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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Acute Care Transitions Advisory Council

Final report and recommendations

Department of Human Services

January 2025

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Cambodian

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wáŋ. héčiŋhaŋ niyé wačhíŋyAŋ wayúiyeska ki de wówapi sutá, ečíyA kiŋ wóiyawa ed ophíye waŋ. Dakota

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Filipino (Tagalog)

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ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में निश्शुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

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Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သူၣ်ဟ်သး. နမ့ၢ်လိၣ်ဘၣ် တၢ်မၤစၢၤကလီလၢ ကကျိးထံလံာ်တီလံာ်မီတဖၣ် အဃိ, ကိးနီၣ်ဂံၢ်လၢ အအိၣ်ဖဲတၢ်လွံၢ်နၢၣ် လၢတၢ်ဖီခိၣ်အပူၤတက့ၢ်. Karen

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تی بێبەرامبەرەرمایەب تیە پێویستەنامەم بەڵگەتکایە سەرنج بدە. ئەگەر بۆ وەرگێرانی ئ،
رەیەوەاو ژمەب ییوەندەرەوەدایە. ئەوا پەسد یەبۆکسەکە لە کە ەکب Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoȟpíŋ. Tóháŋ waŋží thí wíyukčaŋpi kiŋ yuhá níyuŋspe hécha čhéya, lé tkíčhuŋ kiŋ k’é náŋpa opáwiŋyaŋ. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນປ່ອງຂ້າງເທິງ. Lao

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Mandarin (Simplified Chinese)

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Mah Biz’sin’dan.
Keesh’pin nan’deh’dam’mun chi’wee’chi’goo’yan chi’nis’too’ta’man oo’weh ooshii’be’kan.
Ishi’kidoon ah’kin’das’soon ka’ooshi’bee’kadehk ish’peh’mik ka’shi ka’ka’kak. Ojibwe

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Àkíyèsí. Tí o bá nílò ìrànlóẃ p̀lú tí tú mọ̀ àkọ̀ọ́lẹ̀ yìí, pe nọ́mbà tó wà nínú àpótí tí wà ló kè. Yoruba

Authors and acknowledgments

This report was created by a team of individuals and funded by the Minnesota Department of Human Services. The Acute Care Transitions Advisory Council led the development of this report.

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Contents

Acute Care Transitions Advisory Council 1

Authors and acknowledgments 5

Acute Care Advisory Council members: 5

Report preparation 5

Contents 6

I. Executive summary 8

Short-term recommendations 8

II. Legislation 10

III. Introduction 13

Purpose of report 13

IV. Acute care barriers to transition literature review 15

Discharge delays and acute care barriers to transition 15

Community-based acute care barriers 18

Minnesotans experiencing the most frequent barriers to acute care transition 18

Systems of care and strategies for coordinating services in the community 20

Unified measurements systems 26

Measures for culturally responsive evaluation planning 28

V. Evaluation methods 29

ACTAC meetings 30

Participant recruitment 30

Procedures for focus group and interviews 31

Evaluation questions 31

Summary of key public reports and data presentations 33

Quantitative and qualitative Minnesota data on discharge delays and health equity issues 33

Mixed methods evaluation design 33

Qualitative thematic analysis of multiple data sources 34

VI. Results and findings **35**

Council meetings, focus groups and interview thematic analysis 35

Characteristics of individuals experiencing barriers to transition 35

Barriers encountered in acute care transitions 37

Interventions and strategies for addressing barriers in acute care transitions 43

Health equity and disparities in Minnesota 49

Quantitative and qualitative public reports 51

VII. Report and council recommendations **54**

ACTAC council action recommendations: Short-term action plan 57

IX. References **63**

X. Appendix Contents **75**

Appendix A: Examples of common services and systems for children and adults 76

Appendix B: Flyer recruiting focus group and interview participants 77

Appendix C: ACTAC evaluation participant list 78

Appendix D: Quantitative worksheet for public reports analysis 80

Appendix E: Acute Care Transitions Advisory Council (ACTAC) codebook summary 81

Appendix F: Public comment 82

Appendix G: Glossary 120

I. Executive summary

Delayed discharge from the emergency department (ED) or hospital and difficulties transitioning back home into the community are complicated issues affecting Minnesota. These delays happen for many reasons but are most attributed to difficulty finding safe post-discharge care and lengthy administrative or legal processes. While the reasons for discharge delays may vary, the result is that children and/or adults are unable to transition back to their homes in the community after an ED or hospital visit because services are not prepared to support them and/or their families or caregivers effectively.

The purpose of this report is to summarize the findings of the Minnesota Acute Care Transitions Advisory Council (ACTAC) in identifying how discharge delays are related to complex issues associated with barriers to transition into the community. A key assumption of the ACTAC is that all action planning completed by the State of Minnesota must actively work towards eliminating bias, discrimination and health-equity disparities associated with the transition of people from ED or hospitals back into the community. The council recommends the use of systematic strategies for identifying, monitoring and evaluating outcomes for people who represent protected classes as well as other vulnerable and under-represented groups in order work towards dismantling systemic racism in all its forms.

Short-term recommendations

The following recommendations are proposed by the ACTAC. Sources of evidence include council meetings, literature review and public reports, presentations from community partners and focus groups/interviews with community partners. The council met nine times from October 2023 through October 2024 resulting in the following recommendations.

Recommendation I

Given the timeline and complexity of the topic, the ACTAC needs to become a standing unit that meets on a regular basis to continue long-term guidance as the action plan is executed. The council recommends that it continues providing this guidance to the DHS while expanding the representation and diversity of the council and retaining individuals representing the major roles currently present. The goal is to establish a bi-directional communication system between the ACTAC and a team funded via Moving Home Minnesota (MHM) within DHS.

Recommendation II

Expand regional capacity for existing care navigation by building on the Complex Transitions Team funded via MHM in three regions to support children and adults across the lifespan experiencing barriers to transition from the ED and/or hospital. Activities include establishing a communication pathway between DHS leadership, existing Complex Transitions Teams, counties and the advisory council.

Recommendation III

Establish a statewide infrastructure that will improve communication systems, provide coordination/support to regions and monitor the development of a unified measurement system. The goal of this infrastructure is to provide a way to collaborate with regional teams and improve coordination and navigation systems for children and adults who may live and receive services in different areas across Minnesota. The goal of this statewide infrastructure is to improve communication and build more effective systems to support children and adults admitted into acute care settings and transitioning back into the community.

Recommendation IV

Actively 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. The council embedded action-planning steps dedicated to health equity within each recommendation. Examples include increasing diversity of council representation should it become a standing unit and designing effective measurement systems for monitoring over-representation of children and adults from Black, Indigenous and people of color (BIPOC) communities experiencing barriers transitioning into the community.

Recommendation V

Identify the barriers that exist and begin long-term planning, while initiating changes in administrative policy that DHS and other lead agencies can make immediately, to expedite the transition of children and adults out of acute care settings. Examples include, but are not limited to, building short and long-term incentives for direct support staff, providers of existing waiver services and/or organizations that support children and adults while in the hospital to assist with transition planning; expanding on current funding policies for HCBS providers supporting the transition planning process while children and/or adults are in the hospital; assessing practices related to guardianship while addressing the rights of individuals and families; and developing strategies related to expediting MnCHOICES assessments.

II. Legislation

Enacting Legislation

MN Laws 2023 Ch 61 Section 82

Sec. 82. ACUTE CARE TRANSITIONS ADVISORY COUNCIL.
Subdivision 1. **Establishment.** The commissioner of human services shall establish an Acute Care Transitions Advisory Council to advise and assist the commissioner in establishing and implementing a statewide vision and systemic approach to acute care transitions in Minnesota.
Subd. 2. **Membership**. (a) The Acute Care Transitions Advisory Council consists of the following members:
(1) two individuals or their representatives who have lived experiences with acute care transitions;
(2) two members representing home and community-based services providers;
(3) two members representing the Minnesota Hospital Association;
(4) one member representing the Minnesota Association of County Social Service Administrators;
(5) one member representing the Local Public Health Association;
(6) one member representing a Tribal government;
(7) one member representing the University of Minnesota;
(8) one member representing the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health;
(9) one member representing a public sector labor union;
(10) one member representing the Minnesota County Attorney's Association;
(11) one individual who has had an acute hospital stay initiated during a crisis;
(12) one parent of a child who has had an acute hospital stay initiated during a crisis;
(13) one individual who meets the definition of a caring professional;
(14) the commissioner of human services or a designee;
(15) the commissioner of health or a designee; and
(16) the commissioner of education or a designee.
(b) To the extent possible, the advisory council members must represent diverse populations and different areas of the state.
(c) A member of the legislature may not serve as a member of the advisory council.
Subd. 3. **Cochairs**; convening first meeting. The commissioner of human services shall convene the first meeting. Advisory council members must select advisory council cochairs at the first meeting.
Subd. 4. **Compensation**; expenses; reimbursement. Advisory council members must be compensated and reimbursed for expenses as provided in Minnesota Statutes, section 15.059, subdivision 3.
Subd. 5. Administrative support. The commissioner of human services shall provide meeting space and administrative support to the advisory council.
Subd. 6. **Public and community engagement**. The commissioner of human services shall conduct public and community engagement to obtain information about barriers and potential solutions to transitioning patients from acute care settings to more appropriate nonacute care settings and must provide the information collected through public and community engagement to the advisory council.
Subd. 7. **Duties**. (a) By October 1, 2024, the advisory council shall develop and present to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services

finance and policy and the commissioner of human services an action plan for creating a systemic approach to acute care transitions for Minnesotans. The action plan must include but is not limited to the following:

(1) recommendations to 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;

(2) recommendations to create a measurement and evaluation system using implementation science to analyze regional and statewide data in transitions and make ongoing recommendations for policy and program improvement; and

(3) statewide strategies for improving access to transitioning from acute care settings with a focus on addressing geographic, racial, and ethnic disparities.

(b) The advisory council may contract with a private entity or consultant as necessary to complete its duties under this section, and is exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

Subd. 8. **Limitations**. (a) In developing the action plan, the advisory council shall take into consideration the impact of its recommendations on:

(1) the existing capacity of state agencies, including staffing needs, technology resources, and existing agency responsibilities; and

(2) the capacity of county and Tribal partners.

(b) The advisory council shall not include in the action plan recommendations that may result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.

Subd. 9. **Expiration**. The Acute Care Transitions Advisory Council expires October 2, 2024, or the day after submitting the action plan required under subdivision 7, whichever is earlier.

Legislative Overview

Challenges associated with barriers to transition are varied and complex requiring solutions that address changes in state policies, systems change in healthcare and increases in funding for community services. Such solutions require coordination, collaboration and action by partners including people with lived experience, families and caregivers, hospitals, counties, state champions representing behavioral health, disability services, children and family services and education. However, the differences in priorities of partners who are working together to effect change can cause challenges. For example, while hospitals are focused on meeting the needs of all patients, running hospital systems efficiently and managing operational costs, community-based organizations may be focused on promoting each person’s self-determination, managing worker’s compensation due to injuries, addressing staff-attrition related issues and dealing with funding deficits (Cadel et al., 2021).

The Legislature established the ACTAC to advise and assist in implementing a unified statewide vision and systemic approach to address acute care transitions in Minnesota. Members of the council are posted online on the Boards and Commissions website and the Minnesota ACTAC webpage reports all activities related to the council. The commissioner requested public and community engagement be obtained about the barriers and potential solutions to transitioning patients from acute care settings to more appropriate non-acute care settings and while providing the information through public and community engagement.

The ACTAC was charged with presenting action-plan recommendations by Oct. 1, 2024, to the chairs and ranking minority members of the legislative committees and divisions with authority over health and human services finance and policy and the commissioner of human services. This action plan is meant to recommend a systemic approach for addressing acute care transitions for Minnesotans. The requested action plan recommendations address (but are not limited to) the following:

1. Improving 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.
2. Creating a measurement and evaluation system within the context of implementation science to analyze regional and statewide data in transitions and make ongoing recommendations for policy and program improvement.
3. Outlining statewide strategies for improving access to transitioning from acute care settings with a focus on addressing geographic, racial and ethnic disparities.

The advisory council contracted with the University of Minnesota Institute on Community Integration (ICI) to facilitate the meetings, gather data, collect partner input and document council recommendations in a written report. Council duties were exempt from state procurement process requirements under Minnesota Statutes, chapter 16C.

In developing the action plan, the ACTAC took into consideration the impact of its recommendations on the existing capacity of state agencies — including staffing needs, technology resources and existing agency responsibilities — and the capacity of county and tribal partners. The ACTAC council did not include any recommendations in the action plan that would result in loss of benefits for the individuals eligible for state health and human services public programs or exacerbate health disparities and inequities in access to health care and human services.

III. Introduction

Delayed discharge from the ED or hospital is an extremely complicated issue affecting Minnesota, the United States and other countries across the world (Bhatia et al., 2020; Cadel et al., 2021; Cavallaro et al., 2023; Pellico-Lopez et al., 2019). These delays are most attributed to difficulty finding safe post-discharge care and lengthy administrative or legal processes. Hospitals have become the location of last resort with children and adults arriving with no other options leading to EDs and hospitals becoming *"… a long-term destination rather than…a way station for those who, once their acute care needs are met, are better served in a non-hospital setting."* (HANYS, 2022, p. 1). Today, many children and adults experiencing acute crises are entering hospitals, often via EDs, with increasing frequency (Cushing et al., 2023; Lytle et al., 2018). These individuals, who often have complex discharge needs (e.g., self-injury, suicide, aggression), find themselves unable to transition back to their homes in the community because services are not prepared to support them and/or their families effectively (Stock et al., 2023).

In Minnesota (and other states), communities are ill-equipped to support transitions from acute care settings, because the incentives for organizations to support children and adults requiring tailored and intensive services are not available (Huang et al., 2005). Long waiting lists for treatment programs and services cause challenges for families and community partners (Levy et al., 2003). Services in settings where more supports can be accessed vary a great deal in both quality and intensity (Lord et al. 2005; Stahmer, 2006). Access to training and mentoring is not available for families, caregivers and staff to effectively implement evidence-based practices (EBPs) when children and adults require more intensive supports (Bruns et al., 2016; Huang et al., 2005; Stock et al., 2023). In some cases, families and caregivers experiencing acute care crises report that they are given the message that they are unfit and/or are responsible for their child or ward's challenging behavior by professionals representing various service systems (Jain et al., 2019). This, in turn, leads to a reluctance to reach out for assistance from providers on the part of family members or caregivers.

The pandemic has led to increased acknowledgment within society of widespread mental health disparities and the need for equity and advocacy for marginalized youth, including ED visits from Black and Hispanic or Latinx youth (Abrams et al., 2020; Tyson & Ponoose, 2024). Black and Latinx with and without intellectual and developmental disabilities (IDD) are at more risk for hospitalizations and death related to multiple chronic conditions compared to white individuals (Zandam et al., 2024). The use of restraints during ED visits for mental health-related issues are twice as likely to occur with Black young people compared to white youth (Kalb et al., 2019; Nash et al., 2021; SAMHSA, 2023; Wong er al., 2023). Harsher response patterns towards BIPOC populations compared to the white population appears across several societal settings including medical systems, education, child welfare and the justice system (West et al., 2023). Structural racism endemic in today's society must be addressed as an integral part of the problems encountered within acute care barriers to transition.

Purpose of report

The purpose of this report is to summarize the findings of the Minnesota Acute Care Transitions Advisory Council (ACTAC) in identifying how discharge delays are related to complex multi-faceted issues associated with barriers to transition into the community. Bender and colleagues describe this as: *"…a systems issue that* *manifests itself in the [emergency departments], which is a common pathway for the problem; but the real problem is about capacity in other parts of the system, adequate funding and being able to move patients to the level of care they need."* (p. 2, Bender et al., 2009). A scoping review published in 2021 warned that interventions focusing on only one type of system or part of the acute care problem will just "move" the problem rather than solve it: *"…adding more intermediate care [inpatient] beds may alleviate pressures in acute care in the short-term but eventually also be at full capacity if community resources are not available."* (p. 25, Cadel et al., 2021).

Moving the problem rather than solving it is reflected in the history of the deinstitutionalization movement for people with intellectual and developmental disabilities (IDD) where policy changes focused on decreasing the number of institutional settings where people with IDD were being placed. Advocates fighting for the rights of individuals with IDD made it clear that all people have the right to live in their homes and communities (Lucyshyn, Dunlap, & Freeman, 2015). However, failing to invest in interventions for building effective, well-paid community services for people with more complex systems needs has led to a steady increase in 911 calls when organizations could not provide the services needed. Although this is only one explanation for the increased challenges associated with transition, it exemplifies how even interventions that are well intended and necessary can lead to iatrogenic, negative and unintended problems.

IV. Acute care barriers to transition literature review

The literature review used to prepare this report included the following topics relevant for action plan recommendations: a) ED and hospital discharge delays and barriers to transition from acute care settings, b) evidence-based strategies for addressing effective transitions, c) culturally-responsive implementation science to support increased regional and community capacity, d) systems of care strategies for improving coordination across community partners and e) a statewide unified measurement systems for addressing acute care barriers. This section of the report outlines national and Minnesota-based contextual issues related to the acute care transitions barriers.

Discharge delays and acute care barriers to transition

Even before the COVID-19 pandemic, discharge delays were becoming a problem in EDs and hospitals across the world (Ahlin et al., 2022; Bhatia et al, 2020; Cadel et al., 2021; Cushing et al., 2023) with the earliest study on the topic occurring in 1987 (Goncalves et al., 2016; Kennedy et al., 1987). Emergency room delays related to boarding — defined as events where children and adults awaiting inpatient hospitalization are in a holding pattern until inpatient psychiatric admission beds are available — were increasing (Overhage et al., 2023).

Overhage and colleagues reviewed health insurance claims for young people 5 to 17 years of old, from March 2019 to February 2022. Results indicated a 6.7% increase in mental health ED visits and an increase in the ED visits that led to hospitalization (8.4%). The percentage of prolonged boarding episodes increased by 76.4%. A review of data by the CDC reported that from April to October 2020, there was an increased proportion of mental health-related visits to pediatric emergency rooms for children 5 to 11 years when compared to 2019 data (Leeb et al., 2020). A reported 50.6% increase in ED visits occurred related to suspected suicide attempts by girls aged 12 to 17 years with data collected from February through March. 2021 (Yard et al., 2021).

Minnesota faces increasing challenges in supporting children and adults who require more flexibility in services than current local, regional and state systems provide. A number of key reports have noted that discharge delays from ED and/or hospitals in Minnesota are associated with a complex array of challenges across different services and systems, resulting in negative experiences reported by people with lived experience and/or their families (Dillon & Thompson, 2016; Dillon et al., 2024; Engler, 2022; 2022; MHA, 2019; MMA, 2023, see Table 1). People experiencing mental health or wellness crises arrive at local ED and hospitals desperately seeking help, only to find themselves unable to leave EDs and/or hospitals for days, even months, waiting for an inpatient psychiatric bed to open, or for services to be established/available in their homes or communities (Eldred, 2024; Erdahl, 2023). These challenges are associated with varied, unique and complicated conditions associated with systems issues such as funding, the capacity of organizations to tailor services for children and adults and their families or caregivers and the ability of organizations/services/systems to coordinate and communicate effective transition plans (Bender et al., 2009).

Reports by the hospital and healthcare systems highlight challenges in designing transitions to post-discharge settings such as state inpatient psychiatric beds, chemical dependency units and intensive residential treatment facilities (Dillon & Thompson, 2016; Dillon et al., 2019; Engler, 2022). The delays in discharge from ED and hospitals result in negative outcomes associated with patient "flow" issues (ED backlogs, cancelled surgeries, delayed medical care), increases in healthcare costs for patients and negative patient experiences (Rojas-García et al., 2018; Walker, 2011). Many people do not receive needed treatment while in the ED or hospital delaying the opportunity for healing (Cadel et al., 2021; Chen et al., 2012).

Although acute care settings have a role to play in the care continuum, when previous levels of care are unavailable or fragmented and/or when training and clinical support in the community are unavailable, children can remain in these acute care settings for long periods and/or experience frequent readmittance to these systems (AAP, 2019). Children and adults are placed in locations that are not suited for their needs increasing the likelihood of challenging behavior and/or experiencing further traumatizing events. Individuals experience a decrease in their ability to participate in activities of daily living, may become more frail or medically compromised, can experience additional health and wellness issues and/or experience further cognitive impairment/behavioral challenges (Rojas-García et al., 2018). Chemical and/or physical restraints are used in the hospital to address challenges that arise when individuals are awaiting transition to appropriate services (Nash et al., 2021). While hospital staff generally indicate that all attempts are made to reduce the use of restraints, these physical and chemical interventions are used to address self-injury and aggressive behavior (Bender et al., 2009).

A scoping review assessing the types of interventions studied related to discharge delays reported that while some interventions are promising, none addressed sustainable long-term implementation (Cadel et al., 2021). Scoping reviews have reported a varied number of interventions that have been used to address acute care discharge delays (Abdelhalim et al., 2023; Cadel et al., 2021). The authors of this scoping review advocated for using an evaluation plan to track outcomes related to effective transitions across longer periods of time using developmental evaluation methods that take into account the dynamic and chaotic features involved in acute care transition problem solving (Cadel et al., 2021; Patton, 2008).

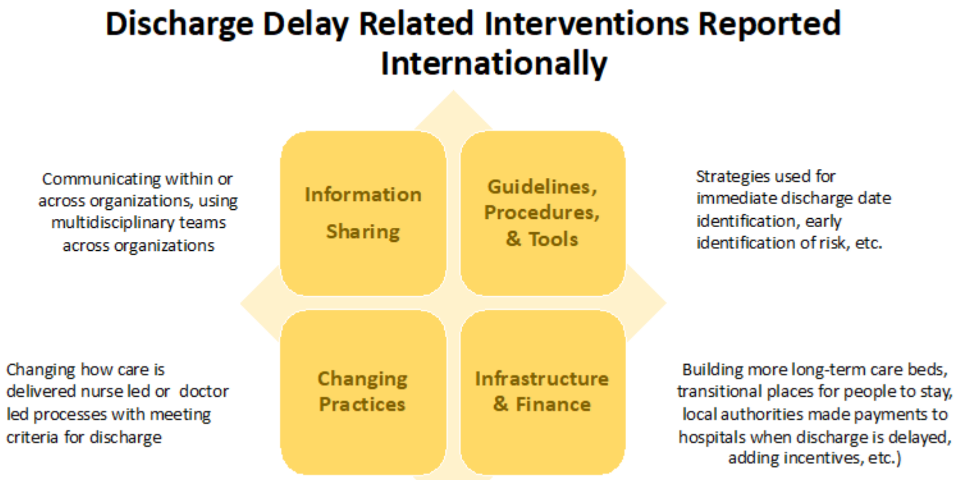
Table 1: Summary of Minnesota-based reports on the acute care barriers to transition and improving health equity and disparities

Author	Organization responsible	Report citation
Dillon, Vang, & Hierlmaier	Minnesota Department of Health	Dillon, K., Vang, M., & Hierlmaier, N. (2024). *Transfer and discharge delays for behavioral health patients at Minnesota hospitals: Results from the 2023 health behavioral health collection*. Saint Paul, Minnesota.
Dillon & Thompson	Minnesota Hospital Association & Wilder	Dillon, K. & Thompson, D. (2016). Reasons for delays in hospital discharges of behavioral health patients. Saint Paul, MN: Wilder.
Minnesota Hospital Association	MHA	Schindler, J. (2024). *Minnesota Hospital Association's survey of hospital discharge delays*. Acute Care Advisory Council presentation [meeting]. Minnesota Hospital Association.
Pearson et al., (2022)	MN Governor's Council on Developmental Disabilities & Market Response International	Pearson, T., McCullough, S., Schreifels, L., & Pearson, D. (2022) Impact of the intersection of developmental disabilities and other population profiles on experiences with discrimination. The One Minnesota baseline quantitative survey. MarketResponse International.
Pearson et al., (2023)	MN Governor's Council on Developmental Disabilities & Market Response International	Pearson, T., McCullough, S., Schreifels, L., & Pearson, D. (2023). Phase II intersectionality study, for the Minnesota Governor's Council on Developmental Disabilities. The One Minnesota baseline quantitative survey. MarketResponse International.
Chomilo	Medicaid Medical Director	Chomilo, N. T. (2022). Building racial equity into the walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans. *Minnesota Department of Human Services Report*. https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG.

