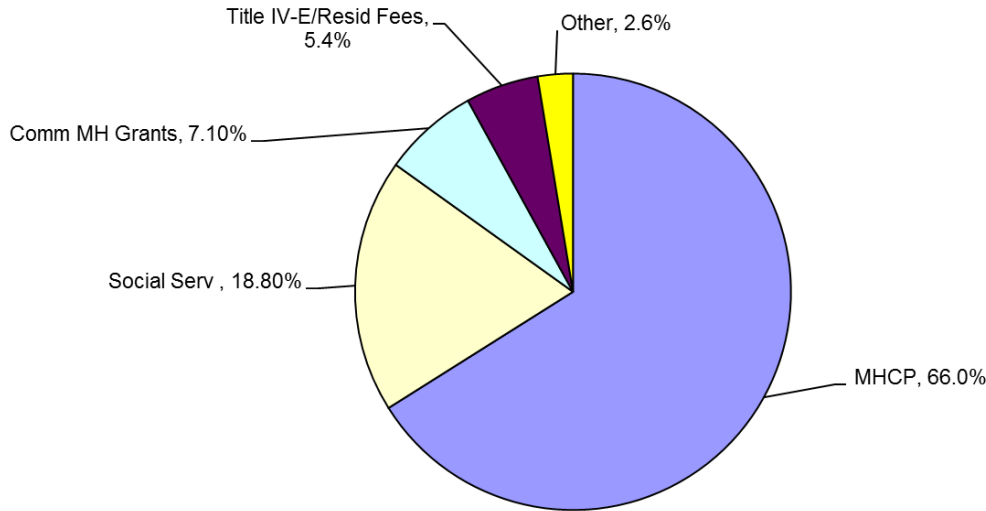
Core Mental Health Benefits...

- Case Management
- Assertive Community Treatment (ACT)
- Children's Therapeutic Services and Supports (CTSS)
- Adult Mental Health Rehabilitative Services (ARMHS)
- Crisis Response & Stabilization
- Intensive Residential Treatment Services

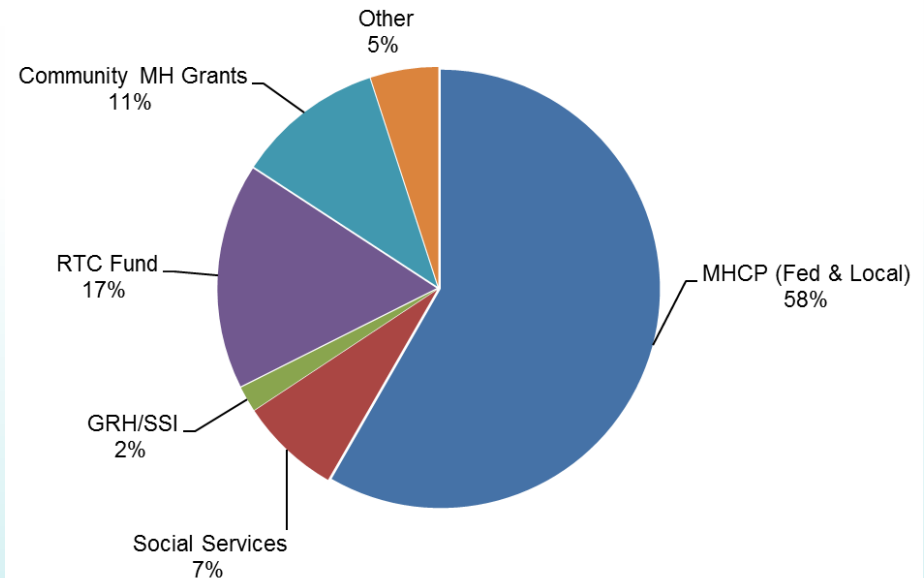


DHS spends \$930M on Mental Health (FY12)

