Update on Acute Care Transitions for People with Complex Support Needs | Human Services Committees

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DEPARTMENT OF HUMAN SERVICES

Presentation Roadmap

- Who, what, when, where, why? | **(slides 3-6)**
- Current state, action, collaboration | **(slides 7-11)**
- Where do we go from here?| **(slides 12-16)**

Hospital Decompression versus Acute care transitions

Hospital Decompression

- Began as a COVID-related initiative
- Objective: make room in the hospitals

Acute Care Transitions

- Evolution from decompression to supporting individuals returning to the community or to another clinically appropriate setting
- Problem: people are getting stuck in acute care settings such as hospitals
- Objective: support person and families in a place of their choice, including step-down and home and community settings

What do we mean by “stuck?”

(1) In an acute care setting (hospital bed, ED):

- Without an acute care level of need
- Have met treatment objectives
- No longer meet hospital level of care

(2) Difficulty accessing community supports

- Denied by multiple providers
- Engages in serious aggression or self-harm
- Service termination from a residential provider
- Higher staffing ratio needed

Who is getting stuck?

Children (under 20)	Adults
Engaged with child welfare	Criminal histories
Native American children over-represented	High medical needs
Autism	Multiple hospital stays

- Individuals with acute aggression who injure parents or caregivers
- Trauma present
- Reputation with providers as being hard to serve – burned bridges
- Under serviced – receiving only PCA – this applies a lot to the BIPOC community
- Non-verbal
- Dual MH and IDD diagnosis

Why are people getting stuck?

- Not enough units at specific levels of care (i.e. PRTF, individualized foster care setting)
- Appropriate and therapeutic level of care to meet the need does not exist
- Capacity issues + demand may lead to provider adverse selection and hospital individualism (competition) instead of overall community need determinations
- Psychopharmacological, positive support needs aren’t being met in the hospital
- Care giver training (receiving provider)
- Worsening of mental health issues due to lack of upstream services (low MA outpatient reimbursement rates)

Working with community to understand the problem

Children’s Mental Health Collaboration Hub data

- **Most common risk factors:** aggression, self-harm, suicidality, elopement risk, substance use, developmental disabilities
- **Most common referrals:** group home, children’s residential facility, therapeutic foster care, crisis stabilization, psychiatric residential treatment facility (PRTF)

Care Providers of Minnesota data

- **Most common characteristics of referrals turned down:** complex behavioral and physical needs, undetermined payor source, bariatric care

Values for this work

- The right service at the right time
- Use of positive support practices to support people that use services and their teams

Values for community collaboration

- Center on creating or maintaining relationships
- Avoid re-creating systems that already exist;
- Understand the situation from multiple perspectives;
- Use culture of safety approach – blaming and shaming doesn’t lead to accountability;
- Define current roles and responsibilities AND be open to playing new roles;
- Acknowledge that the ideal set of services for a person may not be available
    - Explore changes to service models and new MA benefits
    - Acknowledge informed choice is necessary and service options are often limited.

Positive Supports

- The term Positive Support refers to practices that are —
  - Person-centered and or family-centered,
  - Culturally responsive,
  - Evidence-based or evidence-informed,   promising practices
  - Implemented in a manner that allows for ongoing evaluation and monitoring,
  - Often implemented together   Often implemented with more than one practice, and
  - Used across the life span

Positive Support Approaches

Approaches DO:

- Builds on a person's successes, strengths, and desires
- Includes a person's expectations and cultures
- Achieves a person's outcomes and goals
- Works to enhance quality of life
- Offers solutions that are effective
- Ongoing measurement of impact

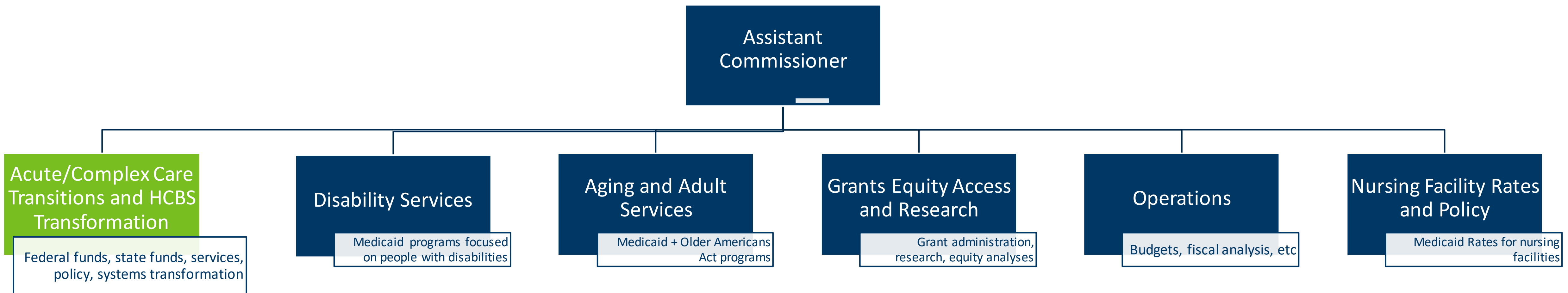
Approaches DO NOT/ARE NOT:

- Do not include the use of punishment or disrespectful, demeaning or dehumanizing practices.
- Not a quick fix
- Not a final or static product

Current Action

1. DHS assisting with most acute patients, as identified by the hospital systems
2. One “front door” at DHS for hospitals to contact DHS to refer cases and coordinate assistance (will be beginning source of comprehensive data)
3. Accelerate hiring of federally-funded Complex Transitions Unit to establish regional and statewide leadership teams
4. Proactive communication plans with hospital systems, community providers, advocates
5. Acute care transitions advisory council (see DHS overview of the council)