Community-based acute care barriers

Community-based services and supports for families are not present in many states creating the conditions where discharge delays occur (Bruns et al., 2016; Pires & Stroul, 1996). Temporary flexible funds are often needed to ensure services are in place, prepare adequate training and clinical therapeutic supports in community settings and to assist people in navigating the complex challenges encountered during transitions into the community. Policies and procedures can create barriers making community supports more difficult. For example, Medicaid coverage policies appear to favor institutional settings and nursing home care have resulted in advocates calling for a “rebalancing” of funding allocations toward home and community-based services (Grabowski et al., 2010; Harrington et al., 2009).

Figure 1-types of interventions reported in a scoping review by Cadel and colleagues (2021)



Adapted from Cadel, L., Guilcher, S. J. T., Kokorelias, K. M., Sutherland, J., Glasby, J., Kiran, T., & Kuluski, K., (2021). Initiatives for improving delayed discharge from a hospital setting: a scoping review. *BMJ Open*, *11*, e044291. doi:10.1136/ bmjopen-2020-044291

Individuals and their families or caregivers navigating multiple services to meet the person’s emotional and physical health needs often encounter difficulties when transitioning back to their community. Each service requires different paperwork and/or includes duplicative reports or planning documents, while children or adults and their caregivers are expected to attend multiple meetings across multiple services each with similar goals (Freeman et al., 2015). Fragmentation across these different services can contribute to difficult transitions from acute care back into community settings (Knitzer, 1982). In some cases, repeat visits to the ED and hospital occur because of miscommunication about timing and preparation of services.

Minnesotans experiencing the most frequent barriers to acute care transition

The need for support in health care transitions, especially for youth and young adults with long-term conditions, has been widely acknowledged for 40 years by professionals across pediatric, adolescent and public health care (Blum et al., 1993; McGrab & Millar, 1989). Individuals experiencing behavioral health, IDD and/or co-occurring conditions are most profoundly impacted by delayed discharge and barriers to transition. (HANYS, 2022; Mirzaian et al., 2024). A common barrier for children with co-occurring mental health and IDD is the lack of experience and knowledge of professionals in addressing both IDD and mental health-related issues using interdisciplinary and multidisciplinary approaches (ASAN, 2024; Mirzaian et al., 2024). These children and their families are often unable to access adequate services. In one qualitative study, professionals participating indicated, *"…Many families have reported that they are unable to secure mental health services for their adult child who has autism, because all of the child's behaviors are blamed on autism."* (p. 6, Mirzaian et al., 2024). Rather than treat a mental health related symptom, some professionals consider the diagnosis of Autism itself as an explanation for behavioral challenges that are reported.

The fundamental isolation across disability and mental health services is due, in part, to the way services and funding are structured. In many states, it is not unusual for families or caregivers supporting a person with IDD to be turned away from mental health services with the message that their child should seek guidance from disability services. The family member is then told by disability service professionals that their child needs mental health services and that they cannot provide assistance. This longstanding fragmentation between disability and mental health reflects the ways in which funding streams are organized, how professionals are trained and the lack of interdisciplinary and multidisciplinary collaboration in many parts of Minnesota and across the U.S.

Another structural issue that makes systems change efforts more difficult is related to how professionals are funded by their organizations. For instance, mental health professionals in one state lose all contact with the children and adults they support once an event occurs that causes placement outside of the home (Freeman et al., 2014). Billing and reimbursement by these mental health professionals must stop until the child or adult has returned to their home and community, during which time billing for services can resume. During transitions, funding is not available for mental health professionals to participate in planning meetings (Matthews et al., 2019).

Communication problems across and between different organizations and agencies are common when transition plans are needed. One mental health professional in a nearby state indicated that *"…but for some of the kids—particularly foster care kids…if they're coming back to our area, we may not even know that they're getting discharged 'til they land on our doorstep."* (Freeman et al., 2014, p. 54). Transition planning in rural areas often involve planning to bring a child or adult home from a long-distance placement. A Minnesota focus group in 2021 conducted by Freeman, Simacek and her colleagues highlighted this issue with participants recommending that streamlining memoranda of agreement instructions for agencies and systematic state support could help organizations to communicate more effectively when a child or adult is transitioning back home from a metropolitan area.

Minnesota faces extreme shortages of providers across the continuum of care, particularly in geographically dispersed communities (e.g., Greater Minnesota). Focus groups and interviews with Minnesotans representing rural areas of the state report challenges finding and accessing local professionals to provide support, in general, and within medical as well as mental health professional services (Freeman, Simacek et al., 2021). These rural Minnesota participants reported a lack of professional expertise in many areas of the state leading to problems accessing positive supports, psychological and therapeutic practices, medical and/or psychiatric services (Freeman, Simacek, Moore, & Duchelle, 2021; Stock et al., 2023). There are also operating differences across Minnesota counties related to policies, procedural systems, training and other issues that can cause challenges in Minnesota with one qualitative study reporting that the differences across counties can be make it difficult to support people needing services (Kim et al., 2021).

Children and adults, as well as their families and caregivers, who are part of the BIPOC community experience additional barriers in accessing high quality supports and services. Research studies report that complications related to multiple chronic conditions are more severe and frequent among racial minority groups who are covered by Medicaid or Medicare (Zandam et al., 2024). Nationally, there are clear patterns of inequality present in how BIPOC individuals and families are served. Children of color from low-income families are often under-diagnosed (Tolan & Dodge, 2005) and have the highest unmet needs (Huang et al., 2005).

When BIPOC families seeking support from healthcare professionals raise concerns about developmental challenges their children are experiencing, they are not always believed. This, in turn, decreases the referrals made for mental health services at times when acute care experiences could be prevented. These disparities are a common experience in diverse communities where people tend to avoid accessing mental health and other services because of the negative interactions they experience (Turner et al., 2015).

A high percentage of members of the BIPOC community distrust service systems because of the failure of these systems to actively listen to their concerns and/or serve them appropriately (Edwards et al., 2023; Huang, 2002) resulting in people waiting for longer periods of time before seeking assistance. These families and caregivers are also more likely to drop out of services due to the failure of service providers to deal with specific cultural needs and perspectives. A call to address the barriers related to accessing services in marginalized populations throughout Minnesota is increasing, with attention to the disparities encountered by US-born Black Minnesotans, leading to Governor Walz stating in 2019, *“Disparities in Minnesota, including those based on race, geography (and) economic status keep our entire state from reaching its full potential….As long as these inequities impact Minnesotans’ ability to be successful, we’ve got more work to do”* (Pearson et al., 2023, p. 3).

Systems of care and strategies for coordinating services in the community

Systems of care is an approach that uses flexible strategies to improve organizational relationships across an array of services and systems to coordinate support for children and adults (Hernandez & Hodges, 2003). An effective systems of care effort will include the formation of teams at local, regional and state levels to implement interagency collaboration and service coordination (Kutash et al. 2006). Children and adults who experience barriers to transition are often receiving services across various service systems. Examples of these systems include a) education, b) primary care, c) mental health, d) child welfare, e) juvenile justice/justice system, f) substance abuse treatment services, g) developmental disabilities services, h) early childhood services, i) recreational services, j) vocational services and k) transition services (Tyson & Punnose, 2024). Effective communication across these systems is essential for a person who is transitioning from the ED or hospitals back to a home in the community (see Appendix A).

Although each of these services are important and play a role in stabilization, maintenance and overall wellness, transitioning from the ED/hospital or other settings can be difficult for people receiving services and their families to manage. These transitions require a complex planning process where communication often breaks down across multiple systems (Matthews et al., 2019).

For instance, the qualitative study conducted by Matthews and her colleagues found that it is common for a mental health professional to hear about transitions occurring suddenly with no warning, *"...a parent will call me and say, so-and-so's getting out today. And they have no prior warning…"* (p. 937). Without planning and preparation, individuals may return to the ED or hospital quickly because adequate supports are not yet in place. Coordinating systems of care using a continuum model for care coordination can address the challenges family or caregivers face navigating services for their loved one.

Continuum of care

Children, youth and adults who need more intensive supports and/or engage in challenging behavior are served across a continuum of care that ranges in intensity, interventionist and setting in which it is delivered (see Figure 2). When defined broadly, care (or interventions, supports and services) can encompass a variety of intervention providers (e.g., therapists, clinicians, special educators) whose roles are to deliver, oversee or direct the care. They are also served by care navigators (e.g., county case management, special education case manager, care coordinators) whose role is to help connect the person with needed support, monitor and follow up as changes to the plan are needed along with the stakeholders, including the person themselves, their family or caregivers and other relevant members of their community, whose roles are to advocate for care, communicate needs, follow through on recommendations, etc.

When care is delivered throughout the continuum, supports can be 'stepped up' (increased in a dimension of care) and 'stepped down' (decreased in a dimension in care) in a dynamic manner as needed to best meet an individual's evolving needs. The services and supports are the steps and the people supporting the movement from one step to the next are the navigators.

As a person prepares to leave an acute care setting and transition back to their community of choice there are several important considerations. First, there needs to be establishment of the supports and services that the person will receive in the community and the community providers need to be ready, with an effective level of knowledge, training and skill in positive supports for the person. To be effective, this support needs to be coordinated and planned so that strategies and interventions that have been effective in one setting translate to the community.

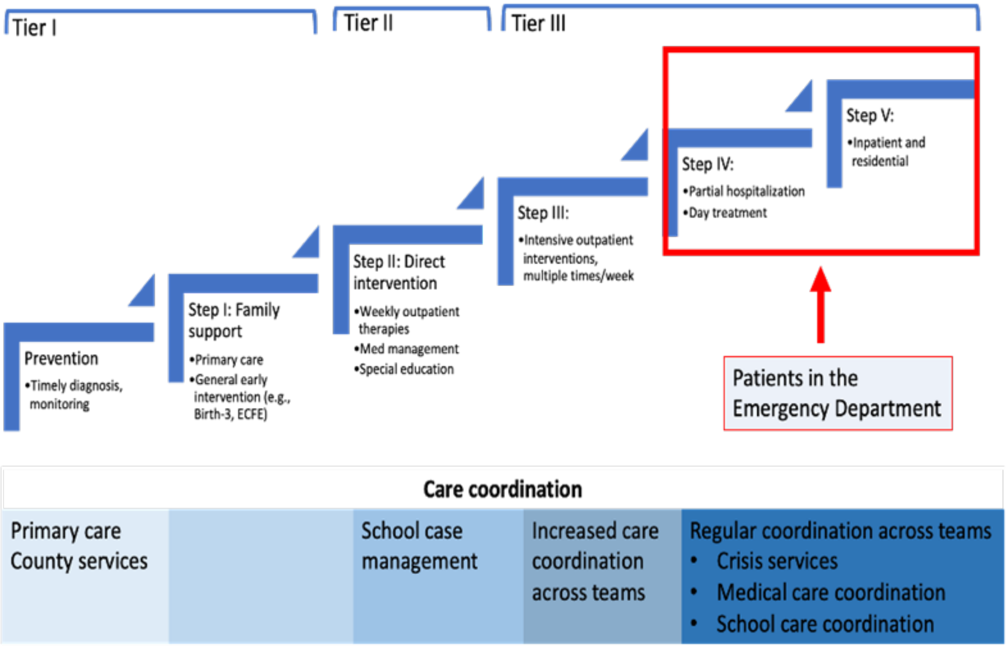
Second, there needs to be on-going monitoring of fidelity to important components of the plan and careful monitoring of the person's progress so that challenges can quickly be addressed prior to escalation to crisis. Implementing these core components poses many challenges. Considerations during this phase include, (a) a firm understanding of the individual's specialized needs, (b) a clear list of resources and staff training needs at the site where the individual is transferring, (c) an assessment of service provider experience and capacity that are involved and (d) access to the history of prior implementation plans (e.g., functional behavioral assessment, cognitive behavior therapy, person-centered or wraparound plan, positive behavior support plan, psychological reports).

Coordinated specialty care models

Although fidelity elements will vary across programs and must include individualization, core elements of multi-element coordinated specialty care models that people with more intensive support needs including severe challenging behavior may need include the following: (a) centering/partnership with the individual and their family (and/or care providers), (b) accounting for and promotion of time-sensitive care (e.g., overcoming of care barriers for provision of immediate support), (c) a team approach comprised of multi-disciplinary expertise with proactive and regularly set meetings and coordination and (d) wraparound training of the team that will be supporting the individual (Addington et al., 2018; Read & Kohrt, 2022; National Academies of Sciences, Engineering and Medicine, 2023).

For example, the Specialized Treatment Early in Psychosis (STEP) model demonstrated that a Coordinated Specialty Care model included key components related to psychotropic medication management, therapeutic approaches for the individual (e.g., cognitive behavioral therapy) and the family (i.e., family psychoeducation) as well as case management to support the transition and success of the individuals back into the community setting (i.e., school or work) led to lower rates of re-hospitalization and increased success in the community (Srihari et al., 2015).

Figure 2-Serving children, youth and adults via a continuum of care



Another example is Navigate, which also takes a multidisciplinary and team approach to supporting people in early intervention for psychosis and uses elements of medication management, individual treatment and family psychoeducation, to address support services for transitioning back to the community. The model also specifies the regular and planned transition supports from the multidisciplinary team (Rosenheck et al., 2016). This model was shown to be effective at reducing acute care needs and improving quality of life that resulted in cost savings. The key elements associated with these specialty care models will likely prove to be useful in supporting transitions from acute care settings for some children and adults.

Assertive Community Treatment (ACT), a team-based approach for supporting people with serious mental illness, is considered an important positive support in Minnesota. The model includes a key contact person who coordinates an array of services offered. ACT is a practice used to assist people with mental illness as they navigate challenges related to transitioning to their homes and community (Mancini et al., 2009). This intensive outreach-based approach includes a 24/7 on-call system, a multidisciplinary team that includes psychiatrists, nurses, social workers, occupational therapists, substance abuse counsellors and peer support specialists using a low staff-client ratio to ensure support (Bond & Drake, 2015; Deitrich et al., 2017). ACT team members include family members, friends, doctors, mental health professionals and nurses. Supports are put in place based on unique behavioral health needs and team members are available when a person is feeling upset, is experiencing a psychotic episode, needs help related to substance abuse issues or is dealing with work or relationship problems. The goal is to help each person meet their own personal goals and manage the everyday problems associated with daily life (Dixon, 2000). Goals can include making new friends, getting to work on time, taking medication and staying healthy. ACT has been shown to be a practice that assists people with severe mental illness to be successful at home and at work while improving their quality of life (Mueser et al., 1998).

Another practice, wraparound planning, helps to ensure that the services a child or adult requires is coordinated and that collaborative approaches are used amongst the providers involved. Wraparound planning processes are driven by the voice of the person and individuals who are important to that person, involve a team approach and build on the strengths of the person and their community (Bruns, 2004). In addition, individualized wraparound plans are culturally competent and based on the strengths of the child or adult, with a focus on improving social, emotional and quality of life outcomes. Important considerations for people transitioning out of acute care settings should include types of differing challenging situations that may exist in the community, such as the involvement of multiple team members, different settings (e.g., a home setting, a school setting and varied other community locations, such as stores and recreation locations). Since risk factors for youth exist across individual, family, community, local environment and societal issues can shape mental health outcomes (U.S. Surgeon General, 2021), wraparound efforts require a biobehavioral approach that addresses these social and environmental factors (National Academies of Sciences, Engineering and Medicine, 2023).

Evidence-based strategies for addressing effective transitions

There are several evidence-based practices (EBPs) that assist children and adults in improving quality of life, expanding social growth and learning to regulate and manage strong emotions. The term evidence-based practice refers to the extent to which research has been used to document how well an approach improves outcomes for a child or adult and is based on a scientific method that includes showing that a given approach has been demonstrated to work with a diverse population of people (APA, 2024). Applied behavior analysis, assertive community treatment, cognitive behavior therapies, culture of safety and positive behavior support are just a few examples that are found in Minnesota. Practices that are person-centered, culturally responsive, evidence based or promising, include systems for collecting fidelity and outcome data and are often implemented with other similar practices are referred to as Positive Supports (Freeman, 2016). The term ‘positive supports’ is used in Minnesota when referring to EBPs.

One of the well-known challenges associated with positive supports is that the research needed to establish a practice as effective is different from the type of research needed to demonstrate how it can be implemented in everyday settings by families, providers, and other individuals (Fixsen et al., 2019). Translating research to practice has not kept pace with the need states have for effective positive supports in applied settings (Bruns et al., 2016). One of the challenges mentioned in Minnesota, across states’ reports and in the literature across fields is that children and adults often encounter barriers related to the lack of effective services for people who need more tailored and intensive positive supports (HANYS, 2022; Stock et al., 2023). Traditionally, organizations addressed new positive supports by sending staff to workshops and hoping this would be sufficient for implementation (Sailor et al., 2000; Smith et al., 1992).

A three-tiered public health model framework is now used in many education, mental health and human service systems to establish and deploy positive supports across a continuum of increasingly intensive interventions (Gorden, 1983; Walker et al., 1996; WHO, 2004). At Tier 1, all people (staff, managers, family members/caregivers and people receiving supports) in each setting work together to improve their social and emotional skills by building positive relationships, recognizing/celebrating success and encouraging people to improve the quality of their lives. Tier 2 strategies are used to monitor and problem solve when minor challenges occur that have an impact on social interactions and quality of life. Simple strategies are used at Tier 2 to help people who need a little more support. Data is used to identify people needing support as soon as possible before a crisis occurs. Tier 3 interventions are the most costly to implement. There are times when people need more intensive and individualized support at Tier 3. A few people will need more intensive plans at Tier 3 and a more structured plan to address complex challenges during life transitions. At Tier 3, a team forms around a person to help in problem solving. Different types of positive supports are used at Tier 3 based on each person's strengths and needs.

There are three statewide training and technical assistance infrastructures currently in place in Minnesota using a tiered approach (Freeman, Danov et al., 2021; Freeman, Simacek et al., 2021; Johnson, 2017; McIntosh et al., 2010). Early childhood systems, school districts/schools, provider organizations and other systems engage in these long-term sustainable efforts to improve outcomes for children and adults by applying a three-tiered model for implementing positive supports such as positive behavior support, trauma-informed supports and person-centered practices. School-linked mental health services in Minnesota improve access to positive supports and are linked to tiered implementation efforts in education. Minnesota statewide efforts support implementation of multiple practices that are integrated into schools and organizations, an approach referred to as multi-tiered systems of support (McIntosh & Goodman 2016).

Implementation science (Fixsen et al., 2019) is another important field of study used in Minnesota as the framework for implementing positive supports at a scale of social significance (local, regional and statewide levels). Implementation science is a field that has evolved to address the challenges associated with implementing evidence-based practices in homes and community settings (Fixsen et al., 2005; Fixsen et al., 2013). The leaders of implementation science are interested in the features associated with sustainable and long-term use of EBPs. These researchers conducted a synthesis of the literature to understand the most important features associated with adoption of positive support practices whether these efforts occurred in education, IDD mental health, juvenile justice or any other human service organization (Fixsen et al., 2005; Fixsen et al., 2009). These core components are called implementation drivers (Metz & Bartley, 2012). Three major drivers are related to staff competency, organizational issues and leadership-level skills.

Actions, mechanisms and resources needed to improve the necessary knowledge and skills of people receiving services, staff, managers/supervisors and administrators implementing tiered support models are all considered "competency drivers" in implementation science (Fixsen et al., 2010). Four elements of competency drivers outlined by Fixsen and his colleagues include performance assessment, selection, training and coaching (see Figure 3). "Organizational drivers" are the systems elements used by teams to establish a training infrastructure needed to support an EBP (Metz & Bartley, 2012). The organizational drivers are used to monitor progress and maintain feedback communication loops that allow teams to share information in a transparent manner (Bertram et al., 2011). The leadership levels skills in implementation science refer to *"technical challenges"* and *"adaptive challenges*." These types of leadership skills explain the different types of problem-solving leaders need throughout implementation (Metz & Bartley, 2012). Technical challenges are associated with basic management and facilitative administrative skills needed to manage and coordinate implementation efforts. Adaptive challenges are more complex, involving more complex social and contextual problems.

In the past, the common approach organizations took was to address cultural responsiveness by hiring a professional with expertise to provide an annual workshop. This approach does little to change the behavior within organizations (Freeman et al., 2023). Researchers have studied whether presenting data without any other culturally responsive interventions in a system would have an impact on equity-related outcomes and found only minimal changes occurred (McIntosh et al., 2020). Organization-wide approaches including interventions such as relationship-building are also needed to encourage active listening and empathy, share stories/experiences of people and facilitate action planning within an organization (Fallon et al., 2023).

Figure 3-Integrating culturally inclusive practices into implementation science

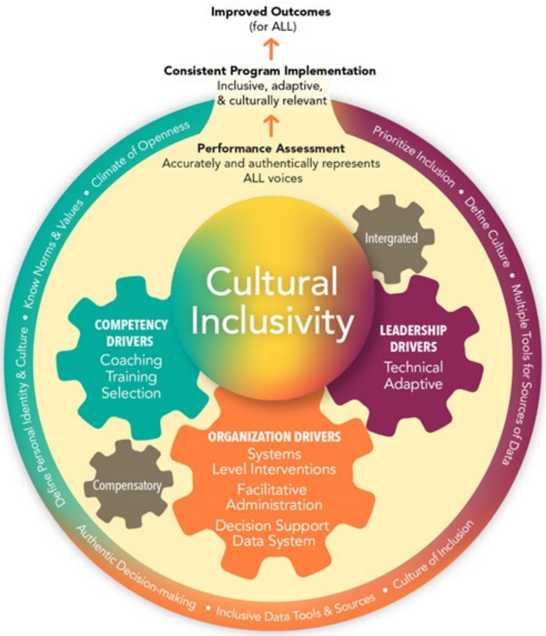


Figure 3 provides a more comprehensive strategy for integrating cultural responsiveness across each of these drivers to ensure organizations, regions and state training systems are improving cultural competence with the context of positive support practices (Freeman et al., 2024). Embedding culturally responsive strategies within competency, organizational and leadership drivers and throughout the implementation of positive supports increases the likelihood that organizations will be able to address implicit bias, identify policies that have a negative impact on marginalized communities, and create a climate that welcomes diversity. Researchers and trainers in positive supports have worked hard to build resources that can be used within implementation science including fidelity of implementation and assessment tools, curricula that teaches staff to identify times when implicit bias may be more likely to occur, coaching and training systems to teach self-awareness and empathy and other efforts to embed cultural responsive practices into implementation (Ferro et al., 2023; Gage et al., 2019; Leverson et al., 2021; McIntosh, Barnes, et al., 2014; McIntosh et al., 2020).