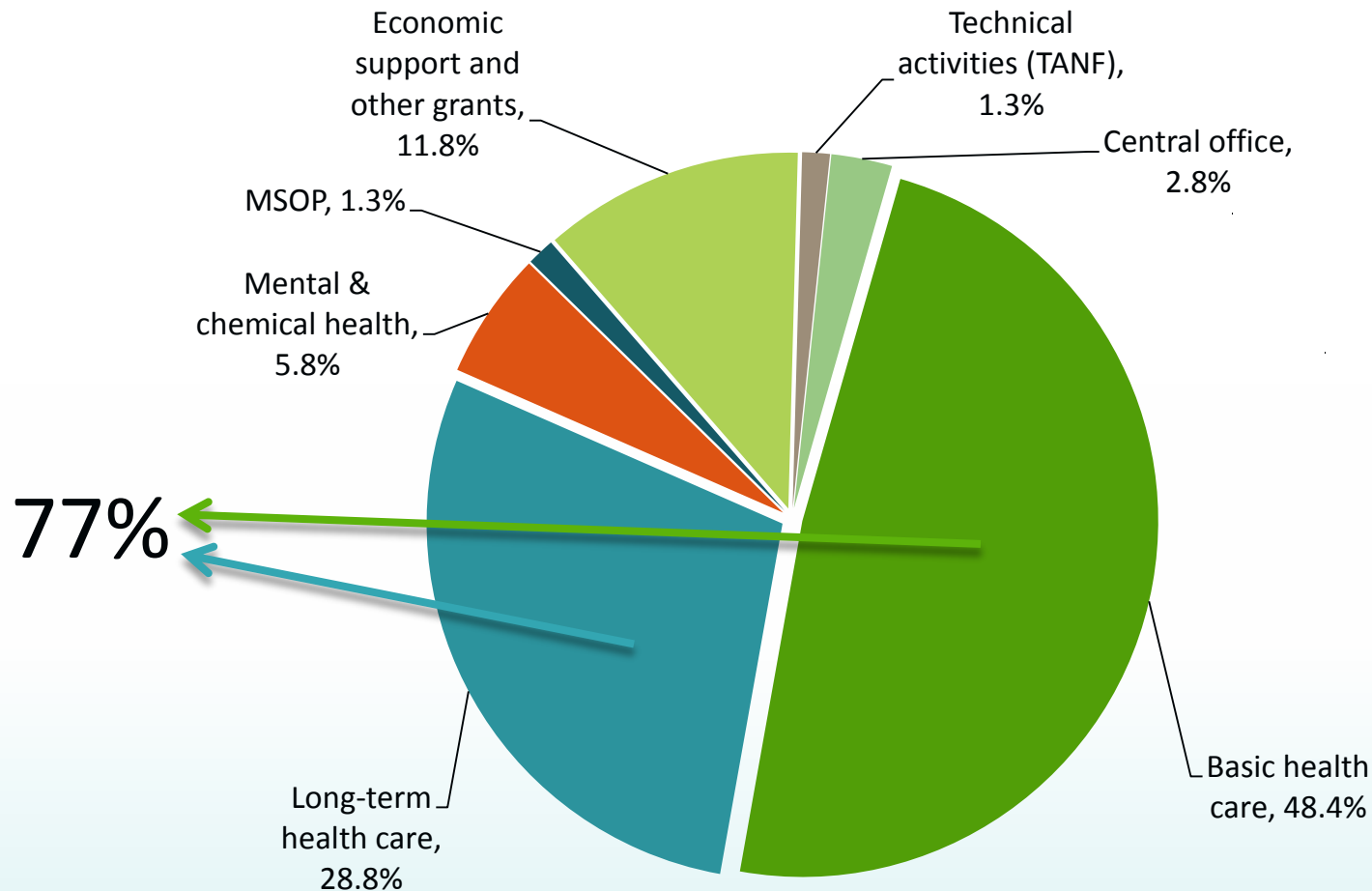
Children - Total Funding: \$276,209,000



Adults - Total Funding: \$654,506,000

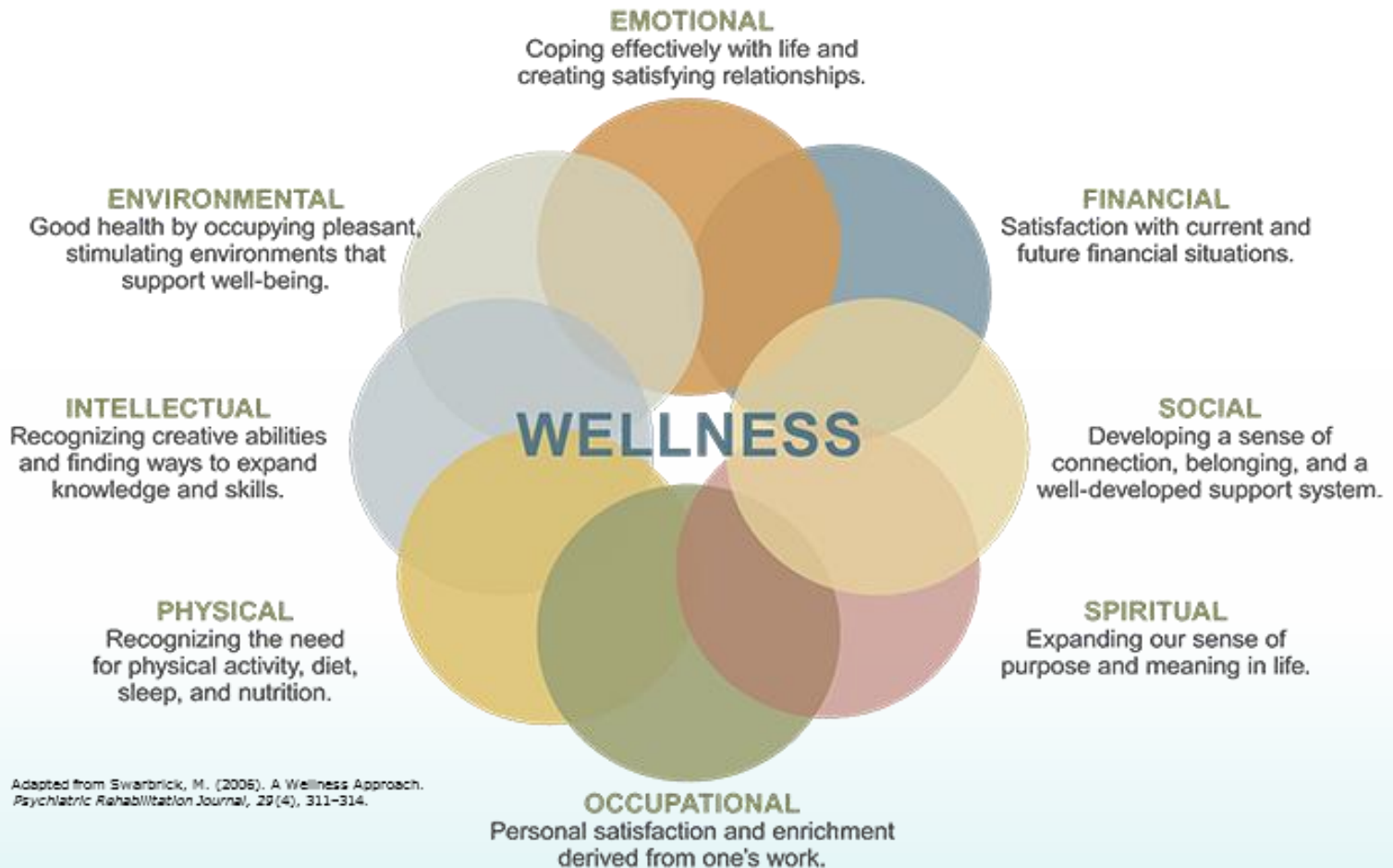


DHS spends 6% on mental & chemical health on grants to cover benefits not Medicaid eligible



2014 – 2015 direct appropriations for DHS
Source: Minnesota Management & Budget

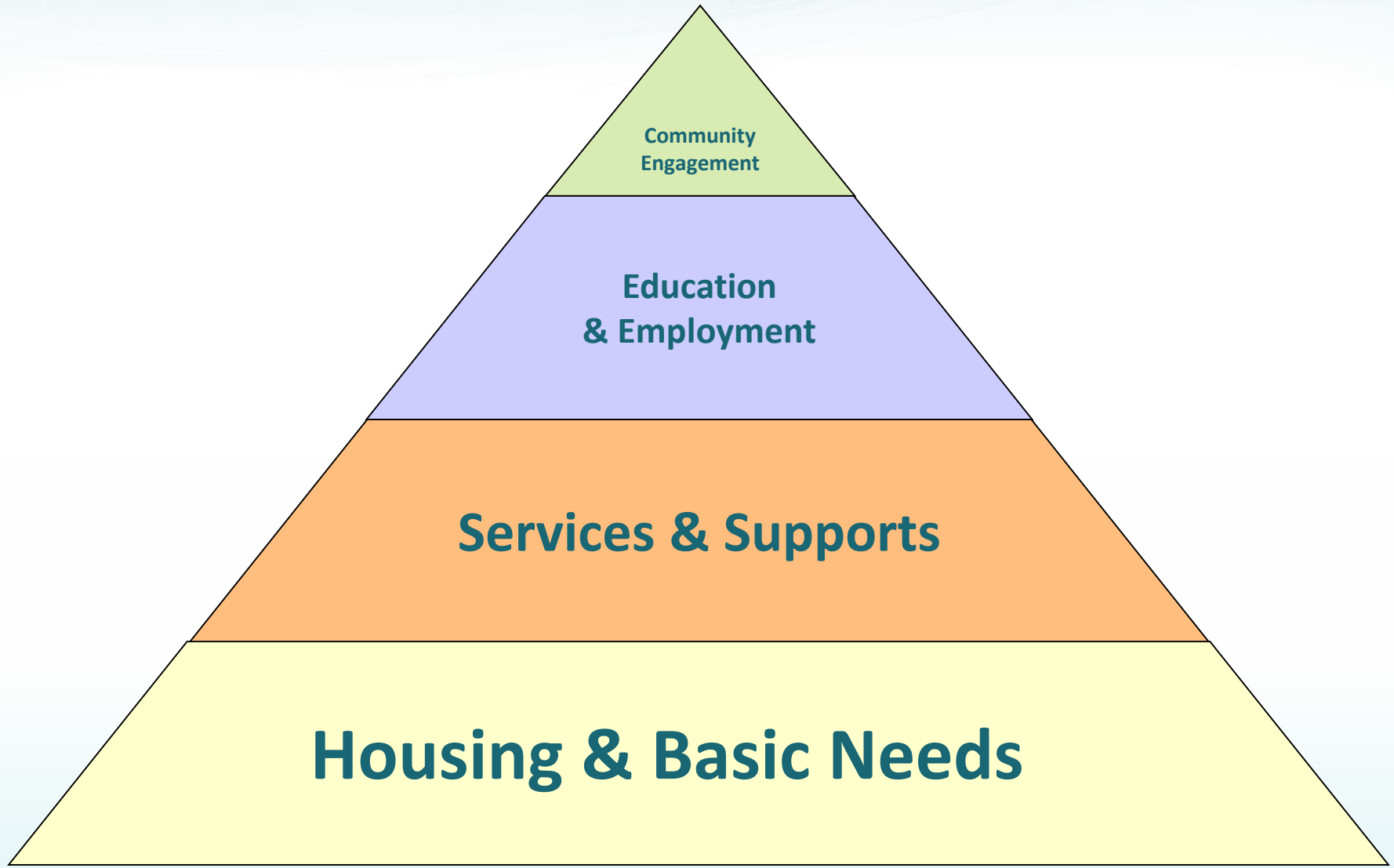
What is wellness?



Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal*, 29(4), 311-314.

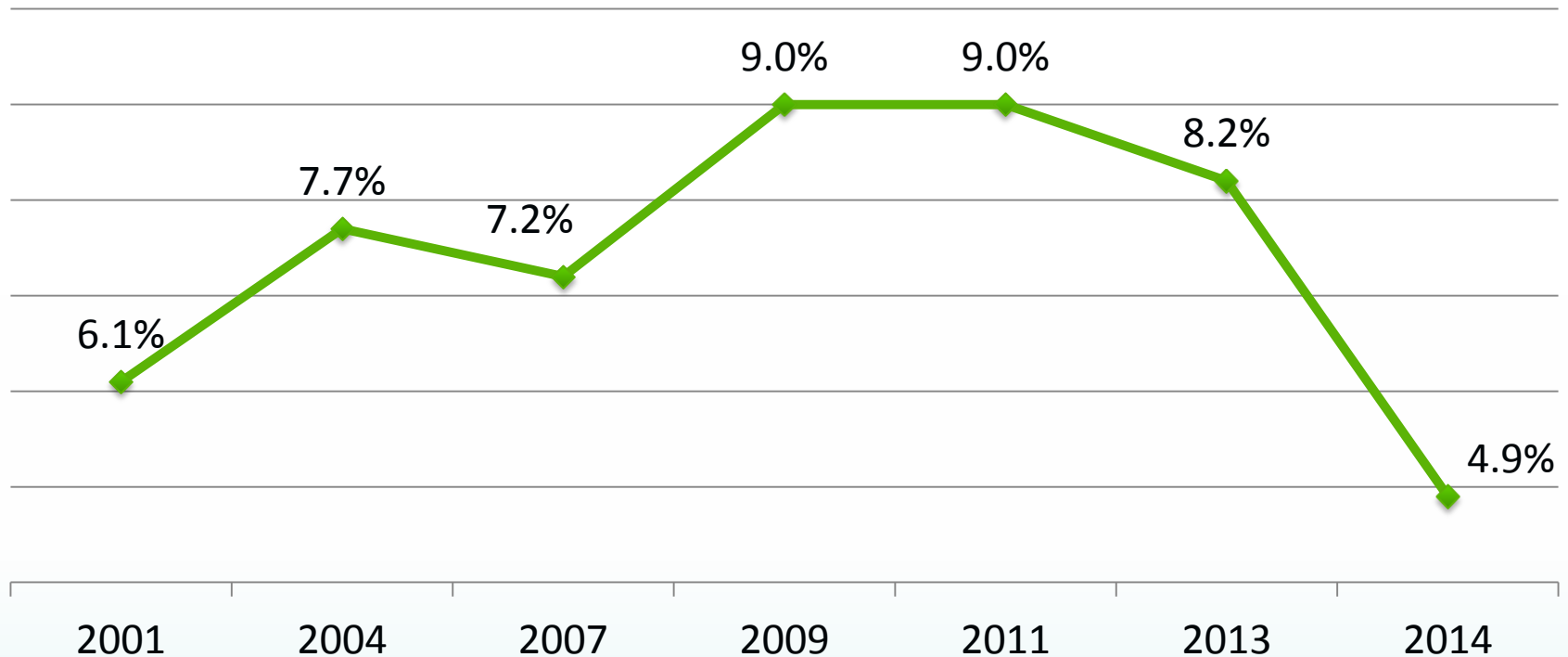


What leads to wellness?



We have invested in health care expansion to cover more Minnesotans

Percent of uninsured in Minnesota



Source: 2013 Minnesota Health Access Survey, Minnesota Department of Health and University of Minnesota, School of Public Health's State Health Access Data Assistance Center

What investments have we made?



*School-linked mental health grant announcement,
Edison High School, Minneapolis*

- School-linked mental health
- Crisis response for children and adults
- Increased some payment rates and new benefits established
- Access to family peer specialists