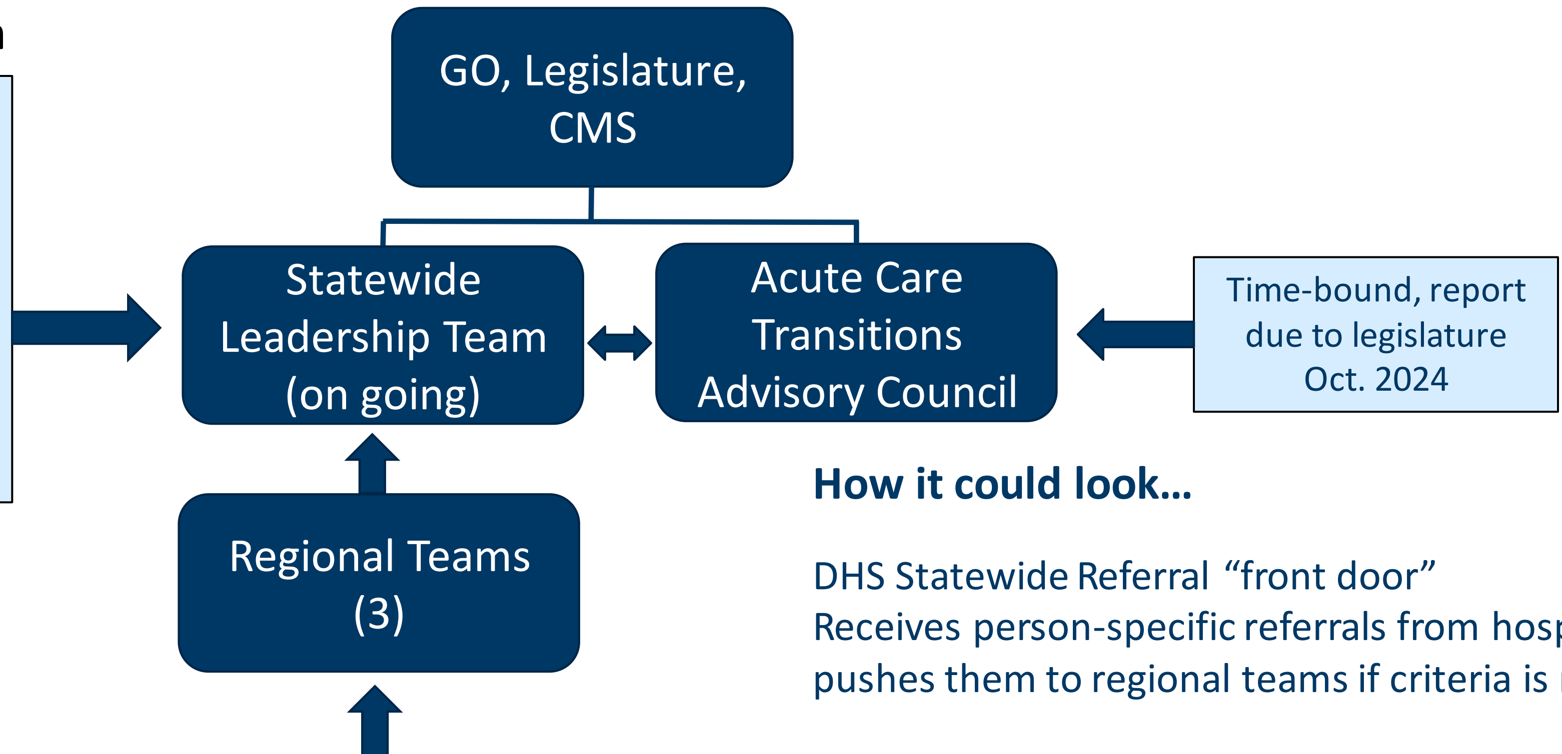
Aging and Disability Services Administration: New Acute Care Transitions Division



Complex Transitions Unit

Statewide Leadership Team

- Multi-agency leadership from lead agencies, hospitals, and DHS
- Multi-disciplinary forum for collaboration to support people with complex needs
- Receives and acts on recommendations from regional teams, e.g. legislative changes for services, funding, or other changes



Regional Teams

- Person-specific technical assistance, referred by hospital systems and lead agencies; connect support/care teams with existing services and resources
  - Escalate extraordinarily complex person-specific situations to Statewide Leadership Team
- Builds sustainable regional approach with lead agencies and regional providers to address gaps and barriers to successful transitions to community life.
- Increase capacity for data collection on people who are stuck
- Provides policy and funding recommendations to statewide leadership team based on analysis of person-specific data.
- 3 regional teams with ability to add more as needed.
- Includes representatives from hospitals, lead agencies, DHS, other state agencies, and providers.

Role of Counties and Lead Agencies

DHS coordinates with counties to play the role for which they are responsible:

- Assessment, eligibility determinations
- Authorizing services, including rate exceptions
- Ensuring service plan meets safety needs and preferences
- Final placement decisions (with person or legal representative)
- Monitoring of plan, case management
- County mental health authority

Future Solutions: administrative, clinical, legislative

- **Crisis stabilization**
- **Community provider capacity building, staff training, support**
- **Direct support professionals in hospitals, reduce restraints**
- **Hospital training on guardianship, supported decision-making, discharge coordination with county systems**
- **Assessment flexibilities**
- **Adjust elderly waiver caps**
- **Statewide data collection and referral coordination**
- **Flexible funds to support acute care transitions, landlord mitigation fund**
- **Increase mental health outpatient rates**

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Thank You!

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