Another important way to improve acute care transitions is by using data-based decision making as one of the organizational drivers in implementation science to establish unified statewide measurement, developmental evaluation planning, as well as local, regional and statewide problem-solving teams.

Unified measurements systems

The literature on barriers to transition from acute care ED and hospital settings call for a focus on better monitoring and evaluation with a focus on sustainability and long-term problem solving (Cadel et al., 2021). This section of the report is organized by (a) the need for data-based decision making and evaluation, (b) the importance of unified and clear operational definitions and measures related to acute care transitions and (c) establishing organizational, regional and statewide systems for sharing data.

Data-based decision making and evaluation

It is challenging to fully understand the scope of the problem in Minnesota related to the multiple and complex needs for improving effective transitions in acute care setting across populations of people experiencing different types of acute care barriers and who represent various ages, ethnicity and race, medical diagnoses and geographic diversity. Important contributions have been made by different sectors including groups such as the Minnesota Hospital Association (MHA), the Minnesota Medical Association (MMA), organizations dedicated to evaluation such as Wilder and the state's reporting via the Department of Health. One way to improve communication across the different organizations and systems is to create opportunities to meet and review data that are gathered based on a common language.

Interagency systems change requires a common language across different state divisions, hospital and provider organizations, people with lived experience, their families and caregivers, universities, civic organizations and other community partners (Freeman et al., 2009). Building a common language and common measurement systems allows for information to be shared and discussed. Adding ongoing meetings that form "feedback loops" for reviewing data and making decisions together helps build a common understanding and experience across the different partner groups — e.g., people with lived experience, families/caregivers, hospitals, behavioral health professionals, state leaders, providers, etc. (Freeman et al., 2009).

To accomplish this task, an evaluation plan is needed. Evaluation allows the state to establish goals and map out a logic model that will help implement changes in acute care transitions over time. Logic models can be used to show the relationship of acute care interventions to the resources and actions that are taken to address the barriers to transition. They are described as a road map or pathway to show how the state will reach it intended outcomes. Statewide logic models have been used in several states to implement different positive supports using implementation science methods (Freeman et al., 2009; Matthews et al., 2019).

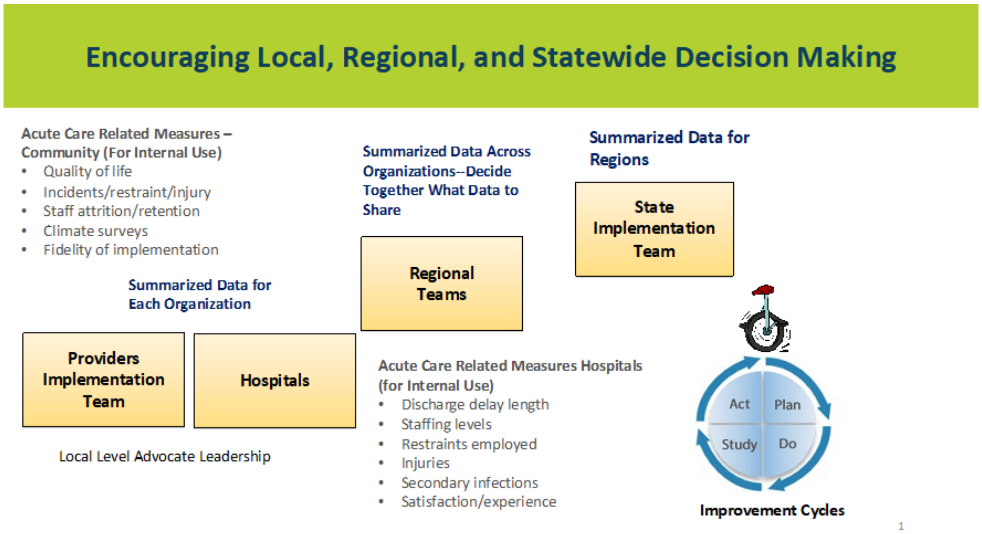
Unified and clear definitions related to acute care transitions

Scoping reviews investigating acute care and barriers to transition both within and across countries have highlighted the need for consistent definitions of key terms associated with discharge delays (Abdelhalim et al., 2023; Cadel et al., 2021). The differences in how discharge delays are measured can contribute to confusion and/or difference in interpretation (Glasby et al., 2004). Fortunately, leaders within Minnesota have already conducted research related to this topic and can contribute to operational definitions for the study of discharge delays (Dillon & Thompson, 2016, Dillon et al., 2024; Schindler, 2024).

Organizational, regional and statewide data collection

Establishing local, regional and statewide systems for monitoring individuals experiencing discharge delays and/or problems is necessary for effective transitioning into the community. Figure 4 is a visual adapted from an EBP related to positive support that is using implementation science to ensure that information for data-based decision making is established in a manner that allows for information to be shared at local, regional and statewide levels. Figure 4 outlines how training and technical assistance, policy and systems change efforts can be used to organize the collection of data. All organizations use data and are required to report information. Agreements across these groups lead to summarized data at the regional level. These summaries help regions to share priorities, action plan and make recommendations to state leaders. Once regional data is shared, the state team engages in the same activities, summarizing data across regions to report an overall state report. Since the individuals experiencing barriers to transition vary, the data systems that are needed must be organized to address different target populations, age ranges, diagnoses and health challenges, and types of organizations providing services.

Figure 4-Using cascading logic for data-based decision making



Measures for culturally responsive evaluation planning

Measures dedicated to monitoring cultural responsiveness and equity in services are important elements of the evaluation of acute care barriers to transition and any future action plan implementation. The Minnesota report written by Chomilo (2022) provides an example of important strategies used when attempting to fully understand the experience of groups of people who may traditionally not have been heard in statewide planning. The report indicates that it *"… aims to continue the evolution of how policy within the Minnesota Department of Human Services (DHS) is designed, proposed and considered by intentionally striving for community co-creation."* (p. 1). In prior reports funded by DHS, focus groups in Minnesota exploring the implementation of positive supports, professionals have advocated for the following:

- Listening sessions dedicated to specific rural areas with people representing traditionally marginalized communities.
- Recruitment of people from underrepresented populations to participate in co-creations of new services and systems.
- Intentionally building relationships as a dedicated activity.
- Reaching out to communities rather than expecting them to seek out opportunities to provide feedback (Freeman et al., 2021).

Relationship building and co-equal leadership with people representing the diversity of Minnesota is an important first step to establish "reciprocal trust" that might lead to any effective measurement systems that are created (Fallon et al., 2021). The Minnesota Governor's Council on Developmental Disabilities (2023) has indicated that *"If progress in reducing discrimination in Minnesota is the goal, then there needs to be a research system put in place for obtaining baseline measures of incidences of discriminatory behaviors and practices and tracking changes over time."* (p. 2, MN Governor's Council on Developmental Disabilities, 2023).

V. Evaluation methods

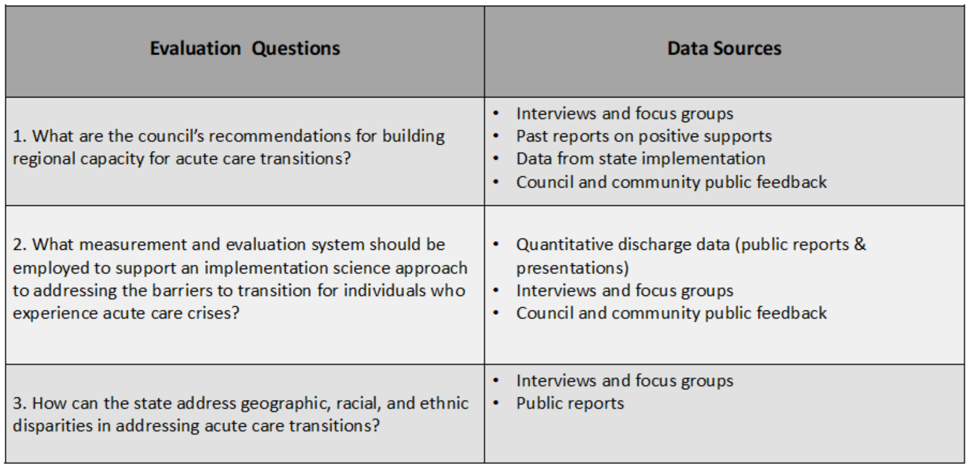
Information was gathered and shared with the ACTAC across eight meetings starting in November 2023 through September 2024. This information assisted the council as they considered action-plan recommendations in this report. Professionals from the ICI at the University of Minnesota, conducted focus group and interview sessions, analyzed all data gathered by the council and summarized the results. The methods used to gather and summarize these data are described in this section of the report. The methods section describes participants involved in ACTAC information gathering, procedures for focus group and interview sessions, key public reports summarized and the overall mixed methodological evaluation strategies employed to analyze the results.

The evaluation questions the Acute Care Transitions Advisory Council was asked to explore and subsequently provide action-planning recommendations are outlined in Table 2. Multiple sources of data were used to address these questions including:

- Council related meeting transcripts and public comment.
- Focus groups and interviews with community partners across the state.
- Quantitative and descriptive public reports and/or presentations of data on the topic of discharge delays.
- Public reports on disparities related to geographic, race, ethnicity and other marginalized populations in Minnesota.

The plan for evaluation was submitted to the University of Minnesota Institutional Review Board (IRB). The IRB process is used to ensure that the rights of participants and data collected throughout the study are secure and that individuals are protected from potential harm related to study activities. The IRB confirmed that the study was exempt from full review due to the minimal potential for harm to participants. However, it is important to note that due to the short timelines associated with the council’s activities, focus group and interview data related to people with direct lived experience were not collected. Involving individuals with lived experience, some of whom with various disabilities, required a more rigorous protocol with a longer timeline for completion.

Table 2-Council evaluation questions outlined by Legislature



Evaluation Questions	Data Sources
1. What are the council's recommendations for building regional capacity for acute care transitions?	• Interviews and focus groups • Past reports on positive supports • Data from state implementation • Council and community public feedback
2. What measurement and evaluation system should be employed to support an implementation science approach to addressing the barriers to transition for individuals who experience acute care crises?	• Quantitative discharge data (public reports & presentations) • Interviews and focus groups • Council and community public feedback
3. How can the state address geographic, racial, and ethnic disparities in addressing acute care transitions?	• Interviews and focus groups • Public reports

The council strongly recommends that additional steps be taken to gather information from children and adults who have been directly impacted by barriers to transition following an acute care visit to the emergency room and/or hospital. This evaluation is considered incomplete without this essential information.

Evaluation took place starting in spring, 2024 beginning with a literature review across the topics outlined in the introduction of this report and an analysis of public reports from Minnesota and other states. Focus groups and interviews were completed from August 2024 until September 2024. Thematic analysis began immediately in August 2024 and was conducted in an ongoing manner until the recommendations were finalized by the council.,

ACTAC meetings

Acute Care Transitions Advisory Council's meetings used a modified Roberts Rules of order to run meetings with business, invited presentations and activities, and discussion occurring across eight meetings. Meetings were streamed live after Nov. 6, 2023 and included open sessions. Quorum was met at every meeting that was scheduled. Table 3 summarized dates of meetings and number of council members in attendance.

Participant recruitment

Participants in the evaluation included community partners across the state of Minnesota with experiences related to barriers to acute care transitions. These participants included people representing family members and/or caregivers, individuals representing Indigenous people/tribal nations, counties, providers and hospital professionals. Flyers were created and distributed, inviting people representing the community partners listed in the purpose section to sign up for either focus group sessions or interview sessions via Zoom. The flyers were distributed via state and local listservs, professionals involved in acute care related work, websites and members of participants representing different community partners. Focus group flyers included a registration site where people registered to participate and subsequently received calendar invitations with a Zoom link (the Appendix B contains the flyer used in this evaluation).

There was a total of 64 individuals who contributed to this evaluation via council meetings, focus groups and interviews. Council members (N=36) included the individuals selected as acting members, as well as invited presenters, State Representatives, university personnel and staff supporting others on the council. Some council members participated in all meetings while others attended one or more meetings. There were eight focus group participants (five individuals in one session, three in the second focus group) and a total of 20 people recruited for interviews (one person contributed to both council and interviews but was counted once). One individual with lived experience served as council member. A pseudonym was assigned for each participant and information gathered describing the person's geographic location, role and type of data source. The list of participants, how they participated, their roles and geographic location are available in Appendix C.

Procedures for focus group and interviews

Two, two-hour Zoom-based focus group sessions were held with seven to eight people attending from across the state. One or two university professionals facilitated sessions with one person leading the conversation and another taking notes. Interviews were conducted by Zoom although telephone-based interviews were offered based on participant preference. Interviews were offered for participants who did not want to participate in group discussion or could not make the dates set for the focus group sessions. Interviews were approximately 45 minutes to an hour in length, based on the comfort level of the participant. The interviews, public meetings and focus group transcripts were recorded and Zoom chat information from public meetings were used in the analysis.

Evaluation questions

The evaluation questions developed by the council for focus group and interview sessions included the following:

1. What are the most common barriers to acute care transitions that occur in your region of the state?
2. What challenges have you encountered related to this topic personally or in your professional role?
3. What could be done to improve transitions for people who encounter barriers returning home? Are there promising practices or facilitators (i.e., things that have improved transitions home) that you can share?
4. What measures or data sources would help the state in better understanding the challenges associated with transitions from acute care settings?
5. Have you experienced geographic, racial and ethnic disparities personally or in your professional role at work?
6. How can the state address geographic, racial and ethnic disparities in addressing acute care transitions?

All data sources including public meetings were de-identified including names, organizations, towns and references to other people to protect confidentiality. The initial recordings were deleted once transcripts were de-identified and confirmed for accuracy.

Table 3-ACTAC meetings and topics

Date	Number of Council Members	Topics Addressed in Meeting
Nov. 6, 2023	14	Introduction to ACTAC goals.
Jan. 25, 2024	14	DHS legislative process.
Feb. 29, 2024	13	Complex Transition Team introduction.
April 30, 2024	13	Positive supports and implementation science.
June 4, 2024	13	No invited presentations. Focus group and interview outreach and questions.
July 15, 2024	13	Minnesota Department of Health discharge delay study & Minnesota Hospital Association presentation.
Aug. 14, 2024	14	Data summarized from DHS Complex Transition Team.
Sept. 11, 2024	12	No invited presentations. Council discussion on recommendations.
Sept. 30, 2024	12	No invited presentations. Council discussion and vote on report and recommendations

Summary of key public reports and data presentations

Facilitators of the ACTAC conducted an informal literature search on the topic related to barriers to transition from the emergency room and/or hospital. Search terms included were used in Google Scholar and other University of Minnesota library search systems including: acute care transitions, alternate level of care, emergency room/hospital discharge delays, bed delay, hospital boarding, transition planning (and related subthemes: Autism, IDD, emotional behavioral disorder, evidence-based practices and acute care discharge, older adults, complex health issues, mental health), systems of care, implementation science, equity and disparities (and related subthemes: across services and supports, health care, BIPOC community), stepped down care, complex health care and acute crises, interventions, evaluation of acute care crises. All articles were uploaded in folders under varying categories of the search (e.g., Minnesota reports, other state reports, emergency room (ED) boarding and hospital discharge delays, older adults, etc.).

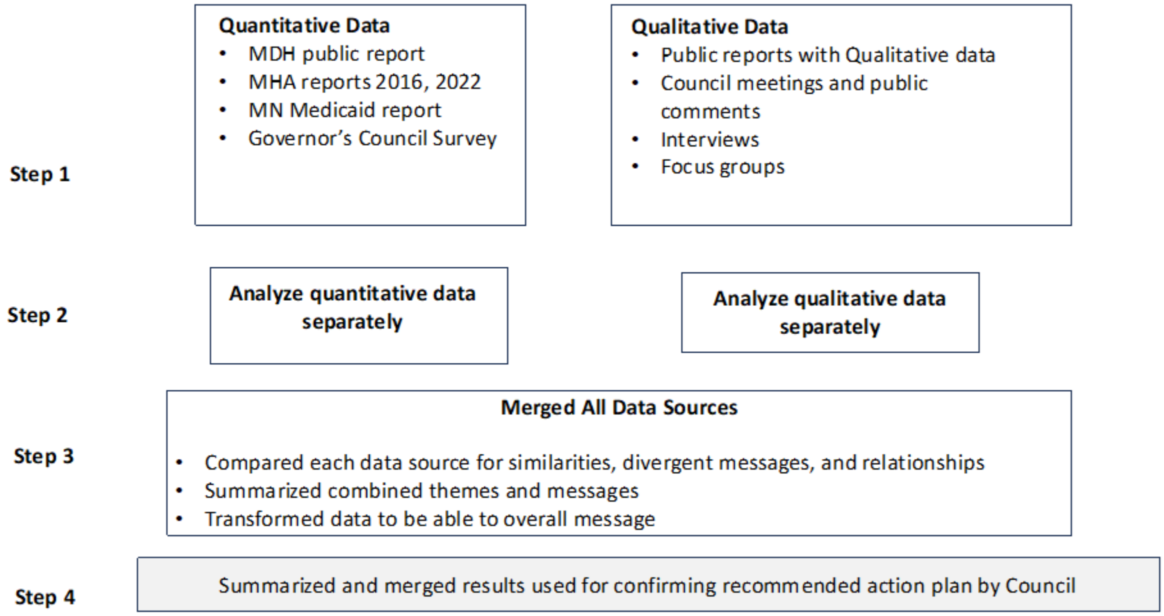
Quantitative and qualitative Minnesota data on discharge delays and health equity issues

Minnesota public reports related to discharge delays were collected for review. Each public report selected for analysis was summarized using a worksheet to capture core information about the type of data reported, rigor of methods, results and recommendations made by the authors. A copy of the worksheet appears in the Appendix D and summarized data are available upon request. The list of reports selected for descriptive analysis is included in Table 1. A total of six public reports or presentations were summarized related to hospital discharge delays/emergency room boarding. Three reports including data related to health equity and disparities in Minnesota were included in Table 1 as well. Other Minnesota reports were used within the report process and informed the literature review and recommendations made by the council.

Mixed methods evaluation design

The council report relied on methodological foundations of mixed methods design to analyze council transcripts, focus group and interviews and public reports on the topic of acute care barriers to transition (Cresswell, 2014; Cresswell & Clark, 2011). The mixed methods approach merged the results of public reports, council meetings, focus group sessions gathering feedback from the community and interviews with individuals with experience associated with barriers to acute care transitions. Figure 5 provides a visual description of the steps occurring across the evaluation. The methods included an inventory of existing data sources related to acute care barriers to transition as a first step in evaluation. The mixed methods design in Figure 5 shows that the design is convergent with quantitative and qualitative strands collected and analyzed concurrently as separated processes.

Figure 5-Mixed methods design for merging qualitative and descriptive report data



The major findings were then triangulated across these different data sources (Cresswell, 2009). Data were merged to assess possible convergence or divergence of findings, contradictions occurring across sources of analyzed data or the identification of relationships that appear across the quantitative and qualitative data sources (Cresswell & Clark, 2011). Themes that appeared across multiple sources of data, across the state and by multiple community partners helped the Council better understand the internal validity of information gathered its potential import.

Qualitative thematic analysis of multiple data sources

The multiple transcribed data sources (i.e., meetings, focus groups and interviews) were analyzed using qualitative data analysis methods defined by Creswell (2009). An inductive approach was taken to establish codes used and the themes that were identified by the authors of the report (Braun & Clarke, 2006; Patton, 1994). This means that the themes identified were linked to the data itself rather than the authors establishing codes in advance by three major questions posed in Table 2.

The transcripts were broken down by themes with codes indicating what data source was used as each code was identified. For each coded section of the transcript, the pseudonym, data source and date, role of the person (i.e., county, hospital, university, etc.) and location in the state (i.e., metropolitan area, northeast, etc.) were noted using a code to represent each category (e.g., Lyra-CM-Nov6-University-Metro). This allowed authors analyzing the coded content to quickly identify the main characteristics associated with each coded section of the transcript. As more data was collected, potential categories and themes were discussed, identified, organized, triangulated and prioritized (Merriam, 2009; Creswell, 2009). The codebook used in the evaluation is available in the Appendix E.

VI. Results and findings

This section of the report summarizes the major findings of the mixed methods evaluation study. Results are organized by each type of data source:

- Council meeting, focus group and interview thematic analysis.
- Descriptive analysis of public reports:
    - Emergency room and hospital discharge delays.
    - Related to geographic, ethnicity and race disparities in Minnesota.

Each data source is summarized and a merged results section combining the integrated data sources is provided.

Council meetings, focus groups and interview thematic analysis

Since the coding did not change significantly across data sources, the results section has summarized council meetings, focus groups and interviews together. Four primary themes evolved from the data sources related to acute care action planning activities:

- Characteristics and description of people experiencing barriers.
- Barriers encountered, before and after transition.
- Interventions and strategies for addressing barriers.
- Healthcare disparities related to ethnicity, race and geographic areas of the state.

A summary of the major four themes and each of the corresponding subthemes are presented in Appendix E and represent the contributions from community members engaged in this action plan. The barriers described by each of the participants in the council meetings, focus groups and interviews reflected their direct experiences related to barriers to acute care transitions. The subtheme patterns broke down the overall four major themes into smaller more specific topics and issues. The results section describes these four overall themes introducing some of the subthemes for each section. More details about the overall and subthemes are available upon request.

Characteristics of individuals experiencing barriers to transition

Children and adults across the lifespan were described as experiencing discharge delays from early childhood to older adults over 65 years of age. However, no really young children (1 to 3 years old) were discussed in this report. Participants discussed the challenges associated with the many diverse characteristics of people (age, race/ethnicity, gender, location in state) experiencing these barriers to transition and the corresponding complexities that result in delays moving back home or into alternative placements (inpatient unit, psychiatric residential treatment facility, foster care, etc.).

The subthemes in Appendix E list the various types of participants who are more likely to face challenges in transition. One participant summarized some of the more common characteristics or defining features *"… people who are in an acute care setting, so a hospital bed or emergency department…[who] no longer have an acute care level of need…or weren't appropriate for hospital admission in the first place and [have] difficulty* *accessing community supports and discharging to the right level of care, often, because they've been denied by…a high number of providers… They may engage in serious aggression or self-harm. They've often received a service termination notice from their current providers because of some of that aggression…or they need supports…that are very difficult to find in the community, like maybe a two-to-one staffing ratio or something like that."* (Luca, council participant).