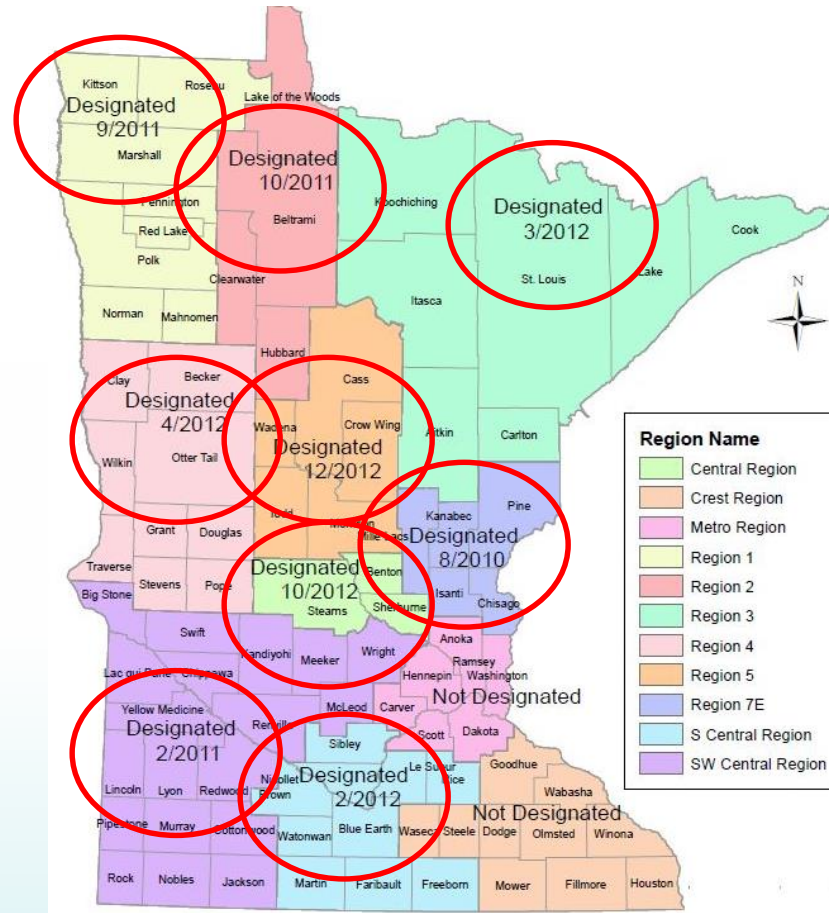
Challenges that still exist

- **Rates are often insufficient to cover the cost of services** - Riverwood Centers, which served some 3,000 clients, closed suddenly in 2014
- **Existing community capacity does not meet needs** - Anoka Metro Regional Treatment Center has a waiting list of 77
- **Lack of treatment services for the most acute children and adults** - The system does not have adequate resources for the most aggressive clients
- **Some children's services are not available in Minnesota** - We have between 300-400 children each year who would be best served in Psychiatric Residential Treatment Facilities
- **We have work force issues** - Most of Minnesota is designated as a Mental Health Professional Shortage Area
- **Focus has been on treatment and interventions, leaving prevention and early interventions behind**



Challenges that still exist

Minnesota Mental Health Professional Shortage Areas






Source: Minnesota Department of Health, Office of Rural Health, June 2014

Why is mental health our priority for 2015?

Nearly 30 years after passage of the state's Comprehensive Mental Health Act, the vision of a state-wide system of adult mental health services is far from complete.

Adult Mental Health Provider Availability		Ratings Based on Provider Location															
		Adult Mental Health Initiative Areas															
Adult Mental Health Service	Statewide Capacity	Anoka	BCOW	Carver Scott	Comm-UNITY	CREST	Dakota	Hennepin	NW 8	Ramsey-Washington	Region 2	Region 3	Region 4 South	Region 5+	Region 7E	South Central 10	SW 18
Inpatient Psychiatric Hospitalization	▼	▼	▼	⬮	▼	▼	▼	▼	▼	▼	●	▼	▼	▼	▼	▼	▼
Intensive Residential Treatment (IRTS)	▼	▼	▼	⬮	▼	▼	▼	▼	▼	▼	⬮	▼	▼	●	⬮	▼	●
Mobile Crisis	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	●	▼	▼	▼	⬮	▼	▼
Assertive Community Treatment (ACT)	▼	▼	⬮	⬮	▼	▼	▼	▼	⬮	●	⬮	▼	⬮	▼	⬮	⬮	●
Permanent Supportive Housing	▼	▼	▼	⬮	▼	▼	▼	▼	⬮	▼	⬮	▼	⬮	⬮	▼	⬮	⬮
Partial Hospitalization	▼	▼	⬮	⬮	▼	⬮	⬮	●	⬮	●	⬮	▼	⬮	⬮	⬮	⬮	▼
Residential Crisis Services	▼	▼	⬮	⬮	▼	▼	▼	▼	●	▼	⬮	▼	▼	⬮	⬮	▼	▼
Adult Rehabilitative MH Services (ARMHS)	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Case Management- MHTCM	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Medication Management	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼

 Service Meets Demand
  Limited Service Availability
  Red = No provider is located in this area.



Why is mental health our priority for 2015?

25 years after passage of the state's Comprehensive Mental Health Act, the vision of a state-wide system of children's mental health services is even less developed.

Children's Mental Health Provider Availability		Ratings Based on Provider Location												
		Children's Mental Health Region Areas												
Children's Mental Health Service	Statewide Capacity	1	2	3	4	5	6E	6W	7E	7W	8	9	10	11
Inpatient Hospitalization	▼	▼	⬮	▼	▼	⬮	▼	⬮	⬮	▼	⬮	▼	▼	▼
Psychiatric Residential Treatment Fac. PRTF	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮
Children's Residential Treatment CRT	▼	▼	⬮	▼	▼	⬮	⬮	⬮	▼	▼	⬮	⬮	▼	▼
Treatment Foster Care	▼	▼	⬮	▼	▼	▼	▼	▼	▼	▼	⬮	▼	▼	▼
Partial Hospitalization	▼	⬮	⬮	▼	▼	▼	▼	▼	⬮	▼	⬮	⬮	⬮	▼
Youth ACT	▼	⬮	⬮	⬮	⬮	▼	⬮	⬮	⬮	⬮	⬮	⬮	▼	▼
Day Treatment	▼	⬮	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Crisis Services	▼	▼	●	▼	▼	●	▼	●	●	▼	▼	▼	▼	▼
Case Management	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Family Peer Specialist	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮	⬮
Children's Therapeutic Serv&Supports CTSS	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
School-Linked	▼	▼	▼	▼	▼	●	▼	▼	⬮	▼	▼	▼	▼	▼
Early Childhood MH	▼	●	●	●	▼	●	●	●	▼	●	▼	▼	●	▼
Outpatient Treatment	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Psychiatry	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Diagnostic Assessment (0-5)	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼
Diagnostic Assessment (6-21)	▼	●	▼	▼	▼	●	▼	▼	▼	▼	▼	▼	▼	▼
Integrated PCP	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼	▼

Current as of 032714



Service Meets Demand



Limited Service Availability



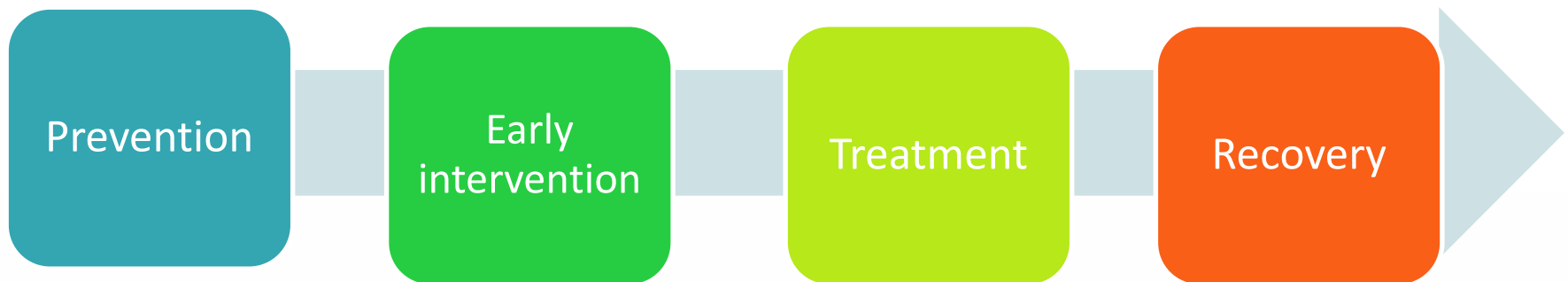
Red = No provider is located in this area.