Participants described children younger than 20 years old as more commonly experiencing barriers when living in family or foster homes and may later be placed in group residential settings, psychiatric treatment facilities or inpatient settings. Children who are citizens of tribal nations, Black or African-born children were described as over-represented and often had a diagnosis of Autism or IDD and/or other co-occurring diagnoses. Aggression, property destruction and self-harm/suicide attempts or self-injury are often reported as behaviors that are making it more difficult to find placements for children.

Participants also discussed the barriers to transition that adults over 20 years old have experienced. Adults with mental health-related diagnoses and/or substance use disorders (SUD) frequently encounter transition-related challenges. One focus group participant stated that she and her colleagues struggle *"sometimes to find placements for people with kind of an unfortunate combination of physical and mental health and sometimes chemical dependency issues."* (Val, provider, focus group participant). Val also indicated that *"we have people who, for all practical purposes will discharge…really, they're discharging to homelessness. They're leaving detox to homelessness, and that makes it really hard to…help people get their needs met and just stay safe."*

The issue of being without a home when transitioning out of acute care was described as particularly true for adults representing tribal nations, *"we have a lot of folks, and the people who end up in the hospital, of course, are the ones who are most vulnerable who are more likely to be houseless."* (Nora, interview). Nora went on to say that although the number of people representing Native Americans [experiencing acute care delays and not having a home to transition to] are low, however, *"…that's a large portion of our community relative to that of Whites, you know, that might happen to like 20 Whites …but for us, just a couple is a large portion of our population…"*

Participants discussed the challenges associated with transitions for individuals who are receiving bariatric care and need supports to transition from the ED or hospital. Appropriate housing, transportation and other supports were discussed as important considerations related to bariatric service barriers to transition and readmittance to the ED or hospital for this population.

Older adults (over 65+) were also described as experiencing barriers related to transition. Participants described issues that can create barriers for older adults including diagnoses related to dementia, depression or other diagnoses and/or substance use disorder. An older adult who arrives in the ED or hospital may no longer be safe at home without additional supports as part of a transition plan. This places pressure on home health providers to protect individuals.

One provider stated during a council meeting that when older individuals do not have a safe plan for transitioning home, *"… what we experience sometimes is that individuals are being discharged from a hospital setting to home care. And they're really not…If there's not a safe care giving plan in place…they're really not an appropriate referral for home care and then we're stuck in a situation with patients that are medically fragile, complex and may not have a safe caregiving plan in place in the home…"* (Zoe, council participant). One barrier that came up across focus groups, interviews and within the council was how the lack of time for transition planning increases the likelihood of re-admittance to the ED or hospital.

Discussion in the council meeting focused on how to proceed given the great diversity of challenges, age ranges, systems and characteristics of people involved. This, in turn, led participants to talk about the differences encountered across Minnesota regions *"…Like for some hospital systems…the challenges [may be] guardianship and dementia… related behaviors for seniors…then others it's children with just a mental health diagnosis,…So I would just say that I feel like part of the data question…I think that we have to let the data drive us …"* (Luca, council participant).

As an example, several participants discussed how closures of SUD-related treatment facilities in one region and hospitals in another area or region impacted barriers to transition. Another participant indicated that availability of nursing home beds was a big problem for the region. Several participants felt that these regional data patterns clarify overall statewide patterns.

Participants indicated that multiple diagnoses and/or complex medical issues complicate transition planning. For instance, one participant described a person experiencing challenges in managing diabetic symptoms while also addressing serious chemical dependency issues. A provider may be well-suited to address one issue while being under-prepared for another complex behavioral or medical issue. A participant provided an example of this by indicating that children or adults with IDD and SUD can create challenges for home and community-based providers, *"… we're learning how to do a lot of the…positive behavioral support stuff to serve people with behavioral complex behavioral needs. But when you add chemical dependency to it, it is one of the things that at least my experience is, we're not very good at it…It is just a challenge for us, and it's hard to partner with people or find people that can help us…"* (Xael, focus group).

Another person representing medical health care for people from tribal nations indicated that individuals from Indigenous backgrounds often reflect higher disparities resulting in multiple concurrent conditions and that this results in a higher number of complexities required for transition and continued health care treatment. The number of complex healthcare challenges a person may be addressing in their lives has an impact on whether they will experience barriers in transition from acute care.

Barriers encountered in acute care transitions

Numerous barriers were noted by participants who work with and support children and adults across the lifespan. These barriers are listed as four subthemes in Appendix E: a) coordination and communication, b) funding/policy barriers, c) challenges accessing community services and d) discharge delays.

Coordination and communication problems

Many participants described the need for increasing coordination and communication across systems to address the complexity involved in improving transitions for children and adults across the lifespan. Participants acknowledged that state leaders, providers, hospitals, counties, and any other systems responsible for supporting people in need of transition must work together to solve the complex challenges associated with transition barriers individuals experience. One state leader stated that *"It's going to take the whole community working together across all different sectors to figure out how to help people move from hospitals to appropriate* *community-based settings,"* (Bua, council participant). However, communicating across the numbers of state systems, providers, clinics, hospitals, lead agencies, and other sectors was described as very challenging by many participants since each organizational system tends to have its own language, systems and processes. A physician interviewed described how she cannot access her clinic data from the hospital because of the electronic systems involved, describing how she must access *"… a certain computer in a certain area"* of the hospital (Nora, interview participant). She went on to say, *"We have all these systems competing against one another to be the one that each clinic or hospital uses…and then they don't talk to each other…they're competing."* Even within the state itself (disability services, behavioral health, education, children and family services, etc.), participants describe coordination and communication as challenging.

According to several participants, when many systems are involved, it can be difficult to confirm that there is one person taking a lead role in guiding the transition and failure to make progress is common. Without this leadership role, Aero, a person interviewed said, *"I think we all get stuck without leadership. There's been times that I have facilitated …kind of the action plan [for a hospital transition team] …because I just couldn't take it anymore."*

A participant working in the hospital highlighted the importance of strong partnerships saying, *"... on the hospital side we often see delays because of communication gaps between county placement workers and county services and ... hospital services and hospital case management,"* (Byla, council participant). The need to make sure hospital staff have the information they need when discharging an individual was shared by one person while another individual talked about how important it is for case managers and contracted case managers to be updated on important policies related to the acute care barriers to transition such as guardianship.

The need to assess how to navigate across systems and to understand where problems are occurring between services and systems was shared by a person who responded to another council member, *"…But what was the coordination, and what were the variables? That if those things could have been improved...I'm trying to figure out coordination of care and who's responsible for what,"* (Cora, council participant). Care coordination during transition periods was highlighted by participants who felt that there was not enough communication across services. One provider expressed her frustration with this issue describing calls she received about someone leaving the hospital:

> *"… when I get calls saying the situation [a transition] happened…they're gonna discharge Thursday, and it's Monday, and then I'm expected to get equipment set up…try to find a staff in time to help provide additional coverage for that person…and like you can't move fast enough through that like…okay, they no longer need to be at the hospital …they're leaving today. Well, [number] 1-They don't have a ride home…[number] 2- They don't have a staff to help support them,"* (Yana, focus group participant).

The pressure to move individuals out of the ED or hospital quickly was described as something that added negative pressure impacting relationships with individuals across services. Each participant expressed this frustration in different ways depending upon their roles. Hospital staff expressed the importance that people understand that a child or adult is not in an appropriate setting when delayed in the hospital and therefore, they need to move on immediately. County professionals expressed their concern that hospital staff sometimes place a great deal of pressure on providers who end up feeling that they, *"…. really don't want to work with the* *hospital anymore because they think they're just not wanting to help them and get someone discharge,"* (Mada, focus group participant). Other providers stated, *"that the feel they are fighting each other all the time,"* (Zaci, focus group participant). One person described this situation saying:

> *"But it's always that transition piece. And what's the next step? And it seems like it's hard to even say we're bottlenecked at any one place, because it seems like every time you need to do any kind of placement, you're potentially looking at another bottleneck you know… So, we end up with this kind of letting people out of the hospital or discharging them from the hospital early and they end up going right back in…"* (Val, focus group participant).

Many participants representing county and provider roles argue that a statewide approach is needed even when regional problem solving is occurring. These individuals report that many children and adults end up receiving services in multiple different places across the state over time. When there are no memoranda of agreements to allow communication, information cannot be shared by professionals across the state and across organizations. In most cases, participants indicate that there is no information available during each move. The result is that people are starting over each time they are in transition:

> *"... If you have someone that bebops all over the state they're switching psychiatry every single time…And it's just so detrimental to that case, that there would be a higher support system to … follow them through the state ... you've followed me for three years, although I went to six placements around the state … you're starting fresh every single time and for someone to have to tell their traumatic story every single time…"* (Yana, focus group participant).

Funding and policy barriers

Participants discussed several funding and policy barriers that make it more difficult to assist children and adults in transition from the ED or hospital. As the case in other states, Minnesota systems for providing funding and policies that impact acute care transitions can introduce iatrogenic barriers (well-intentioned efforts with negative outcomes) making those transitions more difficult. Problems mentioned by several people are delays that occur while individuals are awaiting assessments and/or services. As one participant described it, *"We all have patients in our hospitals right now that are waiting just for those rate adjustments…MnCHOICES [assessment]…and need a way to be able to have those prioritized in the system so that they can be acknowledged and mitigated."* (Ava, council participant).

Delays that occur in the assessment and application process creates challenges, *"…having a MnCHOICES assessment done while they're in the hospital as opposed to discharging them home…and then we have to refer from the community…and then we get told….they won't be called for five months, you know, just to have the assessment scheduled. That's a huge gap and lag time in getting needed services to help them stay safe and to help stabilize their situation,"* (Zoe, council participant).

Several participants pointed out that funding for community services for older adults (65+) is not adequately funded, *"…hospitals get the highest pay and then nursing homes and then home care,"* (Mada, focus group participant). Funding and policies are organized to provide more funds to services such as hospitals and nursing homes while inadequate funds are available for care in the home:

> *"…because the cost of the services is simply not reimbursed through the State Medicaid system through Medicare Advantage and…they're not even able to pay wages sufficient enough to hire people,"* (Mada, focus group participant).

These policies and funding issues are described as problematic for older adults since it makes it difficult for people to transition home safely: *"We're not able to provide 24-hour care to them. We're not able to have a nurse in the home or a home health [aide]…in the home for six hours a day. I mean, that's just not how our services are structured it and we know it. But we're trying to help them access additional services to meet that need. But there's a huge gap and a huge delay in being able to get those services in place,"* (Zoe, council participant). Another participant described the negative outcomes associated with being placed in more restrictive settings:

> *"… We have…quite a few elderly folks that I think sometimes end up in the wrong place. They end up in a memory, a locked memory, care, facility, and they really shouldn't have to be there. They shouldn't have to be so restricted. But we don't have a better, more appropriate place for them that's safe. And so, they end up…probably they're biggest nightmare of their lives being stuck in a…you know, memory care, facility when maybe it doesn't need to be that restrictive,"* (Val, focus group participant).

Another policy-related barrier related to adults that was mentioned by participants has to do with capacity building across the state. Several individuals mentioned the problems associated with reimbursement for positive support services. These reimbursement rates are not high enough to offset the cost of implementation and many individuals across the state have indicated that they do not use the service as a result. Meeting the qualifications for being eligible to bill for positive supports is a challenge, primarily because training and supervision is difficult to find: *"…The qualifications are too strict, especially for analysts. So, you can't find an analyst to work with you, which then really limits your ability to use positive supports. So, when you need those kind of supports to help care for or support a person in the community…It's a challenge to get this, the waiver system funding stream…for those positive support services to work. And so, what happens is a lot of providers don't do it."* (Xael, focus group participant). Another participant simply stated that using positive support services was proving to be problematic because *"… we're finding it very, very difficult to make it even break even with the reimbursement rates,"* (Zaci, focus group participant). The result of these challenges means that participants are reporting that few people can provide positive supports, especially in rural areas.

> *"… For this service, I know, the county case managers that I supervise and work with would love to be able to refer to positive support services more frequently. It's just incredibly difficult to access in our area of the state and perhaps, you know, that's not the case, I guess across the board. But I think certainly different regions of the state would really struggle to be able to refer to the service, so we can train you know, about the availability of the service or about the service and what it's supposed to provide. But unless we have people to do that work? I think that will be a challenge,"* (Iris, council participant).

Participants described the need for changing qualifications to allow for a competency-based training approach so that in areas of the state where it is difficult to find individuals who have completed college and university degrees, an alternative option is available. In addition, several individuals recommended that positive support policies be written that build in incentives for staff by creating a pathway from the specialist services level at the direct support staff, to analyst and all the way to the professional role.

Other participants highlight the need to consider whether the referral to the hospital was necessary in the first place or more likely occurring due to the challenges providers need training in evidence-based practices or positive supports. One person described this by saying people are *“placed into hospitals without fair reason of needing hospital level, of care…because of staff shortages or an incident that you know the staff didn't respond with positive behavioral supports. And there wasn't that appropriate response or support…at the time and then they are…they're just stuck there,”* (Aero, interview participant). A number of participants felt the attention on transition is essentially waiting until the crisis has escalated which is too reactive.

Difficulties accessing community services

Most participants discussed the challenges associated with access to staff and was evident when discussing supports for children and adults across the lifespan. The funding available to pay staff salaries is so low it makes it difficult to support children and adults, especially those experiencing barriers to transition. One participant described the challenges she experienced supporting her son: *“…And it's very hard to get support staff, even in the cities…That is part of the reason why my son lives in a group home because we were not able to do the structure and cares he needed in a healthy way, 24/7 as a family…”* (Byla, council participant). Several providers indicated that it is difficult to find people to provide services in the home with one person: *“…right now it is getting harder and harder for people to get home health nurse, physical therapy in home or any other services within the house…”* (Yara, council participant). A provider supporting older adults (65+) indicated that this challenge results in organizations discontinuing services:

> *“So that's one of the things. And then home health aides and homemaking, especially homemaking services, and I'm sure those of you from the county and some of the others can speak to that. Those homemaking wages are…so incredibly low. They simply can't hire homemakers. So, a lot of the agencies have discontinued that service and that's actually one of the things that keeps people in their home is, if you can have aids and homemakers that can keep them out of the hospital and in their home,”* (Mada, focus group participant).

Several participants discussed the problems with accessing services that will meet the needs of the child or adult experiencing barriers to transition. This can result in people feeling that they must settle for services that do not meet their needs. One person who is diagnosed with a bariatric diagnosis described this by saying: *“…because the first place they put me wasn't even suitable for me. I mean, they had the equipment and everything. But the staff wasn't there. And now the place I'm in right now. They just sort of look down on you because you're that size… it's just hard to get the help I need and like for rides and stuff…”* (River, council participant).

Discharge delays and the need for placements

Participants reported that discharge delay evaluation data were collected by both the Minnesota Hospital Association (MHA) and the Minnesota Department of Health (MDH). MHA provided a report on discharge delays prior to the pandemic and again in 2022. These evaluation studies were described by participants as being similar in methods and design providing the state with snapshots from multiple hospitals for short periods of time (please review the public report section of this report for more details related to these data): *“…And so we are talking about hundreds of patients within this specific two-week period…these delays, regardless of…what the timeframe is are really difficult for patients. They put strain on a hospital system and, given that the majority* *of the patients in the study are experiencing delays in both inpatient and emergency departments,"* (Myra, council participant). Council members highlighted the importance of focusing on both emergency room visits and hospital delays, especially since, *"We tend to admit people instead of leaving them in the emergency room"* (Alma, council member). One individual described how problematic it is for children and adults to remain in the hospital waiting for services saying, *"…it's not the right place for kids and for adults to be in…and we've had stories of patients who have been in the hospital for over a year. That means they haven't been outside for over a year. That means they haven't probably seen family in many cases for over years"* (Jack, council participant).

The pressures on hospitals to be available to serve the larger community is described as one of the challenges associated with children and adults who are delayed for long periods due to barriers encountered in transition and therefore are using beds that might go to others in need. In addition, hospitals are described as an inappropriate place for children and adults who have complex behavioral, mental health needs or have medically complex needs. As Alma pointed out, these children and adults who are delayed in ED and hospitals, *"... they live in a place that's not safe for them. I think we're seeing hospitals as safe and they're not. They're low supervision. They don't meet their clinical needs. They don't meet their behavioral needs. And there's a place you can get sick. We know we're not a secure facility. People can walk out and get injured... I mean, those are the kind of things that that put people at risk."*

One of the major reasons for discharge delays identified in both ED and hospital settings, according to participants who are involved in hospital settings or conduct evaluation research, is the lack of inpatient psychiatric beds or other placement options that are meant to provide a safe place for these individuals. Other top reasons reported by participants included delays related to implementing a plan of care, delays in medical doctor's discharge orders (from ED data patterns) and delays in civil commitment (related to hospital patterns). Additional common reasons for delay both in ED and hospitals according to participants were the lack of chemical dependence SUD facility beds available.

Participants also described the referrals to the state's Complex Transitions Team highlighting the large number of children who are experiencing discharge delays:

> *"So, when we talk about children, and for these purposes defining them as 20 and under very often children are engaged that are stuck in hospitals or boarding in the in the emergency departments are engaged somehow with the child welfare system. We see that our Native American children are overrepresented, by a pretty large majority and often kiddos have some type of Autism or IDD may or may not be diagnosed…as I mentioned before, another common feature is some type of aggressive behavior,"* (Ivy, council participant).

One person indicated that complexities arise when individuals are also involved in legal adjudication leading to incarceration in prison, *"… that means that people in jails who need to get to the hospital, maybe, then get to an appropriate state facility can't … move through the system as well"* (Sylas, council participant). Sylas went on to say, *"you also have to support the transitions from jails to appropriate facilities with the ultimate goal if possible…when things stabilize for those people that they can return to home in community as well."* One participant discussed this as a problem associated with a failure to transition from corrective settings to the hospital, *"… there's like kind of like a lack of transition from those corrective settings to hospitals, even though* *there might be acute care, needs. So again, I'm seeing it kind of more at that intake side, not the discharge side…"* (Fews, interview).

Discharge planning was discussed by a number of participants as an important issue to consider. One person stated that, *"…when we receive that referral…does the person have a discharge plan in place or no…Early information we received was that majority have plans in place. However, now that that's flipped a little bit, you can see about two thirds do not have a discharge plan when we are receiving that referral a lot of times. What we're seeing thus far is…that number is being pushed up because of issues around like MA pending where there's some sort of barrier or challenge and establishing either financial or functional eligibility for medical assistance or Medicaid"* (Lily, council participant). Iris, a council participant said that, *"I've been … personally involved in a number of....situations where people are waiting in the…emergency department and just that collaboration…goes a long way you know... everyone kind of pitching in and taking a piece of the pie…maybe there's a medical assistance application that needs to be completed and…the hospital staff are right there and they can assist in getting that."*

Interventions and strategies for addressing barriers in acute care transitions

Several interventions were identified as both short- and long-term goals that would address barrier to transition from the ED and hospital. These interventions included: a) building regional systems to improve problem solving using effective data systems, coordination and communication, b) care coordination strategies and navigating systems and c) addressing policy and funding issues that may be contributing to delays. Some of the themes reported in Appendix E are collapsed into the three areas for brevity of reporting purposes.

Regional systems to improve problem solving, coordination and communication statewide

Most participants recommended working with the current DHS Complex Transitions Team to expand regional problem solving, coordination, communication and capacity building. Participants describe this Complex Transition team as already starting to work at a regional level. One person said, *"their initial focus is going to be on intake of those…complex transition referrals and helping to navigate through that…but part of their role is also really identifying regional trends. What they need, working with the counties,"* (Lily, council participant). Many of the council participants described a regional systems approach as the best way to create more flexible solutions to problems associated with transition given the unique aspects of each area or region in the state. Sylas, a council participant stated that, *"a whole goal behind some of this, I think, is to keep and transition individuals who need acute care…in closer proximity to their homes."* Another council participant described the need for regional systems to help us in, *"thinking about Minnesota as a county administrative system, and …we're also a very big state, [a] very diverse state, and the resources available in one community or region may not be available in a in a different community or region,"* (Luca, council participant).

Another important reason for creating regional systems described by some participants is its potential to improve coordination and communication. Regional systems may assist in how information is shared with families, people with lived experience, hospitals, lead agencies and providers. Sylas, a council participant, described the importance of sharing information saying:

> *"…we've evolved to a point in Minnesota, where, if you're in Veterans Court and you successfully complete the programming in Veterans Court, you leave without a conviction…So the whole focus is really on rehabilitation and re-entry, and I'm wondering if we could leverage some of the ideas that have come out of that…getting judges and social workers and public health and counties and county boards to work better together than they have when it's just left to county by county."*

An important contribution that regional systems can make is to provide a way in which information can be collected systematically and shared to assess statewide patterns in a more systematic manner. Luca, a council participant described this by saying, *"…so it's trying to find, I think, some type of a path through that and figuring out, how can we leverage technology to create those sort of communities of practice or create the infrastructure to allow that communication to happen."* Another council member emphasized the need to continue expanding the data-based decision-making systems already being developed by the Complex Transitions Team: *"Our data, our ability to collect and analyze data is extremely limited. So, we are looking at building that out and are in process of building that out significantly, but also need we need different systems. We need the ability to do a much more robust data collection and analysis system. So that's partially why the information you receive is somewhat limited."* (Ivy, council participant).

Unified measurement systems and sharing data that already exist were discussed by participants as one way to improve both coordination and communication at regional and state levels. One council participant stated, *"...and then the other piece is for people who are already involved in social services county systems...I found that from our personal experience that often...your data does not flow between the different systems and so then...everyone within your different spheres of involvement are having to like duplicate their colleagues work because they can't access so I think a good area to look at would be how if you're already involved in services how can each of those departments share that data so they can move on to more meaningful work,"* (Byla, council participant). Council members also recommended avoiding developing new measurement systems by assessing what is already available to prevent costly duplication of effort. Lyra, a council participant, emphasized the need for coming together to create statewide operational definitions for key measures: *"I think right now, we have different data sources coming from different places, but they're not harmonized. It's hard to understand how…they all connect together. If things are unique…or we're counting things different ways or defining things different ways..."* Several participants pointed to already existing definitions and measures that can be considered including the data collected by MHA and MDH. Some participants felt that using the regional process to pilot improving data-based decision making would be helpful:

> *"So it's trying to find, I think, some type of a path through that and figuring out, how can we leverage technology to create those sort of communities of practice or create the infrastructure to allow that communication to happen and then capturing, disaggregating, capturing the data in a way that helps us see the problem down the road. So, if we're, let's say, having a some sort of a database or system where we're tracking referrals and we're tracking…we're helping people in real time. Trying to find the right match … capturing disaggregated data that we can there share publicly ..."* (Luca, council participant).

Many council members are in favor of using technology to improve communication regionally as well as statewide using a dashboard to share information about available beds. Participants described working long hours calling different providers across the state looking for a potential placement. *"…you get pretty 'gun shy' making referrals sometimes because you can only, you know you can have 25 denials thinking…we're going to* *like somehow get to the point where we'll have some special something or other that'll magically appear…"* (Val, focus group participant). Another person described longer-term supports across time saying about one child with complex transition issues: *"…we've contacted 172 placements since she's turned 18."* (Yana, focus group participant). Creating a system that will allow transition teams to find possible placements quickly and that was statewide so that individuals who are readmitted across the state can be tracked efficiently was described by many participants as essential. One person indicated that strategy may involve:

> *"… creating a central database that is managed by like a specific like role, so that the various community regional people that are trying to do case management and things like that can actually find resources that are available in real time and efficiently,"* (June, council participant).

Collecting data on the number of contacts made, number of placements a person has transitioned to, the number of times there are clear housing issues occurring at transition and time between transitions are all examples of helpful data that would inform regional teams and state leaders as part of a unified statewide measurement system.

Improving systems for transition planning and care coordination

Several participants talked about the need for improving care coordination and establishing clear plans for children and adults experiencing more complex transitions. Nora, a participant interviewed, emphasized the need for a point of contact for someone as they transition, *"…like a maybe a discharge case manager who follows people all the way through their first follow up appointment, or whatever the discharging provider can just discern how many times that how long that that case manager follows them. Should it be two appointments, one appointment whatever."* Zaci, a focus group participant, spoke about the need for a carefully planned transition and the challenge without it, *"…that has been really difficult, having no way to slowly introduce people into the community before throwing them into some kind of a group home setting and saying, "best of luck.''* Participants talked about creating ways that would allow time for a transition plan to be created using a step-down approach where the person can safely be supported. Yana, a focus group participant described this challenge saying:

> *"I find a placement, I would like that person to be able to stay somewhere for maybe another two weeks, you know, in a hospital setting, so that that new provider can come in and start working with the professionals in the hospital…communicating with them and really getting a behavior plan in place so that once they discharge. It's not a staff, you know, saying, well, I didn't get time to read the plan, and I didn't know that this word was a trigger…allowing for some time would help. You know, I think that's a best-case scenario of allowing time for everybody to kind of review the file and understand what this person actually needs."*

Another person suggested problem solving how to address the challenges arising before the individual goes into the hospital:

> *"So that person isn't going straight to the hospital, maybe to this place for a set transition…so just looking at different programs." (Atlas, council participant*). Lyra, a council participant, indicated that making sure in advance that there are providers who have the skills necessary to support a person in transition was essential*: "...[a] plan to make sure that the providers supporting that person in the*

> *community, you know, are ready and up to...the ability to implement those back practices…"* Lyra went on to say that this planning *" is huge… especially in that window …that six months type window,"* (Lyra, council participant).

Care coordination systems for individuals with a history of acute care barriers was described by some participants as an important consideration and that these proactive plans could be created in advance, especially if there were ways to track individuals over time and across the state. One participant indicated that sometimes this requires a plan for providers to proactively expand training in positive supports so that they are better prepared. Other participants discussed being able to access behavioral specialists who could enter the planning process to assist in an immediate transition plan for an individual who may be moving from the ED or hospital and into a new home.

A concern voiced by several people was that the large number of people often involved in complex transition plans can be one of the barriers: *"…what ends up happening is that there's so many people involved…it's hard to navigate the system and know who to go to for what thing. And so, people are spending a lot of time and energy, trying to figure out who to talk to rather than actually getting the substantive issue addressed,"* (Luca, council participant). A type of positive support highlighted by several participants that helps to address this challenge was systems of care and wraparound. Systems of care is an approach for improving communication coordination across different services supports to solve complex planning needs like addressing barriers to transition from the ED or hospital. Systems of care meetings are not meant to address one specific individual. Instead, it is a planning process that can be used at the local community, regional and/or state level to solve policy, coordination and communication issues that impede efforts to provide effective supports for people with complex behavioral challenges.

Wraparound planning, a practice also mentioned by participants, is implemented concurrently as part of systems of care. Wraparound as a planning tool for empowering a child or adult, families and caregivers to lead the team process building on the person's strengths and setting goals for improving quality of life. One participant highlighted how wraparound and systems of care can help address barriers to transition based on each person's unique needs: *"…If … housing is more of the need ... is it direct support staff… is it residential placements…is it support so that they [a child or adult] can actually just go back to their home… is it behavior specialists, is it therapists that will come in the home, is it…transportation?"* (Isla, council participant). A key element of wraparound planning involved establishing one key care coordinator who works with the child or adult throughout the transition and whose role is to navigate communication with all parties. Systems of care and wraparound, when implemented with a high degree of fidelity has been described by some participants familiar with this positive support as an ideal way to address complex transitions. One person described how important collaboration is across systems: *"All of those teams working together…so the team at either the residential placement or the hospital, the psychiatric treatment facility, the family. If it's an underage person. Their school, like all of those teams working together and having cross-collaborative meetings as we're transitioning out is absolutely critical,"* (Uki, interview participant).

Addressing policy and funding issues to improve transition plans

Many ideas were shared by participants related to changing policies and addressing funding issues that are creating barriers to transition. Some of these strategies have been mentioned earlier while describing other themes. Two of the key issues that participants have used when speaking of the many possible solutions that connect the various funding and policy ideas include: a) creating flexible ways to address a child's or adult's needs during and after transition and b) building incentives for different partners who are struggling to address the costs associated with complex transitions while also considering ways to establish an understanding that there are obligations to people supported. One person described the way the state was thinking about positive changes, *"…we're exploring options where maybe it's not a grant at all maybe it's a payment and an allocation to counties that they can have more flexibility so that when someone is in crisis and does need to transition that they've got that funding available to support them,"* (June, council participant).

Several participants mentioned that the funds currently being spent addressing crises could be used in a different manner. June, a council participant, indicated that at, *"the big picture. that's really important information for us as we work together to solve these issues…flexible funds for complex care transitions, landlord mitigation fund that's something that we've heard from the community where…it is challenging to find a landlord for individuals, where there might be the…propensity for property damage…"*(June, council participant). Xael, a focus group participant, suggested, *"we could look at housing, support funding and say, let's use that money to deal with the property issues that are keeping people in hospitals, you know. So, if it's property destruction, or if it's somebody who needs a one-person home and that's going to cost more…use the housing supports to pay for it, so that providers aren't throwing up a big no sign just because they don't want to lose that money on the housing."*

A number of participants across a number of council meetings, focus groups and interviews advocated for expedited processes to make it easier for children and adults to receive services, *"… if they're above income limits to look at like alternative care services to help get them out more quickly, because I think there's a huge delay in people who aren't already sort of in the …Home and community-based waiver system that it takes a long time for them to get on, get services set up, get them in place to allow them to be able to go home,"* (Yank, interview participant).

Providers participating in meetings, focus groups and interviews were clear that supporting individuals who engage in serious aggression, property destruction, self-injury or other behaviors can often result in providers feeling that they are being blamed when crises occur. Zaci, a focus group participant described this saying, *"We have a lot of people who are … [ingesting items] …So like I had somebody recently swallow a fishhook. You know, and stuff like that…and…those [individuals] tend to come back…staff really do feel like they're having to kind of defend themselves…"* In some cases, these situations are difficult to avoid due to federal and state policies that require investigation of potential abuse:

> *"One [barrier] is at least for children –county maltreatment investigations, a lot of times, make staff feel like they're at the sharp end of the stick…like somebody's looking for somebody to blame. And if you're if you're serving some of the most difficult kids in the state, it's going to be tough, and things are not always going to go perfect, and if it feels like your career or job is on the line because of your work…they're just going to say, I don't need that. I'll go work somewhere else where I don't have these challenging needs or behavioral needs,"* (Xael, provider).

Several individuals mentioned culture of safety as a positive support that is extremely helpful in addressing the context in which challenging behavior associated with aggression, property destruction and other self-injurious behaviors occur. Culture of safety is a strategy described by the National Institute on Safety and Health (2024) as an approach that acknowledges the high-risk nature of organizations providing services and assists state, regional and local leaders in creating an environment where people feel responsible for reporting challenges that arise and working together to solve problems. Participants involved in pilot implementation of this positive support in Minnesota are reporting that culture of safety is helpful when organizations are supporting children or adults who engage in challenging behavior.

One participant mentioned the need to address capacity building for positive supports like culture of safety, systems of care and wraparound planning at the regional level and described efforts already starting statewide. Another individual encouraged the state to invest in longer-term efforts that invest in easy-to-access training and incentives for staff and providers to participate in what individuals describe as more intensive and complex supports for people transitioning from the ED or hospital setting. The discussion across multiple participants focused on how to create ways to create incentives for organizations that take on the difficult task of tailoring systems to meet the needs of children and adults who experience barriers in transition from the ED or hospital. An important issue that arose was that, according to participants, overall, most providers feel there are far more dis-incentives to accept placements when a person has a history of challenging behavior, substance abuse disorder, mental health concerns or are diagnosed as bariatric, medically fragile or have complex medical complications.

Other incentives that were discussed included focusing on ways in which direct support professionals can achieve a career path with corresponding fiscal incentives. One way to accomplish this task is described as adjusting the rates for positive support services and making changes in the policies so it is easier for organizations to meet qualifications for the analyst and professional levels of this service. Establishing a state approved training was described as one potential way in which a person can qualify to provide services and investing in establishing mentors across the state who can provide coaching and supervision in positive supports to integrate positive supports into existing services. One council participant, Akira, emphasized the need to consider how state funded training could be inserted into already existing continuing education or training hours for personal care attendants (PCAs) or direct support professionals (DSPs).

Participants also advocated for community of practice events that the state can use to answer questions providers have related to qualifying for services, share information and roll out changes in policies. Participants indicated that it would be helpful to be able to increase communication about policy and funding issues. One person noted,*"…that's a gap that you need to have information more quickly…I can give you one example…Community First Services and Supports (CFSS), so that's just coming out…it's going to roll out very soon, but I don't think the counties have gotten any training on it,"* (Mada, focus group participant). One area that a number of participants advocated for was active involvement by the state in ensuring technology can be used to maximum effect supporting individuals by training by, *"…making sure that the counties understand how technology can be used, how it can be funded, how to use the HCBS system to do all of that,"* (Xael, focus group participant). Mada indicated that the focus on using technology strategically is necessary since, *"we simply aren't going to have enough people to provide the needs … to [support] folks around Minnesota. We're going to have to use technology to supplement and I think we're behind the eight ball on that,"* (Mada, focus group participant). Zaci, another focus group participant indicated that as a provider: *"I know that we have had active* *arguments with multiple counties about approving technology. And the pushback we always get is we're paying you to double staff them."*

In addition to adding incentives for providers and other systems to take on more complex problem solving associated with people needing support, one of the participants interviewed emphasized the need to build policies that encourage accountability to people receiving support. Some participants urged the state to consider that, in some situations, whether unintentionally, that sending a person to the ER or hospital can become a way for systems that no longer want to work with a child or adult to indicate that they no longer intend to provide services. One participant stated that, *"…it's easier to kick someone out of a group home than it is to kick them out of a nursing home or assisted living facility"* (Gabe, interview participant). Gabe went on to recommend that the same obligations nursing homes have should be true for group home settings:

> *"…once you're into a group home there's obligations. If you want to discharge them, there's obligations of discharge. There should be obligations for discharge planning. There should be obligations to identify a safe discharge location."*

Another participant, Uki, said something similar, *"…and then this idea, that like wherever they're transitioning out from is still on the hook for their transition…because what I've seen happen several times is kind of this…we're at our capacity, not only financially but emotionally…like, we're just exhausted."* These participants were discussed the need to both hold organizations accountable while also assessing ways to decrease the negative systems issues that place stress on organizations until a breaking point is reached.

Health equity and disparities in Minnesota

Several participants discussed disparities including an over-representation of children experiencing discharge delays and disparities related to transition planning including *"…Native American children and individuals of color very much overrepresented in the data,"* (Luca, council participant). Data from one discharge delay study points to disproportional representation of BIPOC children and adults experiencing barriers to transition. One individual reported, *"…we did find that African American, or African-born patients were experiencing delays disproportionate to…overall…inpatient behavior health patients, and that really stood out to us…[it] kind of brings up getting attention to the need to advance health equity,"* (Jai, council participant). The Complex Transition Team evaluation data also point to health equity-related challenges impacting children who are BIPOC and/or citizens of tribal nations and called for better monitoring: *"We need the ability to do a much more robust data collection and analysis system…so far, so we are able to gather some additional information that wasn't gathered previously, and they include…race and ethnicity,"* (Ivy, council participant).

Initial discussions that occurred within the first council meetings included the observation that adequate representation by diverse members representing Minnesota communities was necessary for this Council to give everyone a voice in the problem solving. As Cali, one interview participant noted:

> *"I just feel in any situation when we're talking about a group of people that none of us who have any firsthand experience and we're just kind of we're part of this bureaucracy that our opinions are maybe secondary to those people who are genuinely being affected."*

Lyra, a council member, pointed out that it is important to consider people with IDD who may not be able to verbally describe their viewpoint as well as their family members and caregiver, *"…making sure that…their story is included…so that might include...caregivers also being able to contribute."* A number of individuals expressed concern that the Council needed to include more people representing the BIPOC community and tribal nations. Strategies discussed included making an initial request to expand the council immediately and/or to do so in the future should the council continue.

One reason for adding focus groups and interviews was described by some council participants as a way in which more information could be gathered from more diverse community partners. Atlas, a council member, talked about reaching out to communities thoughtfully said, *"…if we…connect with different people in different communities…it can be ethnicity, you know race, culture…and we get invited in to go into some of those communities and have listening sessions I think that would be very helpful...I guess my question is how do we make sure we're doing it in a way that people feel safe to bring forward their actual thoughts and feelings and not feel guarded because I feel like in a lot of spaces we try to create…certain communities that have experienced you know that distrust or bad experiences or disparities they're afraid to sometimes say exactly what it is because they don't know what the outcome will be…"* Another person mentioned the fact that there is constant pressure on marginalized communities to be involved in these types of activities and that this can impede the professional's ability to get their everyday work completed.

Representation of people from across the state of Minnesota was also highlighted by participants, *"…we're a very big state very diverse state and the resources available in one community or region may not be available in a different community or region and that suggests that there needs to be a way to consider regional aspects needed in the recommendations that are made,"* (Sylas, council participant). A review of the types of people participating in this evaluation (see Appendix C) suggests given the diversity of council members, focus group participants and interviews from across the state needs to be expanded. Participants stated that it was difficult to establish a council with diverse representation since the decisions for seats were designated by the Legislature and the open seat time period was not very long. A number of members stated that the council should continue, and that it will be important to ensure the voices of all Minnesotans are represented.

Children and adults with complex needs and their families are described as more likely to experience disparities in Minnesota by those involved in this evaluation. One medical professional indicated that often people from more vulnerable populations will not engage in follow-up visits after transition from the ED or hospital *"…because the long history of lack of faith in the healthcare system…oftentimes I encountered an independence where people didn't necessarily follow [medical recommendations],"* (Nora, interview participant). Nora, as a medical professional went on to say, *"I have never met a native person that doesn't dislike the emergency department and in my professional role, absolutely…I mean dismissed or thought to be too emotional about the things that impact our communities."* The feeling for Indigenous patients was described as feeling like they did not belong *"….and…they're all white, everybody is white…So you're already ill. You're already not feeling good. And then you start getting stared at the entire time…and then you never, you know, never to ask for pain meds,"* (Nora, interview participant).

Several participants described family members who were actively engaged in helping their child exit the hospital. These family members were described as actively involved, attending meetings and working hard on their child's behalf during the transition. Even so, actions were taken against these families by the hospital to remove the family’s legal decision-making rights and transfer guardianship. One participant hypothesized that, *“…I've heard that there are some providers that don't take folks unless they're under guardianship which I mean, that seems like a whole other…issue,”* (Val, interview). Actions taken to attempt to remove family legal decision-making rights during hospitalization was described as commonly occurring in rural areas of the state but mainly with adoptive parents with BIPOC children who needed support.

Quantitative and qualitative public reports

The most common reports available to the public in Minnesota related to acute care barriers to transition address discharge delays from the ER and/or hospital. Table 1 provides the list of the selected reports that were most closely aligned with acute care barriers to transition. However, it is important to note that these are not the only reports discussing that were helpful to the ACTAC. Additional Minnesota reports are available in the reference section and were used in the literature review. In addition to discharge delays, another type of public report that was selected for review included formal reports addressing race, ethnicity and geographic disparities in Minnesota. A worksheet template was used to summarize each of the public reports in Table 1.

Minnesota Hospital Association (MHA) evaluation reports in 2016 and 2023

Although completed in 2016, the public report by Dillon & Thompson (2016) marks an important contribution to evaluation related to discharge delays. The Dillon & Thompson (2016) report has been used as an evaluation study guide both in Minnesota and other states by investigators. The evaluation investigated inpatient hospital 45-day period of data collection with 22 hospitals documenting their data. Twenty of these hospitals had inpatient mental health units, two did not. Data in this ACTAC report only addresses the data based on the 20 hospitals. The investigators were interested in reasons hospital discharge was delayed and the number of potential avoidable days patients experienced. Data was collected for 45 days during the pilot period, from March 15, 2016, through April 30, 2016. There were 455 patients during the pilot period with potentially avoidable days in hospitals with inpatient psychiatric units. From a total of 32,520 possible bed days in the 20 participating hospitals, a total of 6,052 were described as potentially avoidable. The two most common reason for delays included a lack of available space for individuals in psychiatric facilities and delays due to processing.

The MHA conducted an additional evaluation in 2022 and another study in 2023. A presentation given by an MHA representative at the ACTAC council meeting summarized the results of the 2023 evaluation. The study focused on a) patients who are ready for discharge to alternative sites of care but are stuck in hospital beds awaiting discharge to alternative care sites of care, b) ED boarding where residents of alternative care sites are being dropped off, or show up, at the ER. The MHA study occurred from June 2023, through October 2023, and built on a study completed by DHS conducted study earlier from January and May 2023. The presenter indicated that, *“…the 10-month summary data was annualized by dividing the discharge delayed days total (January-May from DHS, June - October from MHA) by 10, multiplying by two months and adding that figure to the results for an estimated 2023 total.”* The survey hospitals were requested to submit was set up in a spreadsheet with two tabs. One tab was used to complete ER delays and the other tab was used to enter data for inpatient delays. On each tab, hospitals entered patient-level information. Each row contained a patient's MRN, age, gender, as well as the date (and time, if available) of their begin of stay date, their date deemed medically ready for discharge and their end of stay date.

MHA's 2023 study reports data from 101 hospitals. Data indicated that adults represented the higher number of ER and hospital delays and older adults (65+) experienced higher numbers of inpatient delayed days. The survey required that hospitals choose at least one of seven medically complicating reasons why the patient was delayed in their discharge. The seven reasons were obesity, disability, wound care, mental illness, behavior needs, substance use disorder, IV usage and dialysis. A higher number of individuals with reported mental health and behavioral needs experienced frequent delays. Individuals needing wound care and bariatric patients also were reported as higher in both inpatient and ER delays. The study reported that nearly 195,000 patient days of avoidable and unpaid care in occurred in 2023. An estimated $487 million in direct costs/unreimbursed care were documented in 2023.

Minnesota Department of Health (MDH) 2024 study

The study conducted by MDH included 34 Minnesota hospitals from the 128 hospitals who were invited to participate. The data for ER delays included the 34 hospitals with data collected during a 14-day period between Sept. 5, 2023, and Oct. 20, 2023. Data also was collected for 13 inpatient hospital settings with data collected during the same 14-day period and window of time. Approximately 3,064 behavioral health patients were treated in the 14-day study period. Of those, 537 patients (or 18%) experienced a discharge delay, meaning they were still in the emergency department four hours after a disposition decision. These individuals were delayed a total of 560 days (13,442 hours), with an average of one day delay per patient. The lack of inpatient beds (59%) was responsible for most delays in the ER with (14%) of delays related to waiting on discharge or care plans. Transfers that occurred from the ER the most often were to psychiatric inpatient units while a third of the time, the person was sent home "with or without supports" (pp. 7). A total of 38% of delay days were related to a child or adult's history of behavioral issues such of dysregulation, resulting in aggression, self-harm and/or sexually inappropriate behavior while twenty percent of patients including 17% of delay days were associated with substance use disorder. Similar patterns occurred with the 13 inpatient hospital data in this study and can be reviewed in the report.

Minnesota Governor's Council on Developmental Disabilities qualitative study on discrimination

The report, entitled, Impact of the intersection of developmental disabilities and other population profiles on experiences with discrimination was completed in 2022. This report summarized the results of a) a literature review, interviews and focus group sessions with a total of 28 females, 19 males and two individuals who are nonbinary. Of the 49 total participants, 13 were Black, 16 were East African immigrants, four were Latinx, two were Asian, 12 were white and two individuals reported two or more ethnicities. The results of the report describe the types of discrimination people of color with disabilities face in today's society. Disrespectful behavior, barriers to inclusion, stricter rules and failure to provide accommodations to people were described in housing, education, employment, community businesses and social and public spaces. A recommendation from this report is that, *"If progress in reducing discrimination in Minnesota is the goal, then there needs to be a research system put in place for obtaining benchmark (starting point) measures of incidences of discriminatory behaviors and practices, and tracking changes over time,"* (pp. 6).

Minnesota Governor's Council on Developmental Disabilities Phase II intersectionality study

A follow-up study to the earlier 2022 study was published in 2023 by the Minnesota Governor's Council on Developmental Disabilities and was designed as a first step in addressing the need for data systems that collect information on the perceptions of Minnesotans on the topic of discrimination. A survey gathered comparative measures of various forms of discrimination that four major populations experience: a) white people with disabilities (n= 187), b) Black, Indigenous and other People of Color (BIPOC, n=185), c) white people without disabilities (n=64) and d) BIPOC individuals without disabilities (n=157). These 591 survey responses were meant to provide a baseline measure for the One Minnesota Council on Diversity, Inclusion and Equity established by Governor Tim Walz in 2019. Results indicate that people with a disability are less likely to feel welcome in their community and more likely to experience barriers to the types of employment and education they deserve. Specific negative impacts varied across white and non-white participants with disabilities indicating differences in the types of discrimination experienced. More respondents came from the metropolitan Twin Cities area, however, all areas of the state included people who responded to the survey.

Building racial equity: DHS Medicaid report

The Minnesota Medicaid Director oversaw the completion of a report entitled Building racial equity into the walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans. Although this report does not exclusively focus on the topic of acute care barriers to transition, the information included in this document provides important information about Medicaid funding and the challenges associated with addressing systemic racism within state policies and systems in Minnesota. The report by Chomilo (2022) was designed to encourage co-creation of Medicaid policy change by involving U.S.-born Black community members, leaders of community organizations and those working to advocate for racial equity for Black Minnesotans. An assessment and alignment of community input with policy areas led to discussion about changes and stewardship in each respective policy area. Four major levers Medicaid has for addressing racial equity were highlighted, including a) eligibility and enrollment, b) access, c) quality and d) early opportunities. Assessment data were gathered across extant data sources such as Minnesota Department of Human Services, U.S. Census Bureau and other important reports both within Minnesota and at the national level. Race, ethnicity and language demographics were described as one way to gain better insight into the impact and need of culturally relevant care. An important emphasis was placed on avoiding pilot projects where funds end and there is a feeling that people are *"checking the box"* versus the need to invest in ongoing *"tangible"* efforts to address disparities and work towards racial equity (p. 37). Chomilo noted that, *"DHS should integrate not just community engagement in general but longitudinal, culturally specific engagement of [Medicaid] enrollees and their families into routine policy, budget and administrative activities."* (pp. 39).