Partner & stakeholder engagement

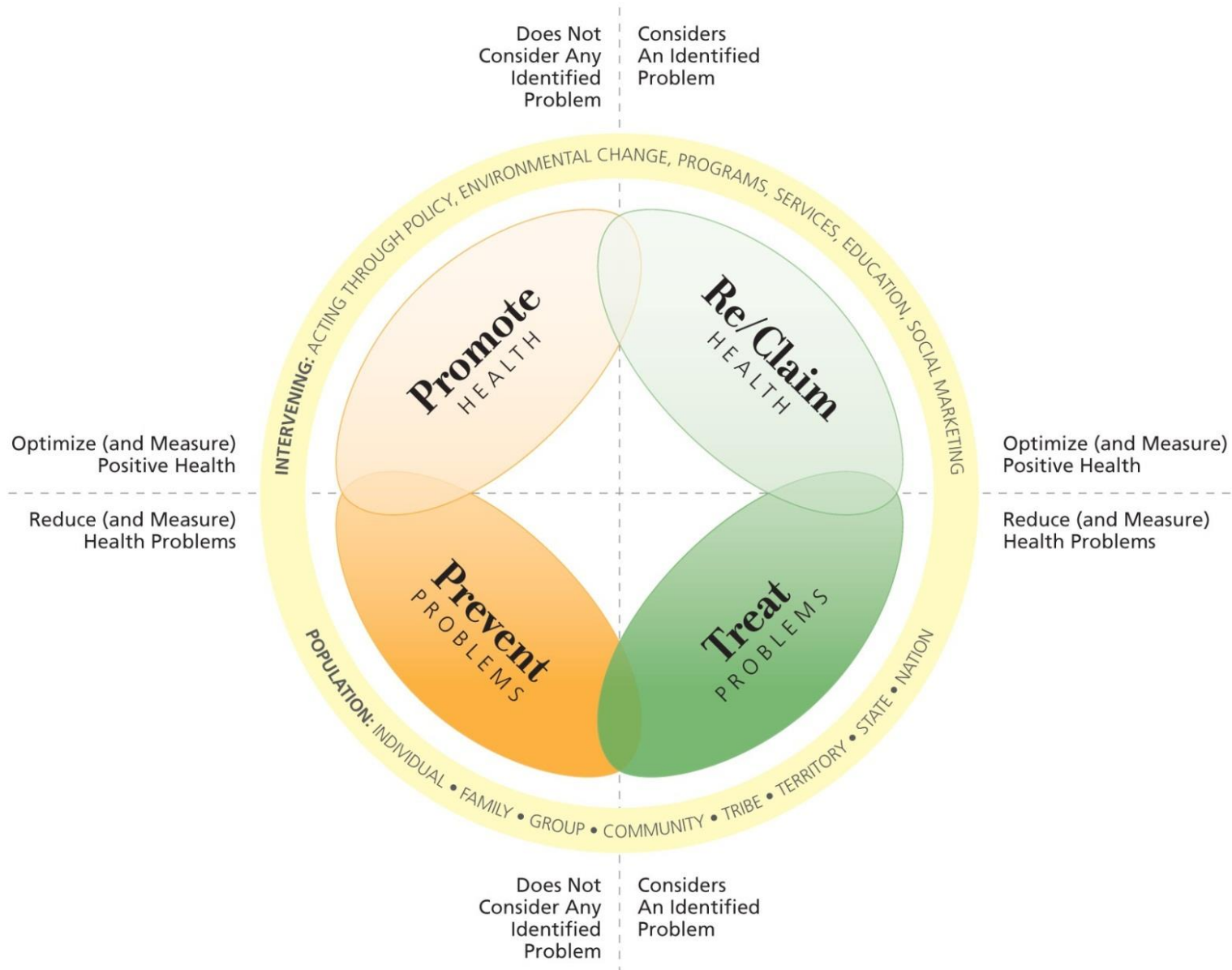


External stakeholders		Internal stakeholders
<ul style="list-style-type: none"> • Consumers • Families • Advocates • Providers • Hospitals • Health plans • Professionals • Counties • Mental Health Legislative Network 		<ul style="list-style-type: none"> • Department of Health • Department of Employment and Economic Development • Department of Corrections • DHS Administrations • MN Housing Finance • Department of Commerce • Department of Transportation • Higher education • State Advisory Council on Mental Health • Chemical and Mental Health Services staff
Legislator 1 on 1s		Other state agencies
Regional roundtables		
Offenders with mental illness	Rate reform	Mental health proposal drafting team
Mental Health Services Improvement Work Group		DHS Core Mental Health Reform Team

What needs to happen in the continuum of care?