VII. Report and council recommendations

The combination of different voices in the council, focus groups and interviews and public reports describe a better picture of the complex nature of the barriers to acute care transitions than any single data source can provide. Figure 6 provides shows how the major messages coming from the data encourages the use of multiple interventions and strategies. These strategies require coordination and communication systems across the state of Minnesota including education, disability services, behavioral health, children and family services and a number of other relevant sectors. Placing an emphasis on both short- and long-term planning with the assumption that, *"Failing to invest in interventions that would build effective, well-paid community services for people with more complex needs has led to 'moving' the problem to hospital settings,"* (Cadel et al., 2021).

Table 4 highlights key findings based on merging data from multiple sources including both qualitative and quantitative analyses. As you can see in Table 4, there are two overarching themes. In the first theme, the results across all data sources point to the need for interventions that address health-equity disparities. The information gathered indicates that Minnesota would benefit from creating measurement systems that provide a way to evaluate progress in addressing and decreasing disparities that people from marginalized communities experience. Discharge delays are one place where these disparities are evident.

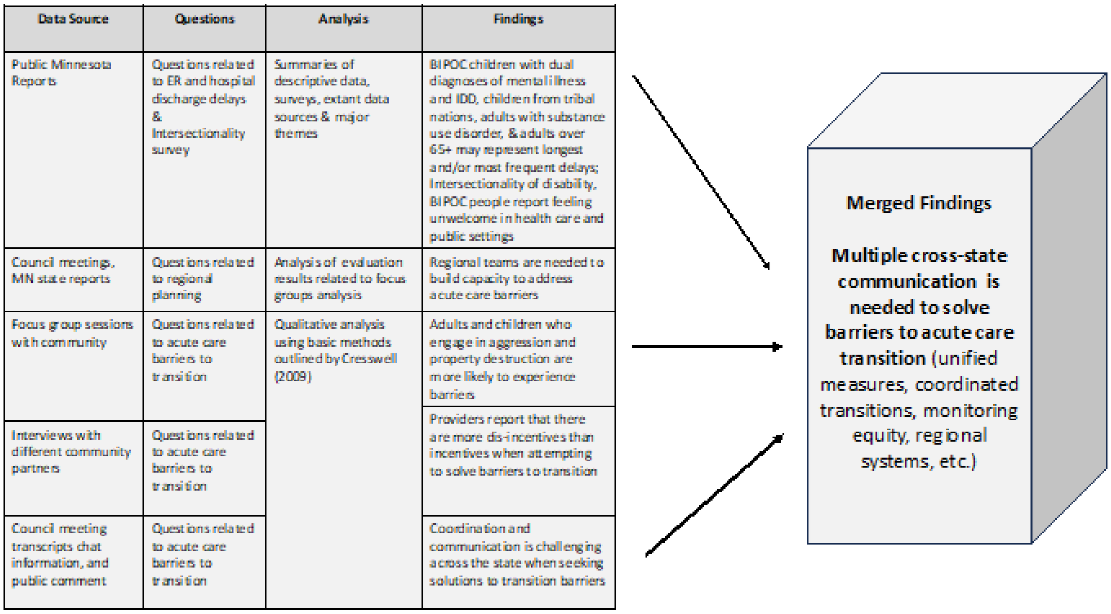
The other overall theme suggests that depending upon the data collected, state-level investments in funding may need to be allocated towards increasing community services or towards the development of inpatient and SUD beds to provide a safe environment for people experiencing barriers to acute care transitions. Again, the development of regional and statewide data-based decision making could help provide more clarity for Minnesota to answer this complicated and vitally important question. The following themes emerged from the multiple data sources:

- Current policy and funding systems are channeling children and adults into more restrictive settings when, in some cases, these individuals could successfully live in their homes and communities with the proper community supports. However, temporary placements are also clearly needed. Data is needed to better understand the different types of people experiencing acute care barriers to transition, especially those requiring inpatient beds, SUD placements, Juvenile Detention Centers, Psychiatric Treatment Facilities and other more restrictive placements. Using data to determine the best choices for policies and funding and improving communication and coordination across systems and services may help address this issue.
- Funding systems and policies are currently organized primarily to fund placements that are intended to provide safe places for individuals on a 24-hour, seven day a week basis. However, these settings are more restrictive in nature and many children and adults may choose to be at home in the community. Unfortunately, the funding for supporting children and adults in their homes is incomplete according to many participants in this evaluation. The ability to fund staff to provide 24-hour, seven-day a week supports at home is described as impossible by participants.
- In the absence of home-based services, there is a natural pressure to fund more restrictive placements and with staffing problems related to poor wages for PCAs, DSPs, families and caregivers, home care is often not possible. This, in turn, creates pressures for the state to invest in funds to build more restrictive placements instead of investing in home-based support. One participant suggested that an

over-reliance on calling 911 and sending someone to the hospital is a signal that the current support systems are not protecting people: *"…throughout history we've been able to provide the support for a lot of our folks and through positive behavioral supports been able to meet their needs in the community…and there's no easy answer with the workforce shortage…but we really have to have some answers and we have to have some protections, and I think some safety nets for this population,"* (Aero, interview participant).

- The active involvement of people representing all Minnesotans must start within legislative Councils like the ACTAC. There is an increasing request by state and community partners to increase the representation of all voices in Minnesota as it relates to processes such as this ACTAC council. In addition to diversity including race, ethnicity, gender orientation and other marginalized groups, the Council needs to be informed by a balance across roles of community partners. One council participant, Lara, pointed out that for people in Minnesota, *"the point of entry into the mental health system for many is the Emergency Department of the local hospital and the responsibility of providing all-levels of inpatient services has been shifted to the community hospitals. Therefore, it is necessary that any planning for managing acute care transitions have equal input and representation from community providers as well as state and county entities."*
- Added incentives are needed for systems to maintain accountability in supporting children and adults experiencing complex transition barriers, and a process for establishing community expectations for ensuring the well-being of Minnesota's children and adults is needed. The data in this report suggests that a focus on incentives for community service providers is needed to offset the many challenges encountered. Considering ways in which the state can increase accountability of organizations to ensure individuals in transition are treated with dignity and respect while kept safe during acute care crises.

Figure 6. Merging ACTAC findings across data sources



Data Source	Questions	Analysis	Findings
Public Minnesota Reports	Questions related to ER and hospital discharge delays & Intersectionality survey	Summaries of descriptive data, surveys, extant data sources & major themes	BIPOC children with dual diagnoses of mental illness and IDD, children from tribal nations, adults with substance use disorder, & adults over 65+ may represent longest and/or most frequent delays; Intersectionality of disability, BIPOC people report feeling unwelcome in health care and public settings
Council meetings, MN state reports	Questions related to regional planning	Analysis of evaluation results related to focus groups analysis	Regional teams are needed to build capacity to address acute care barriers
Focus group sessions with community	Questions related to acute care barriers to transition	Qualitative analysis using basic methods outlined by Cresswell (2009)	Adults and children who engage in aggression and property destruction are more likely to experience barriers
Interviews with different community partners	Questions related to acute care barriers to transition		Providers report that there are more dis-incentives than incentives when attempting to solve barriers to transition
Council meeting transcripts chat information, and public comment	Questions related to acute care barriers to transition		Coordination and communication is challenging across the state when seeking solutions to transition barriers

Merged Findings

Multiple cross-state communication is needed to solve barriers to acute care transition (unified measures, coordinated transitions, monitoring equity, regional systems, etc.)

- Investing in prevention-focused efforts is necessary; right now, the systems wait until acute care crises arise and then engage in reactive problem solving with limited success. Focusing on preventing situations where individuals are under pressure to transition immediately from the ER or hospital into new home and placement settings requires a different approach, one that regional systems of care and coordination efforts may assist as well.

Table 4-Merged finding across data sources strongly indicate the need for multiple cross-sector interventions for addressing barriers to acute care transition

Qualitative results (Council meetings, focus groups, interviews)	Qualitative & quantitative public reports	Merged implications for measurement systems
Disparities exist in acute care transitions • Over-representation of BIPOC community. • Families experience situations where legal decision making & guardianship is threatened during transition.	**Disparities exist in acute care discharge delays** • Over-representation of BIPOC community occurs in discharge delays. • Minnesotans are experiencing disparities in Medicaid services.	**Better measurement systems are needed** • Prevent disparities in acute care transitions. • Confirm whether changes selected improve outcomes. • Listening sessions with BIPOC communities.
There is a need for home-based services as well as temporary placements to keep people safe *before* and *after* transitions • Creating strategies to intervene before sending people to the ER or hospital will save money but requires investment. • Funding is not allocated to the community services and therefore more restrictive placements are chosen first.	**There is a great need for placements that will keep people safe** • Hospitals are not a safe place for people to be while placement and transition planning is occurring. • Data show that the greatest need is for inpatient beds and other placement options.	**Increasing measurement & data-based decision-making systems could help decide how to invest in funding** • More data is needed before allocating funds to home-based services versus more restrictive placements. • Interviews with people with lived experience may provide important insights. • Gather transition-related measures including person-centered goals.

ACTAC council action recommendations: Short-term action plan

It is the shared responsibility of the state of Minnesota, local governments, hospitals, and other providers caring for people to eliminate bias, discrimination, and disparities when transitioning people in need of acute care. For the sake of eliminating barriers, the DHS Complex Transitions Team should identify and track obstacles and outcomes for individuals in identified protected classes and other vulnerable and underrepresented groups.

I. **Given the timeline and complexity of the topic, it is recommended that this council become a standing unit.**
    A. Continue working with the existing DHS Complex Transitions Team led by DHS leaders from Moving Home Minnesota. Establish a bi-directional communication system between the ACTAC and the Complex Transitions Team with an ongoing system for reviewing progress such as quarterly meetings. The advisory council will provide guidance as new data systems are put in place and as more information is learned.
    B. Use the ongoing council to expand to additional regions, monitor data systems and continue refining action plan, with the purpose of defining an infrastructure for scaling up efforts statewide.
    C. Recruit a diverse range of council members to ensure all Minnesotans have voice in the system (race/ethnicity, gender orientation, geographic diversity, etc.).
    D. Complete long-term recommendations that require more time to accomplish and that may include a future approach organized by subgroups reviewing data by types of acute care experiences (such as SUD, children with mental health/ behavioral concerns, older adults 65+, bariatric or medical issues).
    E. Complete focus group and interviews with people with lived experience.

II. **Expand regional capacity for existing care navigation by building on the Complex Transitions Team in three regions supporting children and adults across the lifespan.**
    A. The ACTAC recommends that DHS and counties in three initial regions work closely together to facilitate effective transitions in local communities for children and adults. Activities needed include establishing a communication pathway between DHS leadership, existing Complex Transitions Teams, counties and the ACTAC to document the process for DHS and counties in regions to work closely together to facilitate effective transitions in local communities for children and adults, to support long-term growth.
    B. Support the Complex Transition Team to complete a Plan-Study-Do process to evaluate existing resources and needs of the Complex Transition Team and support current and scale-up efforts. During this process, regional teams continue providing feedback on the processes, tools and systems used by the Complex Transitions Team to assess the effectiveness of transitions across the three regions.
        a. Engage with representatives to help in guiding the system with the following partners:
            i. Complex Transitions Team regional coordinators from each region
            ii. Local public health and local social services/county social services
            iii. Families/People with lived experience
            iv. Hospitals
                1. Acute care hospitals that provide inpatient and mental health services

        v. Providers
        vi. Measurement expertise
        vii. Court/legal representation
        viii. Key state divisions (children and family services, behavioral health, disabilities, education)
        ix. MDH Office of African American Health and Office of American Indian Health.
    b. Fund and allocate regional administrative support and a coordinator role to manage tasks associated in each regional system.
    c. Ensure regions are collecting the same data using statewide quarterly meeting and annual report:
        i. Written report based on the results after one year of implementation
        ii. Each region contributes data and group assesses statewide
    d. Recruit and fund a staffperson as coordinator who will guide the state meetings
    e. Fund data collection to pilot annual summary across three regions
    f. Authorize the sharing of protected data necessary for effective transitions while maintaining the data's protected classification
    g. Offset costs for people with lived experience to participate in regional and state team.
    h. Allocate time of state leaders to review data and make decisions:
        i. MDH
        ii. DHS overall leaders
        iii. County leaders
        iv. MDE
        v. DCYF
        vi. Hospitals
        vii. Providers
        viii. Other community partners.

C. Work with the Complex Transitions Team to establish a data-based decision-making system for improving access to information for individuals transitioning from hospitals across the three regional areas of the state. Design the data system so that it can be disaggregated according to race, ethnicity, gender and geographic diversity to address health equity and disparities.
    a. Work with DHS state systems to improve sharing of data across disabilities, behavioral health, older adults, children and families, etc.
    b. Data systems need to be able to report the following (such as):
        i. Behavioral events
        ii. Mental illness (Suicide, psychotic episodes)
        iii. Systems delays
        iv. Complex bariatric and other health issues.
    c. Measures targeted for regional teams, such as:
        i. Agree upon unified operational definitions for the following:
            1. Acute care crisis
            2. Discharge delay

                3. Populations and experiences contributing to challenges (define behavioral vs. behavioral health/mental health
                4. Days of transition
                5. Readmittance
                6. Days of stabilization
                7. Quality of life
                8. Positive supports.
            ii. How many people are experiencing criteria indicating acute crisis (create unified definition)
            iii. Geographic, age, ethnicity, race and gender-related data for individuals experience acute care crises
            iv. Number of positive support trainers, regional team members, etc. representing diversity (geographic, ethnicity/race, etc.)
            v. Summary of individual transition plans for impact and fidelity in each region.
        d. Data collection varies by key populations with priorities to biggest problems:
            i. Autism, IDD and challenging behavior
            ii. Behavioral episodes/mental health events
            iii. Older adults and complex issues (dementia, medical, etc.)
            iv. Substance use disorder/housing.
    D. Map out data collection systems collected by regional teams to capture the data needed to assess:
        a. Better understanding of the specific challenges associated with transition-related barriers outside of the hospital related to inpatient beds.
        b. Different types of individuals experiencing discharge delay and transition barriers back into the community due to:
            i. Behavioral health/mental health Issues (suicide and Self-harm, psychotic episodes, etc.)
            ii. Behavioral events that occur when individuals with IDD, autism or other disabilities result in self-injury, property destruction, injuries to others
            iii. Bariatric issues
            iv. Barriers associated with older adults (65+)
            v. Issues related to barriers associated with substance abuse.
    E. Capacity building, mentoring and supports for regional teams to use data systems and make changes by regularly reviewing systems. This should include funds necessary to support the data systems, technology, infrastructure and mentoring support needed by the Complex Transition Teams to put data systems in place and analyze the data to identify areas of need to guide data-based decision making.

III. **Establish overall infrastructure and statewide review process to share data and monitor regional teams while also leveraging existing resources dedicated to addressing barriers to acute care transitions.**

A. Use implementation science strategies to coordinate regional teams. Allow regions to tailor actions while sharing information and establishing data and reporting systems at the statewide level.
    a. Establish quarterly and annual reviews of data at the regional and state review process
    b. Use existing data systems and avoid duplication (avoid "re-inventing the wheel")
    c. Dedicate a state coordinator linked to regional systems (FTE)
        i. Make sure monitoring and review of regions occurs
        ii. Schedule meetings
        iii. Work with measurement staff to summarize and report across regions
        iv. Assist with coordination activities such as access for regions to funds
    d. Allocate capacity-building funds in a manner that directly addresses the acute care barriers
        i. Use funds for positive supports in a manner that directly addresses qualification issues that impact capacity and provides incentives for staff
        ii. Example: direct funds to establish DSP/PCA accreditation training, work with current Positive Behavioral Support (PBS) facilitators to encourage mentoring in region.
    e. Engage the MDH Office of African American Health and Office of American Indian Health
    f. Use recommendations from regional teams and reach out across the state divisions to establish and support completion of data sharing agreements
    g. Support regions by creating policy that breaks down barriers related to communication (memoranda of agreement templates and guidelines to facilitate children and adults moving into the community).
        i. Children and adults transitioning from Metro placement to rural home
        ii. Children and adults transitioning from out of state to home state.

B. Work with existing groups (regions, MDH, MHA, Complex Transitions) engaged in evaluation to stablish a unified measurement system that collects data beyond immediate hospital discharge - use systems already created when possible:
    a. Discharge delays with dedicated attention to systems issues by types of experiences (bariatric, behavioral, mental health diagnosis, substance abuse)
    b. Transition related measures
    c. Readmittance patterns
    d. Diversity (geographic, gender, race ethnicity, etc.)
    e. Transition satisfaction/quality of life in transition
    f. Measures of challenges related to types of experiences (suicide, self-injury, property destruction, etc.)
    g. Transition costs (behavioral consultation for transition, crisis respite, making adaptations to physical location at home, hospital related, etc.)

C. Acquire funds for establishing easy to access statewide training curricula on positive supports directly addressing acute care transitions to the community. Provide examples of how to access these statewide training curricula within existing incentive systems for PCAs/staff.
    a. Use state team to direct new incentives and efforts to support capacity building

            i. Training for DSPs and other priorities highlighted by regions
            ii. Coaching and mentoring to support regions
            iii. Clinical consultation and tele-outreach to support regions
        b. Direct support staff, personal care attendant trainings in positive supports directed by regional teams
        c. Add state approved training to meet qualifications for positive support services (competency-based training, prepare professionals to supervise other professionals).

IV. **Actively integrate measurement and action plans addressing geographic, racial and ethnic disparities in acute care transitions and coordinate with existing state health equity processes.**
    A. Coordinate with existing systems, processes and workgroups to integrate acute care issues into existing efforts to address disparities rather than creating another meeting process. Examples include:
        a. State Advisory Council on Mental Health and Subcommittee on Children's Mental Health
        b. Recommendations by the Medicaid Director (Chomilo, 2022)
        c. MDH Health Equity Bureau
        d. Children's Cabinet on Mental Health
    B. Actively integrate measurement and action planning into regional systems related to monitoring disparities (geographic, age, ethnicity, etc.)
    C. Dedicate funds for regions to reach out and recruit diverse members to participate in the regional process
        a. Allow for stipends used to support the ability of individuals to participate
        b. Create a way for regions to propose tailored actions for increasing diversity.
    D. Fund pilot systems for technology-based information sharing and care navigation
    E. Require regions to report on equity and diversity and how the regions have increased active voice and leadership as part of measurement system
        a. Include data reporting proportion of barriers to transition occurring across the types of populations and population in ED/Hospital discharge delay.
    F. Work with other areas of state to support efforts to listen and support diverse communities including geographic, gender affirming, ethnicity/race and other individuals with a history of marginalization.

V. Identify the barriers that exist and begin long-term planning while initiating changes in administrative policy that DHS and other lead agencies can make immediately to expedite the transition of children and adults out of acute care settings. Examples include, but are not limited to, building short and long-term incentives for direct support staff, providers of existing waiver services, and/or organizations supporting children and adults while in the hospital to assist with transition planning; expanding on existing funding policies for HCBS providers supporting the transition planning process while children and/or adults are in the hospital; assessment of practices related to guardianship while addressing the rights of individuals and families; and strategies related to expediting MnCHOICES assessment.

A. Build incentives for providers within Complex Transition Team regions to work with children and adults encountering barriers to acute care transition
    a. Funds available for providers in three initial regions to access fiscal incentives for supporting complex transitions
    b. Provide capacity building training and supervision while offsetting fiscal costs
    c. Allow for funds to address issues related to transition (property damage, tailored home structural changes, etc.).

B. Use short-term actions to identify additional funding pathways to support effective transition planning between hospital staff, case management and providers and/or caregivers while a person is in an acute care setting

C. Work with MnCHOICES team to assess strategies for expediting situations involving barriers to transition

D. Initiate short-term administrative policy changes -- Add administrative policy or immediate changes that DHS and other lead agencies can make right now, or very quickly, to expedite the process of transitioning folks out, such as:
    a. service authorization approvals on a temporary interim basis
        i. expedited approval for equipment or other needs
        ii. expedited rate exception process for complex behavioral or high acuity individual folks with bariatric needs.

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X. Appendix Contents

Appendix A: Examples of common services and systems for children and adults

Appendix B: Flyer recruiting focus group and interview participants

Appendix C: ACTAC evaluation participant list

Appendix D: Quantitative worksheet for public reports analysis

Appendix E: Acute Care Transitions Advisory Council codebook summary

Appendix F: Public comment documentation

Appendix G: Glossary

Appendix A: Examples of common services and systems for children and adults

Children and examples of services and systems

Children with Autism/IDD

Children with Mental Illness and Behavioral Health Episodes

Children with Substance Abuse Disorder

Children with Complex Health Issues

Children Experiencing Systems Issues

Children with Co-morbid Disorders & Multiple Challenges

Potential Coordination, Communication, and Data Sharing Needed for Transition Planning Across the Following for Care Navigation:

- Families/Caregivers
- Hospitals
- Education
- Independent Clinical (Physicians, BCBAs, etc)
- Residential Providers
- Out of Home Placement (Inpatient, PRTF)
- Legal/Courts, Juvenile Justice
- Counties
- Direct Care and Treatment
- Children and Family Services
- Disability Services
- Behavioral Health Services

Adults and examples of services and systems

Adults with Autism/IDD Challenging Behaviors (Property Destruction, Aggression, self-injury

Adults with Mental Illness and Behavioral Health Episodes

Adults with Substance Abuse Disorder

Adults with Complex Health Issues

Adults Experiencing Systemic Barriers

Adults with Co-morbid Disorders & Multiple Challenges

Potential Coordination, Communication, and Data Sharing Needed for Transition Planning Across the Following for Care Navigation:

- Families/Caregivers
- Hospitals,
- Nursing Homes, Assisted Living
- Home Health Providers (65+)
- Residential Support Providers
- Employment Services
- Legal/Courts, Prison
- Counties
- Direct Care and Treatment
- Children and Family Services
- Disability Services
- Behavioral Health Services
- Independent Clinical (Physicians, BCBAs, etc.)

Appendix B: Flyer recruiting focus group and interview participants

INVITATION TO PROVIDE FEEDBACK

Invitation to provide feedback on barriers to transition from emergency rooms and/or hospitals

SHARE YOUR THOUGHTS

The University of Minnesota and the Minnesota Department of Human Services (DHS) is conducting evaluation study research by looking for people who live in Minnesota who can help them better understand the challenges children and adults who are admitted into the emergency room or hospital experience when they have problems transitioning home. There are many reasons why someone might have problems transitioning home after a visit to the emergency room or hospital. Sometimes services are not available to provide support and in other situations there may be paperwork or procedures that are slowing down someone's ability to transition home.

YOU MAY BE ABLE TO HELP DHS UNDERSTAND THESE CHALLENGES BETTER IF YOU ARE A....

- Family member or caregiver who has a child, parent, friend, or important person in your life who has experienced barriers to transitioning home from the emergency room or hospital,
- County professional supporting people who are experiencing challenges,
- Hospital or medical personnel involved in supporting someone who is in the emergency room or hospital,
- Professional supporting children and/or adults by providing behavioral health or positive supports,
- Professionals leading or working in provider organizations who support people in residential, employment, or family/caregiver settings, and
- Advocates who are working to improve services and supports to children and adults.

DIFFERENT WAYS TO SHARE

- Join a 2-hour online zoom focus group with 6-8 other people who are interested in sharing their ideas:
  August 20th, 12noon - 2:00pm
  September 10th, 5:00pm - 7:00pm

OR

- Participate in a 45-minute, one-on-one phone or zoom-based webinar

HOW YOUR INFORMATION WILL BE USED

You will be asked if it is okay to record and transcribe your thoughts in the focus group and interview sessions. All information gathered will be anonymous. Your name, where you are from, other people mentioned, and other details that might identify you will be removed from notes. You will have an opportunity to choose an interview format that does not involve recording, if you are more comfortable with sharing as a person takes notes. You can choose to leave the focus group or interview session at any time.

Please share your contact information here if you are interested in signing up for a focus group or interview.

SIGN UP

Or, email: jeffr181@umn.edu

Appendix C: ACTAC evaluation participant list

Participants in the Acute Care Transitions Advisory Council

Participants in council meetings as members, presenters, or individuals assisting others with lived experience, focus group participants and individuals interviewed.

Random pseudonym	**Data source** Council participants = CM Focus Group = FG Interview=I	**Role or experience** County = Co Family = Fa Lawyer = La State = St Contractor = Con University = Un Provider = Pr Council only lived experience = Le Tribal Nations=TN	**Geographic area of state** East central = EC Metro=M Southeast=SE Southwest=SW Northeast =NE Northwest=NW West central=WC Not in MN =NiMN
1. Mada	FG	Co	NE
2. Nova	CM	St	M
3. Gabe	I	La	M
4. Sylas	CM	La	M
5. Bua	CM	St	M
6. Oak	I	La	M
7. Zaci	FG	Pr	M
8. Cora	CM	Ph	M
9. Mia	CM	Con	NiMN
10. Yara	CM	Pr	M
11. Pace	I	La	M
12. June	CM	St	M
13 Val	FG	Co	NE
14. Cali	I	La	M
15. Vail	I	La	M
16. Ivy	CM	St	M
17. Joan	CM	Con	NiMN
18. Brid	CM	St	M
19. Atlas	CM	Pr	M
20. Byla	CM	Fa/Ho	M
21. Xael	FG	Pr	NE
22. Isla	CM	*	*
23. Ava	CM	Ho	M
24. Yana	FG	Co	NE
25. Leo	CM	Pr	M
26. River	CM	Le	M
27. Jack	CM	Ho	M

28. Ella	CM	Fa/Pr/Co	M
29. Mack	I	La	M
30. Lily	CM	St	M
31. Alma	CM	Ho	M
32. Aim	I	Co	M
33. Akira	CM	Pr	M
34. Luna	CM	TN	NE
35. Rose	CM	*	*
36. Iris	CM	Co	EC
37. Iben	I	La	M
38. Jai	CM	St	M
39. Zoe	CM	Pr	M
40. Uki	I	La	M
41. Otto	CM	Pr	*
42. Fews	I	La	M
43. Hazel	CM	St	M
44. Rae	CM	Un	M
45. Luca	CM	St	M
46. Waru	I	Co	M
47. Kai	CM	Un	NE
48. Caleb	CM	St	M
49. Lyra	CM	Un	M
50. Caia	FG	Fa	*
51. Aero	I	La	M
52. Dale	I	Co	M
53. Ojai	I	Co	M
54. Halle	FG	Co	S
55. Dana	I	Co	M
56. Lara	CM	*	*
57. Okapi	I	Co	M
58. Aj	I	Co	M
59. Wen	I	Co	M
60. Nora	I	Co	M
61. Myra	CM	Con	M
62. Gabi	FG	Pr	*
63. Ivan	CM	St	M
64. Yank	I	La	M

* Indicates no information

Appendix D: Quantitative worksheet for public reports analysis

Public report worksheet and analysis summary

Citation:

Initiator of report:

Data sources

- Mainly data from literature
- New sources collected
- Multiple data new and from other sources.

Public or informal report

- Report available
- Presentation of evaluation data collected.

Type of quantitative and qualitative data

- Survey
- Extant data
- Data collected onsite
- Focus groups
- Interviews
- Other ________________________.

Rigor of evaluation (new) data gathered reported

Scoring for each element of design
1=Excellent…2= Good…3=Adequate…4= Poor…5=Unknown logic …6=Unable to score

- Evaluation questions
- Key definitions for measurement
- Methods
- Analysis.

Comments: Strengths of design
Comments: Weakness of design

Summary of important data to highlight related to ACTAC evaluation questions

Summary of recommendations from report

Appendix E: Acute Care Transitions Advisory Council (ACTAC) codebook summary

Major themes and subthemes from council meetings, focus groups and interviews

1. Barriers encountered in acute care transitions	• Coordination and communication • Funding/policy –barriers • Access to community services and staffing issues • Discharge delays/readmittance.
2. Characteristics of individuals experiencing barriers	• Bariatric issues • Behavioral health/mental health (Episodes, suicide, psychotic episodes) • Behavioral events (associated with Autism/IDD, self-injury, property destruction, aggression) • Children, adults, older adults 65+ • Substance abuse disorder • Systems (Insurance, county response, guardianship).
3. Interventions and strategies for addressing barriers in acute care transitions	• Assessment & measurement • Communicating across services • Care navigation strategies • Transition planning • Regional and state systems • Capacity building & incentives (DSPs, county, families, etc.) • Positive supports • Funding/policy/legal interventions • Need for beds (inpatient/nursing home/other beds).
4. Health equity disparities (Geographic, ethnicity and race)	• Diversity of families/homes/culture • Barriers to health equity • Ensuring diverse voices in decision making • Challenges in rural areas.

Appendix F: Public comment

The council heard from a broad spectrum of constituents and stakeholders across Minnesota. Several efforts were made to gather differing perspectives related to barriers associated with acute care transitions. Those attending open sessions were held during council meetings and were documented within the transcript and report. Also, the public was encouraged to attend open sessions held at the Elmer E. Anderson building and/or share information in written form. Once the report was finalized, public comment period was announced occurring from Oct. 17, 2024, through Oct. 31, 2024. Appendix F contains recommendations, additional considerations and responses from the following audience members: Self-advocates, caregivers, providers, support planners, case managers and other interested parties. Feedback in this section identifies barriers and potential solutions for helping people move from acute care settings to nonacute care settings. The information is organized by 1) feedback that came in prior to the finalized report and 2) submitted responses during the public commenting period.

Feedback before the report was completed

Hello,

Thank you for the opportunity to provide input to the Transitions Advisory Council on what can be done to support the transition of people with complex needs to appropriate settings. [name of organization] has been the recipient of a sole-source contract to help us prepare to bring an adult man from the hospital to a 3-bed CRS [community residential setting] home in [name of city/town]. The contracting process for this grant was efficient and effective. It led to [name of organization] being able to take quick action on home modifications, staff training and the purchase of special equipment. My only suggestion to the council about this contracting process is to recognize the effectiveness and try to mimic the process as you move forward with other funding options. Other ideas:

1. One of the challenges [name of organization] has commonly experienced is getting good information on the needs of the person. Hospitals only have what they learn from their very unique setting. Families and case managers often have conflicting priorities (getting their family member out of the hospital and into a community setting versus being candid and honest about needs) and this leads to less than full and accurate information. The DHS efforts to get good person-centered information out to providers has been extremely helpful when it has been able to happen.
2. Everyone knows the workforce shortage is the leading cause of the lack of community options being available. As the council looks ahead to being able to contract beyond the sole-source method, I think it will be important for the RFP [request for proposal] to include asking providers for how these funds can be used to help with recruitment of [direct service providers] DSPs. I hope the funding of items like special recruitment events, sign-on bonuses, marketing materials, etc., can be among the type of capacity building grant items funded by DHS. Rate exceptions for higher wages are available, but we need help getting people in the door as new employees.
3. Property destruction is a common problem for providers serving people with complex behavioral needs. DHS has to be able to get beyond saying property costs, for repairs caused by the people served, cannot be paid through the waiver. This can be a big expense for providers and the only reason needed for saying no to a referral of someone with property destruction in their history. Helping with upfront costs to make a home more indestructible, and repair costs, need to be something a provider can count on when supporting people with complex behavioral needs.

4. Maybe the most important thing the state can do to prevent hospitalizations of children, and the out-of-home placement of children, is to remove the barriers to out-of-home respite. The main barrier is the current requirement for a licensed setting for children's out-of-home respite. This requirement has been in place since 2021 and has led to a drastic reduction in respite options and the increase we have seen in hospitalizations and out-of-home placements.
5. It would be very helpful to have a statewide system for accessing information about people who are ready to move out of a hospital setting. There is a similar portal developed for children by [name of project] (funded by DHS). This model is an example of what would be helpful for adults, as well.
6. There seems like there should be a significant role for regional resource specialists working with transition team members to be a liaison with providers for people from their region who are ready to transition from hospital settings. They could educate providers about available resources, help problem-solve as barriers are experienced and provide follow up and evaluation as they learn from the experience of getting people moved to community settings. This collective experience will be very valuable to county case managers.
7. When a provider steps up to serve a person with complex needs, we know it comes with higher risks. These risks include higher staff turnover and subsequent costs; increased training costs; more chance for staff errors and subsequent maltreatment and licensing investigations; more likelihood of upsetting neighbors and having more NIMBY [not in my back yard] issues; more 911 calls and upsetting local law enforcement, and these are all in addition to the property destruction risks. State policies and procedures need to do more to recognize these risks so that more providers are willing to take them. My suggestion is to broaden the scope of the culture of change project that uses collaborative safety techniques to not look for who to blame but to identify system changes needed to address safety issues and other barriers.
8. In some states, the shared living/life sharing/host home model is used for people with the most complex needs (i.e., Oklahoma). Minnesota's efforts to further develop the life sharing model has been slow and hindered by trying to make existing licensing and funding systems work for this new model. This isn't working and [name] at DHS needs more support and flexibility to design a life sharing model that will work for people with complex needs. Please look at this as one of the new model options that could deliver significant results.

I know there is a lot of pressure to act quickly and find something that will address the problems facing this council. I appreciate the council seeking input. There is a too long a history of DHS going through the motions of seeking input and then moving ahead in a manner that leaves the impression the input was ignored. This has burned out a lot of providers and people in the community and results in frustration that leads to people not offering input. I trust and believe this will not be one of those situations. I mention it to make the council aware this is something they need to overcome as they seek public input.

I’m the [name of organization], an early-stage, senior care industry start-up company, focused on creating a new approach for managing next-level-of-care transitions for Medicare patients.
I recently learned about the Acute Care Transitions Advisory Council, and its role in shaping the “statewide vision” for acute care transitions in Minnesota. I’m looking forward to seeing the report with its action plan and recommendations.

The initiative seems to have a wide scope considering the age range, “geographic” mix and so on. Of the six bullet-pointed items that will be addressed, however, I’m optimistic [name of organization] application could align with a few of them.

Having studied Medicare patient transitions between hospitals and post-acute care providers for quite some time. I believe the demographics of aging will drive hospitals and post-acute care providers to look for ways to increase their capacity, as more seniors enter the system.

We are developing a referral management tool that will streamline care transitions for Medicare patients and providers. Recently, we've started receiving advisory support from [name of group] in connection with [name of group], as we pursue funding goals for development, and adding support expertise.

We will very soon seek a community partnership to establish a proof-of-concept project.
State of Minnesota hospital discharge data indicates [the state has] 56 hospitals, with 470,000 total discharges and just under $39 million in gross patient revenue. Statistics I've seen suggest seniors, (>65) account for approximately 22% on a nationwide basis.

I'm focused on improving the overall experience of Medicare patients and providers engaged in this initiative.

I am writing you today to bring to your attention a bill that was brought forward by the [name of organization] that looked to address the significant fiscal gaps between the actual costs and the [Medical Assistance] (MA) reimbursement rate for federal and state mandated care evaluations for home care services. This bill was brought forward last session and will be brought forward again in 2025.

This bill establishes a new reimbursement rate for a limited number of "care evaluation" visits. Three specific kinds of evaluations are required. These visits are more comprehensive and take 3-5 times as long as a "typical" home care visit. However, home care agencies are required to bill these "care evaluation visits" at the bill rate established for "typical" home care visits.

For years, home care agencies have for absorbed the high cost of starting or resuming care for a client in the home.

Creating a new MA reimbursement rate for start of care visits, recertification and resumption of care visits — collectively known as care evaluation visits — would help ensure that home care agencies remain financially viable organizations as more and more Minnesotans grow older, with fewer people in the workforce.

In addition to establishing a new reimbursement rate for these visits, ensuring that all MA service agreements are issued by lead agencies in a timely fashion will go a long way to removing barriers faced by home care agencies, especially when individuals are transitioning to and from acute care settings.

I am writing as a Senior Director at [name of organization], as well as a Minnesota Home Care Association board member. Thank you for the work you are doing to identify ways to minimize the time patients spend in acute care settings. We believe that improved access to home care is one of many solutions that should be considered. Home care providers are committed to serving individuals in their homes and need reprieve from some of the obstacles that are limiting the access to such care.

- The Minnesota Home Care Association brought forward a bill that addressed the significant fiscal gap between actual costs and the medical assistance reimbursement for federal and state mandated

> care evaluations for home care services last session and we expect to bring it forward again in 2025. DHS has been very helpful with technical assistance on the language. We believe supporting this legislation as a part of your report would be extremely valuable.

The bill establishes a new [MA] reimbursement rate for a limited number of "care evaluation" visits. Three specific kinds of evaluations are required, are more comprehensive, and take 3-5 times as long as a typical home care visit, which is what the current reimbursement rate is set at. The three visits are Start of care visits (required at the start of any new episode of care to develop the service plan), recertification visits (required every 60 days to ensure everything is going well and to make any needed modifications), and lastly, resumption of care (required if there has been an interruption in the plan of care, such as a patient getting admitted to a hospital for more than 24 hours). The 2024 session bill is attached for your information.

Home care agencies have for years absorbed the high cost of starting or resuming care for a client in the home. Decreasing barriers to home care access is now more important than ever as more and more Minnesotans are growing older and there are fewer people in the workforce. Home care providers are committed to helping Minnesotans get access to the supports they need to decrease hospitalizations and rehospitalizations.

Some home care providers are now minimizing the number of Medicaid clients they serve due to the extremely low rates that don't cover the cost of care. This has led to hospitals struggling to find care that is needed for safely discharging patients on MA. This challenge exists with all ages, from infants and young children who require home care nursing (extended care) services to seniors, who remain in the hospital due to a shortage of adequately paid home care staff.

We offer a few other suggestions for your consideration.

- County coordination
    - Increased training for county coordinators, especially for authorizations and CFSS, would minimize home care provider administrative time and allow for increased caregiving hours. Patients are sometimes discharged because the authorization isn't done soon enough or not correctly. We also find that some case managers try to make decisions, such as start dates that aren't appropriate; there seems to be a lack of, or inconsistency with standards. With CFSS implementation on the horizon, that are concerns about a smooth transition and a realization that this may impact timely care. Providers are rightfully concerned about the many outstanding issues. These challenges impact the ability to keep patients in the home and could lead to increased hospitalizations.
    - More proactive communication between counties and home care would also decrease the administrative burden (e.g. inform providers of county staff changes for greater efficiency).
- Hospital training – Our home care providers experience gaps in discharge criteria and other discharge challenges. Providing training for the hospital social workers would increase successful and more efficient referrals. Some of the situations our members experience are patients being referred to agencies that do not provide the services they need or mis-understandings around Medicare requirements.

I serve [name of organization] as senior director, Home Health and Hospice. Our agencies (in [name of city/town] and [name of city/town]) are members of the [name of organization], and I am currently serving as board chair of [name of organization].

I wanted to reach out and thank you for your dedication to this important work. Managing patient flow to ensure that acute care is readily available for Minnesotans is so important to all of us.

I know others in the home care industry have reached out to you as well, and that is because supporting decompression efforts and mitigating length of stay is something home health agencies are equipped for, and interested in. Our agency has worked closely with [name of city/town] hospital and our [name of organization] critical access hospitals to do just that. We have also worked with MDH to support decompression efforts during the pandemic via state funded travel [registered nurses] RNs. That work was successful as we were able to admit more patients to home health, resulting in some relief to the capacity issues we have experienced in [name of organization].

Since then, we continue to try and identify patients that could leave the hospital sooner with the help of more intense home health services. Despite our efforts, there is untapped opportunity in this space. The capabilities of home health are very versatile, which makes it difficult to identify the right patients for this transition. We (home health agencies) are able to manage the simplest cases as well as more complex clinical interventions, and everything in between. Providers/hospitalists are looking for more clear-cut criteria for who should go home early with home health, and that’s where I think we can make more progress.

This committee could be vital in enhancing the understanding of how valuable home health can be in transitioning patients home after an in patient stay, and I hope you will consider that in your work. We would also appreciate any support you can offer for some legislative action to improve reimbursement for home health services within our state.

I would happily be a resource to the committee if needed. Thank you for your consideration and the work you are doing to improve healthcare for all.

I am emailing to ask for your support of our care evaluations bill to minimize the time patients spend in acute care settings. The [name of organization] brought forward a bill that addressed the significant fiscal gap between actual costs and the medical assistance reimbursement for federal and state mandated care evaluations for home care services last session and we expect to bring it forward again in 2025. The bill establishes a new MA reimbursement rate for a limited number of “care evaluation” visits. Three specific kinds of evaluations are required, are more comprehensive, and take 3-5 times as long as a typical home care visit, which is what the current reimbursement rate is set at. The three visits are; start of care visits (required at the start of any new episode of care to develop the service plan), Recertification visits (required every 60 days to ensure everything is going well and to make any needed modifications) and lastly resumption of care (required if there has been an interruption in the plan of care, such as a patient getting admitted to a hospital for more than 24 hours). Home care agencies have for years absorbed the high cost of starting or resuming care for a client in the home. Decreasing barriers to home care access is now more important than ever as more and more Minnesotans are growing older and there are fewer people in the workforce. Home care providers are committed to helping Minnesotans get access to the support they need to decrease hospitalizations and rehospitalizations.

In addition to this bill, it is crucial that a care evaluation team is developed within hospitals and transitional care settings that work with lead agencies and homecare providers. This team needs to be knowledgeable about homecare benefit information and the differences in benefits depending on the patient's benefit eligibility such as Medicare, Medicaid and waiver services. This will ensure that when planning a discharge, care assessments can be completed before discharge by lead agencies and/or home care providers to ensure proper service referrals are placed with the appropriate agencies and available to the patient upon discharge. It will be important this team follows up on the referrals to ensure that the agency is the appropriate agency for their needs and can serve the patient. This will avoid patients going home and being left without services because care evaluations and referrals were not placed appropriately and will decrease rehospitalization.

I'm happy to discuss any of this further with your council. Thank you for your support!

I am on the advocacy committee with the [name of organization] and heard about this committee and wanted to pass along my thoughts on what barriers related to safe acute care transitions that our skilled home health agency is seeing.

One of the biggest issues that our agency deals with are patients that are discharging too early from hospitals or without the proper support system in place. This results in frequent rehospitalizations – sometimes on the same day we go out to admit a patient.

We have one client right now who we admitted to home health that has no support system (no family/friends) and is struggling with basic help such as having someone driving him and being with him after a brief outpatient procedure or help with homemaking tasks such as cleaning his upstairs to make it livable. These are not services that our agency provides.

Increasing access and funding and access to these non-skilled supports so they can get set up sooner would greatly benefit patients by increasing their safety in the home and reducing unnecessary rehospitalizations.

I would also like to ask for your support for the care evaluations bill (the 2023 bill is attached).

The [name of organization] brought forward a bill that addressed the significant fiscal gap between actual costs and the medical assistance reimbursement for federal and state mandated care evaluations for home care services last session and we expect to bring it forward again in 2025. The bill establishes a new MA reimbursement rate for a limited number of “care evaluation” visits. Three specific kinds of evaluations are required, are more comprehensive, and take 3-5 times as long as a typical home care visit, which is what the current reimbursement rate is set at. The three visits are: Start of care visits (required at the start of any new episode of care to develop the service plan), recertification visits (required every 60 days to ensure everything is going well and to make any needed modifications) and lastly resumption of care (required if there has been an interruption in the plan of care, such as a patient getting admitted to a hospital for more than 24 hours).

Home care agencies have for years absorbed the high cost of starting or resuming care for a client in the home. Decreasing barriers to home care access is now more important than ever as more and more Minnesotans are growing older and there are fewer people in the workforce. Home care providers are committed to helping Minnesotans get access to the supports they need to decrease hospitalizations and rehospitalizations.

Thanks so much for your time!

Submitted responses about the report during public comment period

Individual emails

A few thoughts about barriers in getting folks out of hospitals/acute settings. A big barrier as we are all aware is staffing and the ability to find an accepting/appropriate facility or homecare agency due to the high acuity we are seeing more and more. With the continued moratorium, there are few group home/housing with services programs with available openings to serve people.

I believe another huge barrier is funding and access to state programs. With the MA renewal process resuming for thousands all at once, many counties are struggling to keep up with the increased workload of new applications along with processing all the renewals simultaneously. Because of this so many people are stuck without services or stuck in the hospital waiting for their applications to be processed so they can be accepted to a facility/start the services they need. The number of applications and renewals has skyrocketed however the workforce to process them has remained the same (or even decreased in many cases). Delayed processing times has really impacted the amount of time folks sit in the hospital awaiting appropriate placement.

I would like to comment on the inability for people need[ing] [personal care assistance] PCA services — which have now become [Community First Services and Supports] CFSS services — being able to access CFSS transition services or CFSS, in general, until they are in the community.

The new CFSS process does not appear to have any consideration for those who are institutionalized and is creating a bottleneck of folks unable to discharge related to a lack of ability to access the program.

I became a professional guardian this past year and have been asked a few times to take on guardianship of someone who has been stuck in a hospital unable to go into nursing home or other placement due to needing a guardian to make the decision. I have taken three cases this past year with one being an emergency as she needed surgery she had to wait for until the guardianship was completed. I feel that all three should have been "emergency" guardianships because they had to stay unnecessarily in a hospital for months which is detrimental to elderly vulnerable adults. There should be an expedited guardianship process for these cases. There is ample medical information to support the need for the person. The hospitals should not have to foot the bill as they aren't getting paid for these people who sometimes haven't had anyone help them apply for benefits, citizenship or anything they need to get the help they need.

Before I switched from hospital/clinic to homecare, there was a bill passed requiring hospitals to be intentional about reviewing the discharge instructions with the patient or family member.

This is crucial when patients are being discharged to home. They must be trained on things like simple wound care, simple dressing changes and ensure they understand about the follow-up appointment. Also, ensuring they are coming home with a refill of new meds, changed meds and understanding how to take them.

As a homecare provider, I would like to receive a copy of the discharge instructions, so we can offer appropriate support such as ensuring they have everything to follow-thru on the discharge instructions, especially crucial with diabetic patients. Almost always, staff/patients do not remember to let us know about the hospitalization. While CFSS has a timesheet change that may help with that, I would like to have a system that is more intentional about involving those who are closer to the patient, more frequently.