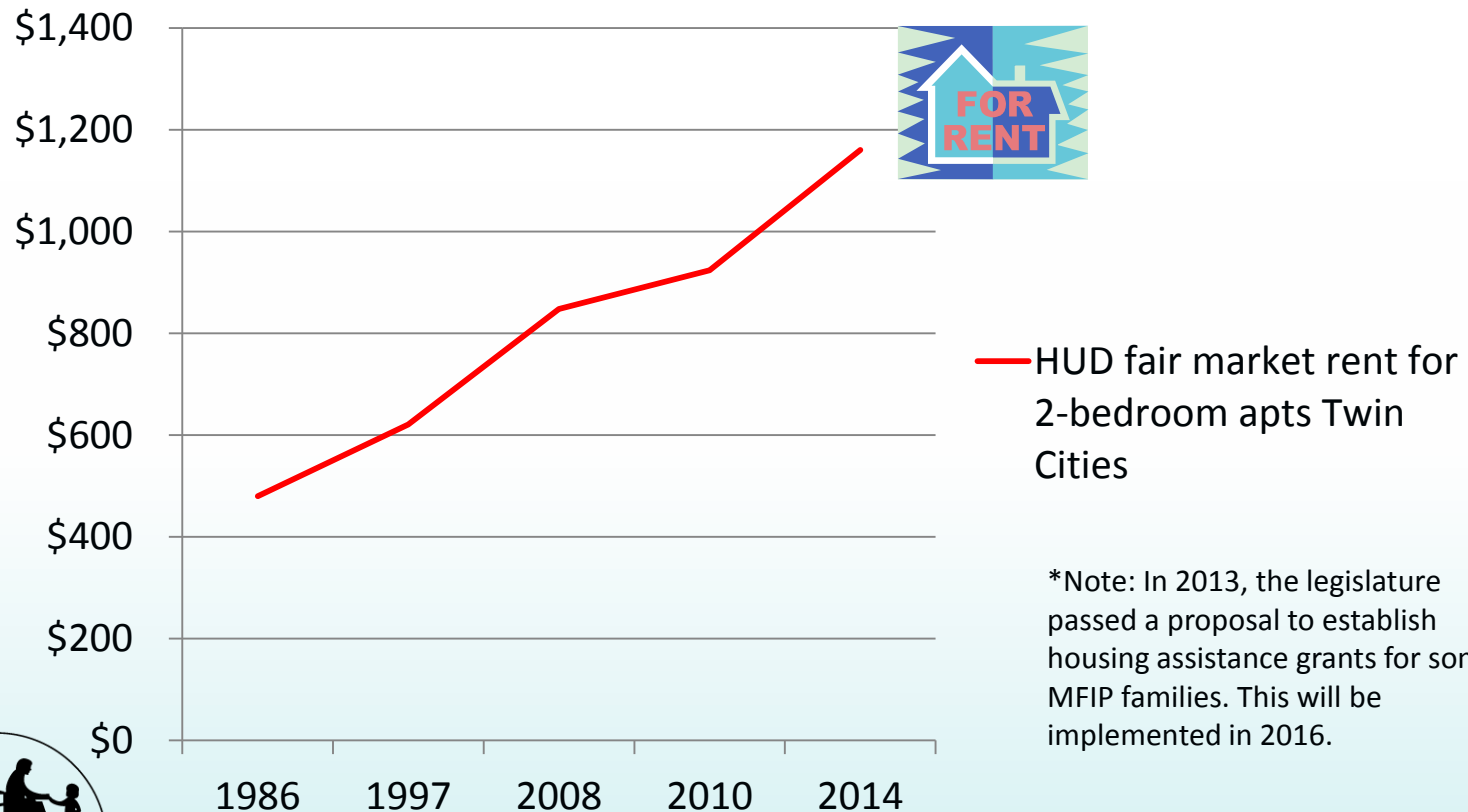
A model for children's mental health?



Challenges that still exist

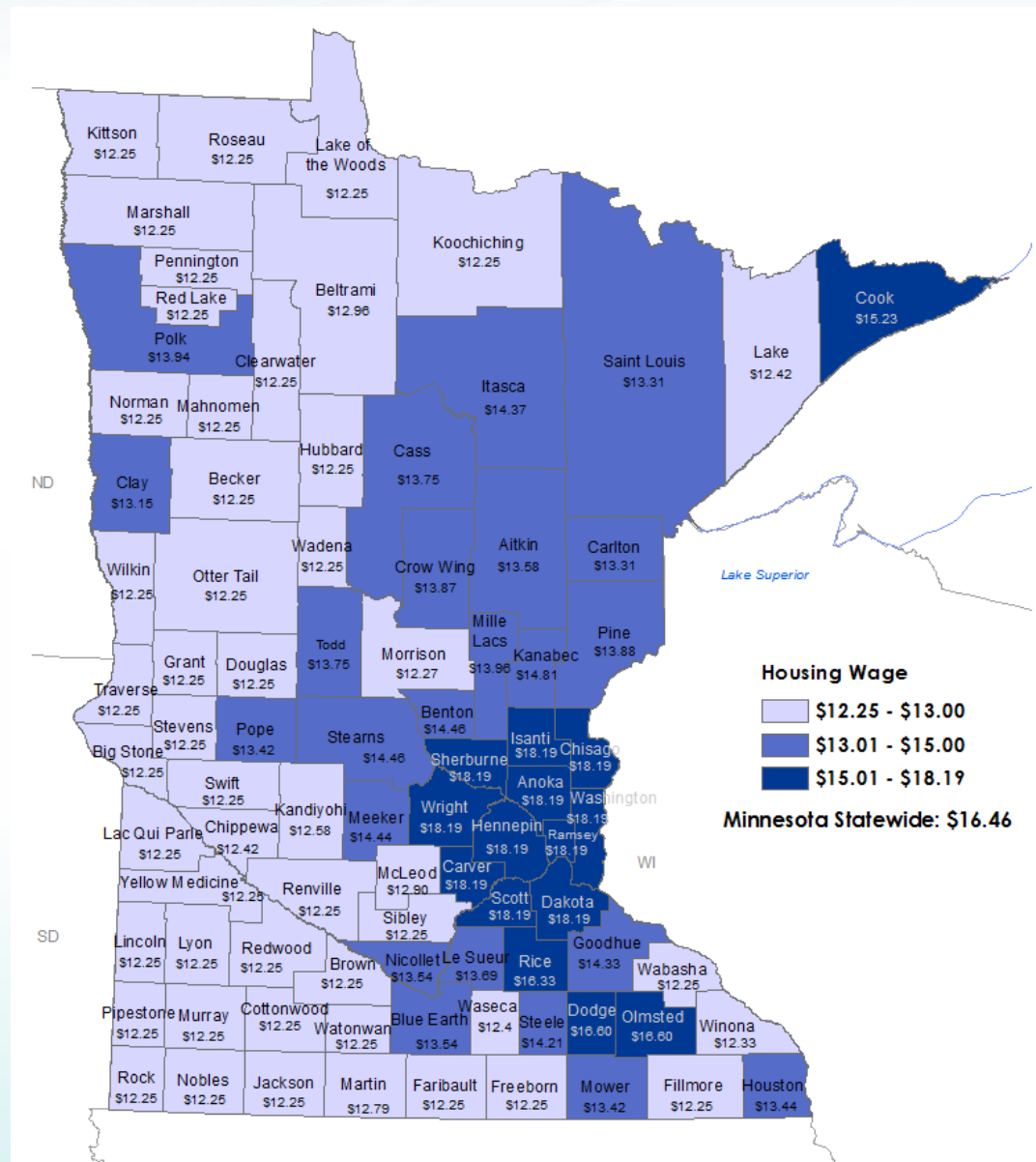
- Rents have dramatically increased

HUD fair market rent for 2-bedroom apts Twin Cities



*Note: In 2013, the legislature passed a proposal to establish housing assistance grants for some MFIP families. This will be implemented in 2016.

Challenges that still exist



Meeting with Lucy in Duluth



Jesson Discusses Improving Mental Health
DULUTH

Mental Health Reform 2015-2018

- **The Problem:** The Mental Health Infrastructure is insufficient with too many gaps, poor measurement, and insufficient service availability.
- **The Solution:**
 - Mental health promotion and mental illness prevention
 - Clinical service stability and quality
 - Community supports
- **The Impact:** 230,000+ adults and 75,000+ Children with MI and their families.

Mental Health Reform 2015-2018

Mental Health initiatives focus on four "Es":

- **Early identification and intervention** to promote mental health and prevent mental illness
- **Easy access** through expanding infrastructure
- **Effectiveness** through research-based treatment and measured outcomes, bringing science into practice and aligning policy accordingly.
- **Empowering consumers** to gain access to community supports that promote recovery and resilience.

Mental Health Reform 2015-2018

3 Goals for Improvements:

1. Rewarding **quality & performance** measurement and establishing **adequate rates**.
2. Fostering a **sustainable infrastructure** for Children & Adults
3. Promoting **healthy and successful living** for people with mental illness in the community.



Contact Information

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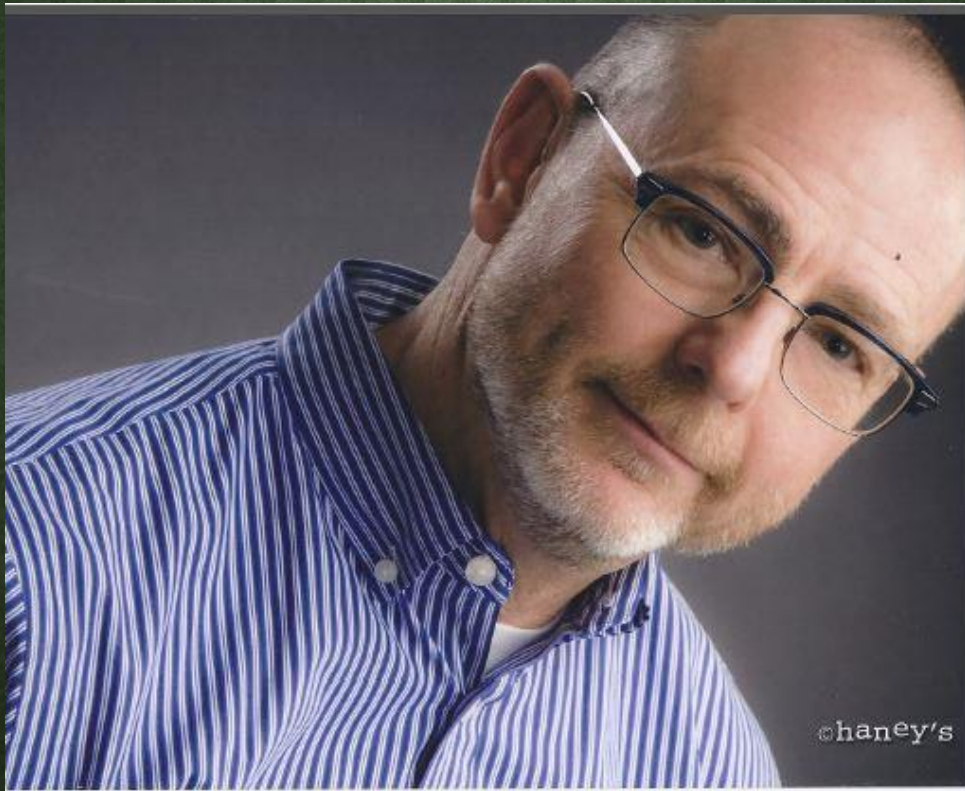
A Vision for the Future: What would ReThink Mental Health Look like?

Elizabeth Faust, M.D.
Senior Director Behavioral Health 
Division of Health Network Innovation, BCBSND



WHAT COULD IT LOOK LIKE?

Lisa Faust



SELF-RIGHTEOUS

- *Adjective*
- Having or characterized by a certainty, especially an unfounded one, that one is totally correct or morally superior.

**“SOMEBODY HAS TO DO SOMETHING,
AND IT'S JUST INCREDIBLY PATHETIC
THAT IT HAS TO BE US.”**

Jerry Garcia

Old Maps No Longer Work

I keep pulling it out—
the old map of my inner path.
I squint closely at it,
trying to see some hidden road
that maybe I've missed,
but there's nothing there now
except some well-traveled paths.
They have seen my footsteps often,
held my laughter, caught my tears.

I keep going over the old map
but now the roads lead nowhere,
a meaningless wilderness
where life is dull and futile.

“Toss away the old map,” she says.
“You must be kidding!” I reply.
She looks at me with Sarah eyes
and repeats, “Toss it away.
It’s of no use where you’re going.”

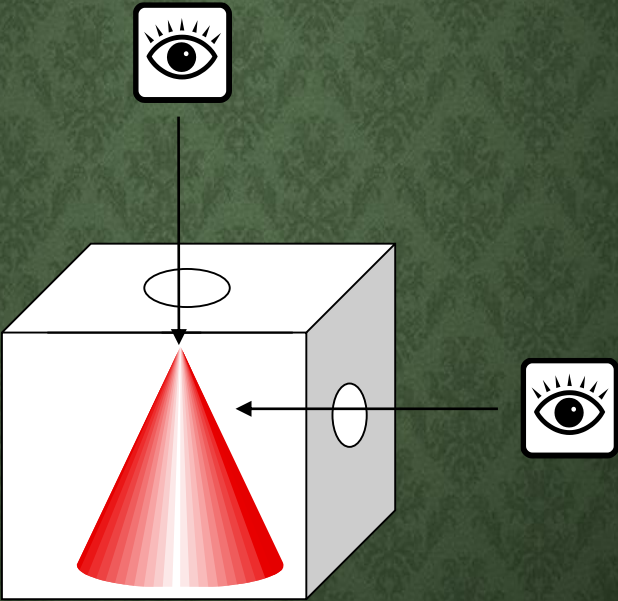
“I have to have a map!” I cry,
“even if it takes me nowhere.
I can’t be without direction.”
“But you are without direction,”
she says, “so why not let go, be free?”

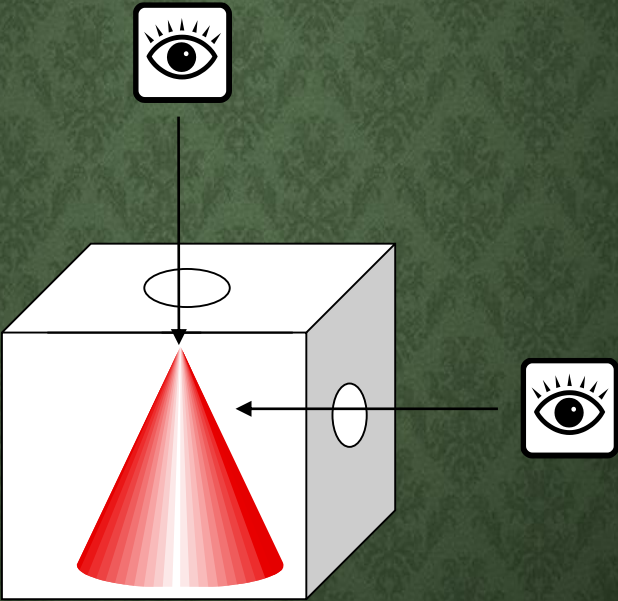
So there I am—tossing away the old map,
sadly, fearfully, putting it behind me.
“Whatever will I do?” wails my security.
“Trust me,” says my midlife soul.

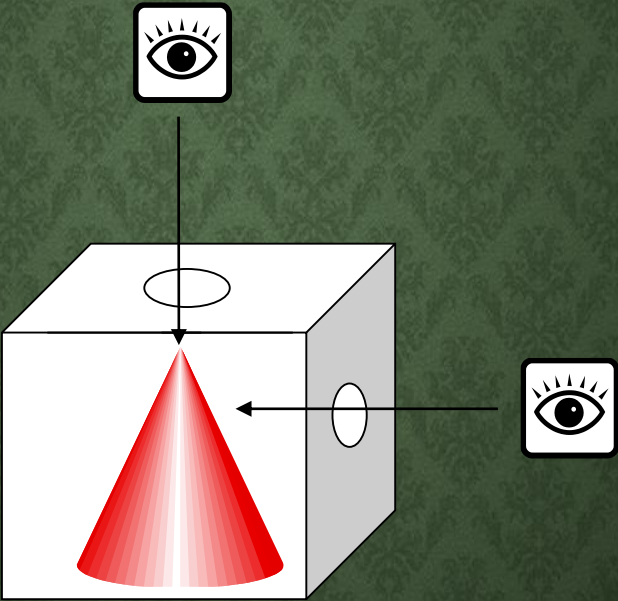
No map, no specific directions.
No “this way ahead” or “take a left.”
How will I know where to go?
How will I find my way? No map?
But then my midlife soul whispers:
“There was a time before maps
when pilgrims traveled by the stars.”

It is time for the pilgrim in me
to travel in the dark,
to learn to read the stars
that shine in my soul.
I will walk deeper
into the dark of my night,
I will wait for the stars,
trust their guidance,
and let their light be enough for me.

- Joyce Rupp







**“If the person you are talking to
doesn’t appear to be listening, be
patient—**

**it may simply be that he has a small
piece of fluff in his ear.”**

—Pooh

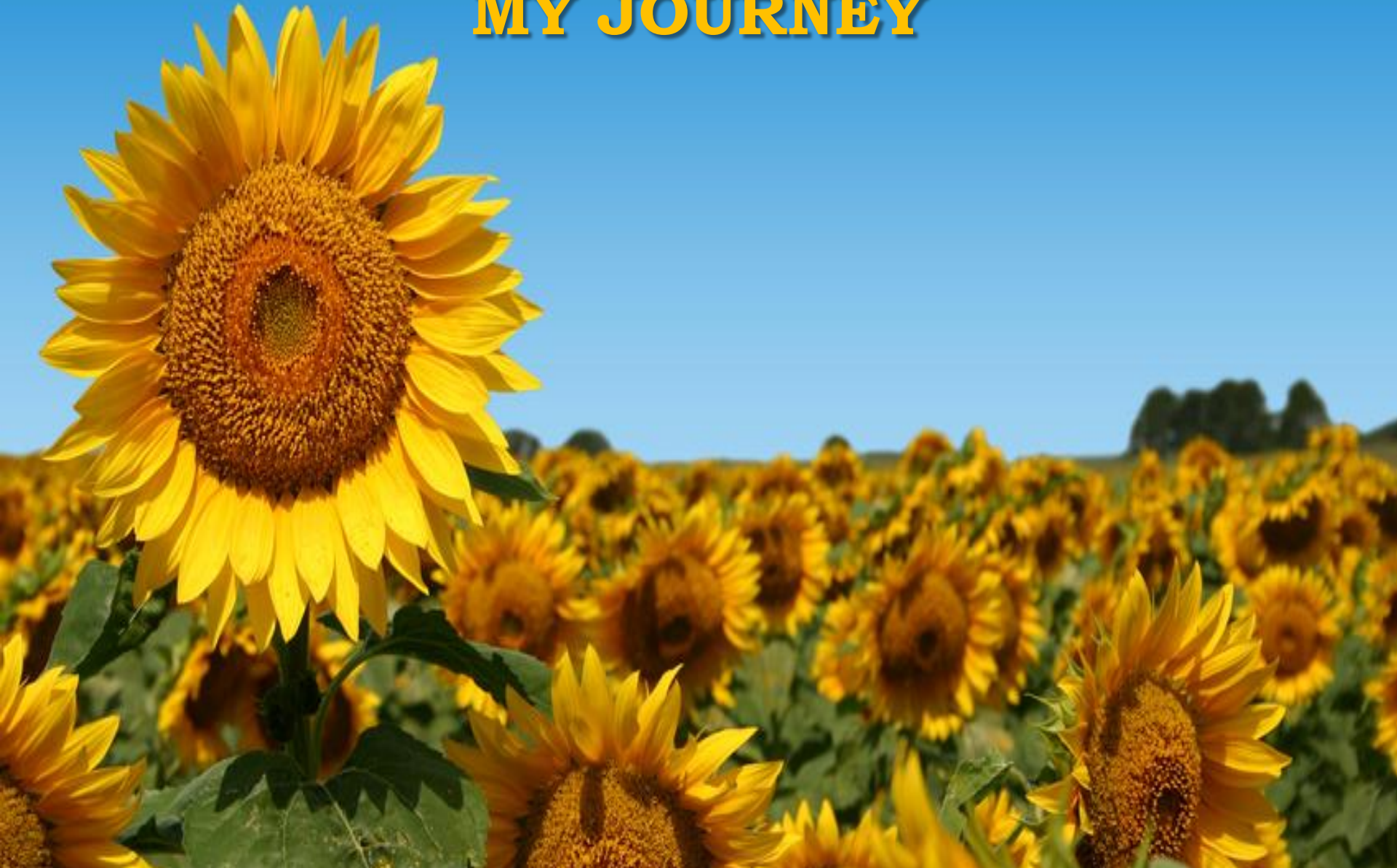








MY JOURNEY





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The opposite of a fact is falsehood, but the
opposite of one profound truth may very well be
another profound truth.

(Niels Bohr)

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POLARITIES WE MUST MANAGE

- Individualized best care
- Sufficient to meet needs
- Clinical “art”
- Clinical integrity
- Increasing access to care
- Protecting privacy
- Centralized organization
- vs. population health
- vs. ideal care
- vs. evidence-based care
- vs. fiscal integrity
- vs. overwhelming staff
- vs. creating information barriers
- vs. local autonomy



Sacred Cows?

WHAT'S NEXT?



“

YOU CAN EASILY JUDGE THE CHARACTER
OF A MAN BY HOW HE TREATS THOSE
WHO CAN DO NOTHING FOR HIM.

”

-Johann Wolfgang von Goethe

WRAP UP