I am an experienced care coordinator from Medica. I use the word “members” as they are not always a patient. I suggest starting with care coordinators getting notifications that our members are at the [emergency room/emergency department] ER. We can if notified (which we are not until days later) work with the ER and get our names attached to the case before the member even goes to the unit. As care coordinators we have most of the needed list of providers or issues for our members. By sharing this information immediately with the social worker on the unit and working with the team of providers in the community we could begin working with that member and team with a plan for discharge which can start immediately.

Some members need to start with a [Community Access for Disability Inclusion Waiver] CADI assessment and the list of people in need is long. It may take six months to get an assessment. The hospitals may benefit by having their own CADI assessors that could work across all counties.

Problems include if member is in need of longer-term treatment (such as at [Anoka Metro Regional Treatment Center] AMRTC or [St. Peter Regional Treatment Center] St. Peter) there is a long waiting list. If the member stays at the hospital long enough and is on medications they get to baseline and are discharged which robs them of the chance to be provided with skills and learning that may help avoid another hospital stay. If a member is on a commitment and returns to the ER the chances of being admitted are high. Starting the cycle over.

Another issue is if a member has legal issues and mental health issues there is a merry go round of continued hospitalizations. If in the criminal arena and are waiting for a bed at AMRTC or St Peter they are put at the head of the list, however the list can be months to years long and the member may not be able to be safely released. Thus, the need for more facilities like these to provide for longer term answers.

In some cases, after discharge an option is an [Intensive Residential Treatment Services] IRTS facility, however these have become more about housing than a chance to learn skills and become more stabilized. Some of these IRTS facilities are inadequate and may need to be shut down or restructured. Often wonder who is monitoring these facilities and what skilled workers are working at them. For the most part in the Twin Cities these facilities are less than adequate.

There is also a hole in the [substance use disorder] SUD field. People can leave the hospital and go to treatment, [and] if that does not work go again and again. Some use the system to find housing and food all in the name of treatment. This is especially true for inmates leaving prison or jail with no housing. They soon find that treatment will be paid for over and over again and use these beds for housing. Minnesota likes to spend a lot of money on treatment for mentally ill and for SUD, however dumping money to pay for treatment over and over again is actually doing these people a disservice. Ask anyone who has struggled with addiction.

One of the best ways to help our members is to have someone working with them who can be helpful when and if they do get admitted to a hospital. There should be one central person who has all that information and can provide it to the social worker on the unit to start the team concept to help a member. This may include a primary care physician, psychiatrist, therapist, target case manager, [parole officer] PO, CADI worker, etc.

Lastly, some of our members are able to use the system to obtain drugs, visit[ing] ERs frequently and use different hospitals. There is a federal program restrictive recipient program (RRP), which is very helpful to track and ensure members are not using the system for personal gains. A state system like RRP would be very helpful to some not all.

From a nonmedical home care provider perspective, our biggest challenge with this transition is the lack of communication on timing. We are often asked with very little notice to have an employee available for a high number of hours a week 20-40+ for non-medical care, but we cannot have anyone tell us what day or even week the care would need to start. In almost all cases we would be hiring a new employee or transitioning caregivers around, but we need to fill their schedules. Late cancellations cannot be charged per the state guidelines, so we are often forced to turn these clients down as our caregivers cannot put their paychecks up against the uncertainty. As a business we already fund too many issues the state has not resolved.

There are also significant issues when there are multiple providers, we are often only supposed to handle the non-medical care, and another agency is supposed to handle nursing-level care, like wound care. The same issues as stated above but even more complicated, when we are told the client will be taken care of and often the other agency never shows up. This leaves us in situations where we are given a choice of leaving the client with no care or going above what we are supposed to do.

Another significant issue is the case managers. Our clients often have to wait weeks to months to get a case manager assigned to them. This is even worse in counties like Hennepin County which have outsourced case managers, compared to in-house counties like Carver County. Working with Hennepin County clients is horrible as they seldom have the same case manager for any length of time. When any change of service is approved, it can take weeks to a month, plus, for the service agreement to come through to us. In situations where someone is transitioning, we often have to take a case manager's word that the service agreement will come through, but this pushes the risk to us to ensure all paperwork is updated correctly after the fact so we are not fined when we are audited. This is another pressure making these clients harder to work with, as DHS is highly sensitive to any minor administrative error, even when there is no question that the work was completed. So, by taking these clients before the service agreement is received, we can be fined the entire reimbursement, plus additional fines above the services provided.

I feel as a person that is getting currently care through my daughter she takes care of me she's my PCA the pay needs to go up and then the services that are provided I need more hours my condition and what I'm going through is not going to get any better this is a lifelong thing there's no medicine there's no surgery that can correct but I'm going through the fact that I'm getting less hours and I'm not getting what I need through DHS because they want to color coat things and they don't want to give her services because I'm in a certain type of housing setting is not okay there need to be more and she should be getting paid more definitely definitely it should be getting more hours for the services that are getting provided to me her hours should never get cut this is an ongoing issue that I've always go through when I get reassessed through people they feel like oh she doesn't need the help so they take my hours away and I always got to fight for them and I should have to go through this this is mentally and emotionally draining for me and that should never happen so I don't know what you guys are going to do about that they need to step up their care when it comes down to people that need to be cared for through other people.

Here are my comments on the ACTAC report and recommendations:

1. It is disappointing to see the report's focus on downstream measures reacting to hospitalizations. There are upstream measures that should be taken to prevent hospitalizations. These include:
    a. Providing more access to out-of-home respite services for children by eliminating the requirement for these services to be provided in a licensed setting. The change to requiring a licensed setting in 2020 resulted in a very significant loss of setting for children's respite. The loss of this option has meant families not being given a break and, in a crisis, having to hospitalize their child.
    b. Providers of community services who experience significant property damage by a person being served in on the hook for this cost with no reimbursement coming from the waiver or housing support funding from the state. This expense leads to providers not being willing to allow a person to return to their home after a hospitalization. There needs to be some mechanism for funding the cost of property destruction in CRS settings.
    c. Children and adults with complex needs are often placed in three- and four-bed settings despite the excessive challenges for them to live with others due to their behavior management needs. Smaller settings are not as available as they should be due to the housing support funding not being able to be adjusted for people who need to live alone, or maybe with one other person. Providers end up having to subsidize the cost of the property when trying to operate a one-bed home.
2. The barriers to hospital discharge and the system changes to address those barriers need to include the following:
    a. Under communication and coordination, an experience we have had is when a hospital implements behavior management techniques that are not allowed under the positive support rule and 245D. For example, [Residential Services Inc.] RSI was willing to admit a child into a CRS children's program but ended up having to say no because we could not continue the behavior management program that was using punishment-based program.
    b. The overall lack of positive support professionals and analysts in Minnesota means providers are left to fend for themselves when admitting a person with complex behavioral needs. The qualifications for the positive support analyst need to be changed to allow more recognition of experience so that there are more resources available.

    c. The biggest barrier to hospital discharge is the lack of qualified staff in community programs. Unless this barrier is addressed with funding increases, the hospitalization problem is not going to get fixed.

3. There are legislative proposals coming from advocacy groups — like Disability Law Center — that want to change the service termination and service suspension statute language to make it harder for providers to terminate or suspend services. The language includes making providers responsible for insuring there is a plan for a move to a safe setting before terminating or suspending services. There are lots of concerns with this legislation, but the one impacting hospitalization and hospital discharges is that providers will be unwilling to admit anyone if there is any concern they cannot serve them. A provider will not want to be stuck serving someone when they cannot keep them safe, or others in the home safe. This risk will result in people with complex needs not having any provider who is willing to try and serve them.

I am writing in response to the public comment period for acute care transitions. I am a public health nurse working as intake staff with MnCHOICES referrals in Itasca County. Our county works with three local health systems, two of which regular experience community members spending long periods of time without a placement option in their emergency departments, Medicare swing beds or hospital inpatient floors. I also work regularly with discharge planning staff in psychiatric hospitalizations, residential treatment settings, IRTS and [consumer-directed] CD treatments settings in other counties trying to coordinate placement for clients who are our CFR. Overall, the complexities of systems/social situations, the layers of processes, staffing limitations across many areas, the lack of understanding due to inexperience, errors and legal considerations all contribute to delays.

Locally, most often I am receiving intakes from acute settings for elderly clients, often with dementia or with care needs that can no longer be met at home. Barriers to placement are complex and multi-faceted:

- Even if the client is appropriate for short-term rehab or long-term care, a [skilled nursing facility] SNF bed can't be located. This may be due to patient's diagnosis, staffing issues or bed availability.
- When patients can't return home, but don't have a three-day qualifying stay, or when a rehab facility isn't found, hospitals transition to seeking [assisted living facility] ALF options. In counties without an urgent referral team, availability of an assessor can be an issue. If an assessment can be obtained, identifying and accessing a public pay source can be complex. Home ownership, uncompensated transfers, complex financial situations, failure of family to provide proofs, and county financial unit issues can all delay quick processing of cases. If the COR and COS are different, a lack of communication can interrupt the transition. Competency of the patient and a lack of decision-making plan can also contribute to delays.

When working with out of county clients, pending a disability waiver, there are challenges common to those described above, as well as some additional challenges:

- Limited placement settings in home communities, or anywhere in the state.
- Complex rules related to customized living settings and disability waivers, and time-consuming information seeking to assure settings meet criteria.
- Lack of or delays in communication between counties when COS and CFR are different. At times, it appears that these cases are not prioritized equally by the CFR and the COS, in an effort to get clients moved from the hospital.
- Misunderstanding by players involved about what steps need to happen in what order.
- Delays in getting a MnCHOICES assessment completed.
- Lack of disability certification and delays with [State Medical Review Team] SMRT process.
- Incorrect information such as CFR.

Even as an experienced worker who understands how the pieces work together, issues with one case can take hours to unravel. Even with strong relationships across hospitals, providers and/or agencies, the issues seem insurmountable.

I am a social worker with the Center for Excellence in Supported Decision Making. One of the main issues we intersect in both my direct client casework as well as on our statewide Guardianship Information Line is the “requirement” by a receiving facility that a person with X diagnosis (often dementia, but not exclusively) cannot be admitted to the facility until a guardianship is established. Often this is without thorough exploration of less restrictive alternatives or a lack of acknowledging [less restrictive alternatives] LRA as an option to support the person.

Additionally, I believe that there is a perceived “risk” on behalf of a receiving facility that if a person with a level of capacity impairment is admitted to their facility without a guardian, then if anything happens, the facility will be liable. There is fear on the part of the corporate entities/legal teams (often not even based in Minnesota) that the facility will be sued or perhaps receive citations when the state comes through to do a survey. It seems that facilities feel they are less “on the hook” if there is a legal guardian as that person holds the responsibility.

There are blanket denials of individuals across entire nursing home providers at times, too. If a provider has 50 or more sites across the state, they hold a lot of power in their admission process. If there is something on paper that seems too “risky,” there is nothing to behoove them to ask clarifying questions or problem solve the issue, it’s simpler to decline the person across their system. In my opinion this seems discriminatory as what’s to say a handful of those 50 sites doesn’t actually have the skillset and staffing to meet the person’s needs due to a specific diagnosis, etc.

Some of the perspective I am sharing is from my 8+ years working in SNF settings and an understanding of how hard it is to advocate/push back against administrators or corporate/legal entities that shy away from certain “red flags,” in a patient chart. Requiring guardianship is cleaner and easier, relieving the admin./corporate folks of concerns re: liability (of citations/fines and or lawsuits).

While I sympathize with the facility position in some capacity, I also see this as a main factor in patients being “stuck” in a hospital bed for months on end.

Thank you for the opportunity to provide feedback on acute care transitions. As a social worker who works in the Center for Excellence in Supported Decision Making and as a medical social worker who continues to work in a metro area hospital, I am very aware of the barriers toward moving people out of hospitals when they are medically ready.

One barrier that increases costs to hospital stays, "logjams" to getting people out of the hospital and creating further health risks to their health by prolonging hospitals stays is the unnecessary request by leaders of nursing homes, memory care, assisted living and group homes that a petition for guardianship be initiated as a condition of admission. As mentioned earlier, this places hospitalized Minnesotans at risk of developing further illness, emotionally decompensate due to being confined to the hospital and increases costs of hospitalization and increase costs of health care for Minnesota families. In addition, it violates the bill of rights for patients and residents. It is also in violation of Minnesota’s guardianship statute which requires exploration of least restrictive alternatives to guardianship.

Thank you for the opportunity to submit comments on this issue. As director of the Center for Excellence in Supported Decision Making, which hosts Minnesota's Guardianship Information Line as well as direct social work in the guardianship arena, this is an issue that we are well aware of and concerned about.

One barrier to hospital discharge is in the belief that guardianship is required to resolve the transition problem. While Guardianship is indeed required sometimes, it is necessary far less often than some might believe/insist upon.

Too often, the hospital and/or the otherwise admitting facility rely on guardianship without adequately trying less restrictive approaches, which they deem to take longer and carry less legal structure and therefore, more risk. This is not necessarily true, but it is a common thought. As my colleague Kathleen Carlson mentioned in her comments to you, too often there is default to guardianship and insistence that a person will not be admitted without a guardian. Their reasoning is understandable, but not accurate. These false requirements that a guardian needs to be put in place creates their own barriers to appropriate discharge times and outcomes.

A paper I wrote about this issue was published last year in the American Bar Association's Bifocal publication.

When guardianship is truly needed, barriers to obtaining guardianship include:

1. **Time**: A person needing discharge from the hospital is not typically considered an emergency in the guardianship statute, and it can take three to four months to get a court hearing to establish a guardianship.
2. **Resources**: If there is no family/friend to serve and a professional guardian is needed, it can be impossible to find a guardian.
    a. For patients who have financial means to pay a guardian/conservator to make decisions for them, including medical and consenting to discharge to a particular setting (guardian) as well as authority to manage the finances to pay for the needed care setting, it is getting increasingly difficult to find professional guardians/conservators willing to accept such nominations, even for these paying cases. The reasons are many, and our office would be happy to discuss with you.
    b. For patients who have neither the financial resources nor the family/friends to serve and who therefore need a professional guardian, the barriers are many:
        i. Finding a guardian willing to serve in these matters for rates set by the counties in which the guardianship would be established. Many counties have no provisions for paying for professional guardians, and even those that do are finding it difficult to find people willing to serve in this capacity due to the complexities plus low rates.
        ii. **Venue**: the Guardianship statute is clear that the venue is the county of residence, however, when the person has a county of residence, but is inpatient at a hospital in another county, and also may have yet another county of financial responsibility, it can be exceedingly difficult for hospital discharge planners to gain cooperation from county APS, Guardianship screening committees, etc., to determine whose budget will pay for the indigent patient's guardianship feels.
3. **Guardians can't solve all problems**: Waiting for the establishment of a guardianship in a situation where even full statutory powers of the guardian can't solve the problem is a waste of time, energy, and money.

    a. Guardianship is a consent power, not a compliance power. Guardians can't make a person accept needed treatment or services.
    b. Guardianship can't address a person's problems related to difficult behaviors which then result in no place willing to accept the person upon discharge. Here the response is getting at the basis for the non-compliance or intrusive behaviors.
    c. Guardianship can't magically produce a resource that does not exist, i.e., a person needing care that doesn't exist such as one-on-one sitting, or complex medical care needs, adequate home care staffing, etc.

Thank you for the opportunity to share these comments, and for your work on the acute care transitions situation. It is indeed troubling and in need of some creative responses.

Excellent report. I wanted to provide you with a report from the legislative working group on youth interventions published February 2024, as a resource to you.

Additionally, I wanted to provide some feedback on some details for your consideration under your goals identified in [independent living care] II.C, II.D, and II.E. This feedback is specifically regarding children. Identifying these points would provide a broader understanding of the issue as it impacts children, which would lead to more refined systems modifications and targeted capacity building and intervention efforts.

1. How did the child enter the hospital that led to boarding (who dropped them off)? Police? Provider? Parent? Other? This could help with understanding where the breaking point is in the community system that leads to the crisis. From there we could identify how to work backward to prevent it in the first place.
2. Were community-based services accessed prior to crisis/boarding event including, but not limited to:
    a. Community-based (and school-based) mental health services such as: CTSS, CIBS, day treatment, PHP, individual or group psychiatric therapy, CMH case management, CMH respite, mobile crisis.
    b. Community-based waiver-funded services such as: IHS, ILS, family training and counseling, positive support services, person-centered planning, respite, crisis respite (a distinct service line from respite).
    c. IEP at school.
    d. Prevention-based child welfare services such as: permanency support services, parental support outreach program, family group decision making, family respite.
3. Mapping **availability** of community based services across the state (not just if providers are licensed or certified to provide service, are they actually billing for the service and providing the service)
    a. Which regions are lacking which kind of services.
    b. Why are the regions lacking these services.
    c. How can the regional centers help in building capacity for these types of services.
4. Does the child have a history of adoption, TPLPC, foster care, child protection involvement? Child welfare involvement may be one of the first points where the child is touched by the system. What opportunities emerge from this system involvement that we could use to provide a child with the right services at the right time to mitigate crisis?
5. Regarding readmittance:
    a. Where is the child discharging to? Home? Residential? Other?

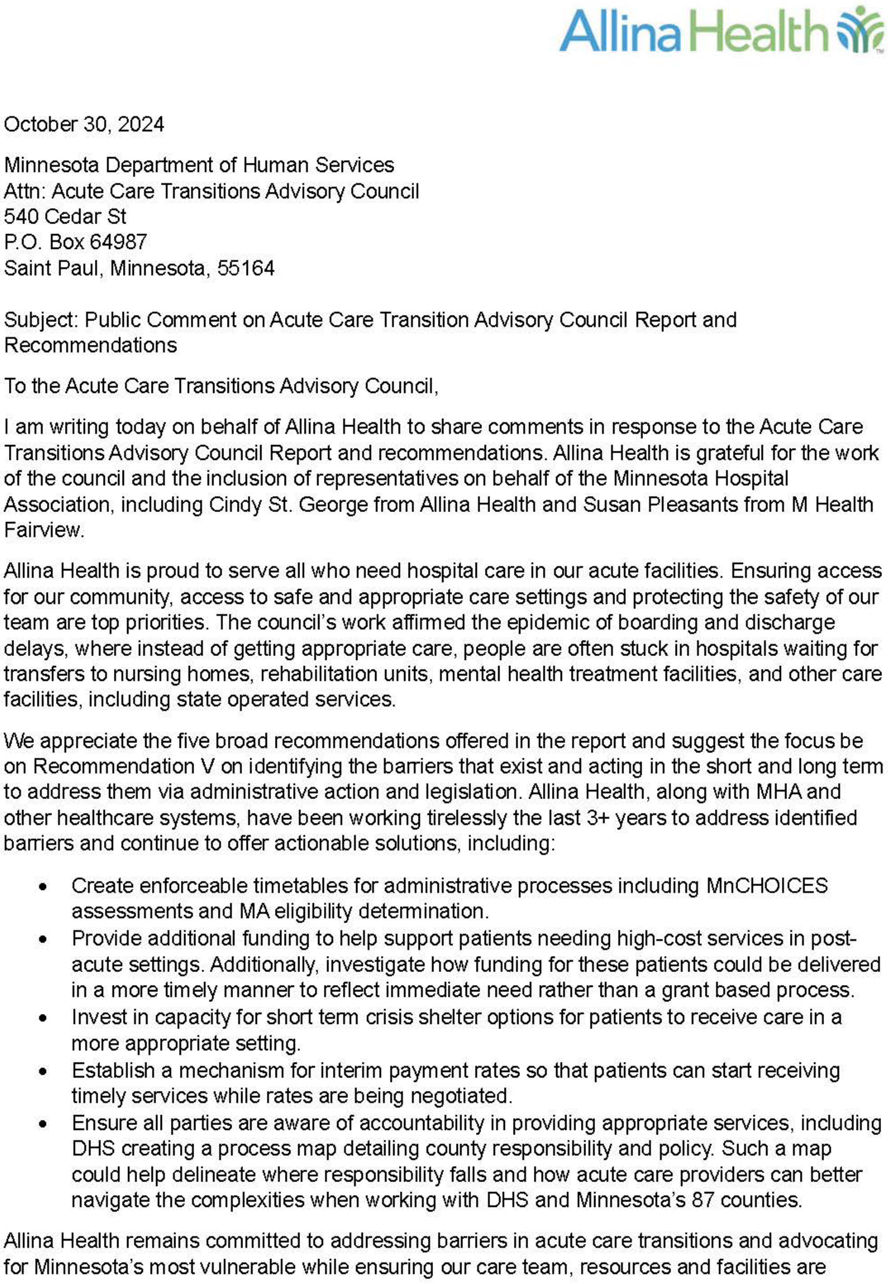
b. What wrap-around services were put in place to support the child's stabilization in their community?
c. How was the child's family or community **supported** to help their child?

We've reviewed the plan, and have just a couple of comments:

1) We support the recommendation for funds related to transitioning, such as property damage, as well as structural changes to homes. Changes to homes can sometimes be covered by environmental modification dollars, but if we are going to be successful in setting up an appropriate number of transitional sites to bridge the gap between hospital and home, these dollars will need to be available for development prior to a specific person being identified.
2) We also support the inclusion of funds to support positive supports. Currently the reimbursement rate for positive behavior supports, particularly for the analyst level, makes it difficult to attract appropriate talent to those positions. We have also struggled due to not being able to bill positive behavior supports while someone is in the hospital because their waiver is off. Being able to utilize those supports to help with preparation and transition will be important so providers of this service need a way to bill during this time period.

Thank you for your ongoing work in this area. With the further analysis this group has proposed, I'm hoping we can find a way to truly develop appropriate transitional space that meets the ever increasing need. Thanks again.

Group Comments



Allina Health

October 30, 2024

Minnesota Department of Human Services
Attn: Acute Care Transitions Advisory Council
540 Cedar St
P.O. Box 64987
Saint Paul, Minnesota, 55164

Subject: Public Comment on Acute Care Transition Advisory Council Report and Recommendations

To the Acute Care Transitions Advisory Council,

I am writing today on behalf of Allina Health to share comments in response to the Acute Care Transitions Advisory Council Report and recommendations. Allina Health is grateful for the work of the council and the inclusion of representatives on behalf of the Minnesota Hospital Association, including Cindy St. George from Allina Health and Susan Pleasants from M Health Fairview.

Allina Health is proud to serve all who need hospital care in our acute facilities. Ensuring access for our community, access to safe and appropriate care settings and protecting the safety of our team are top priorities. The council's work affirmed the epidemic of boarding and discharge delays, where instead of getting appropriate care, people are often stuck in hospitals waiting for transfers to nursing homes, rehabilitation units, mental health treatment facilities, and other care facilities, including state operated services.

We appreciate the five broad recommendations offered in the report and suggest the focus be on Recommendation V on identifying the barriers that exist and acting in the short and long term to address them via administrative action and legislation. Allina Health, along with MHA and other healthcare systems, have been working tirelessly the last 3+ years to address identified barriers and continue to offer actionable solutions, including:

- Create enforceable timetables for administrative processes including MnCHOICES assessments and MA eligibility determination.
- Provide additional funding to help support patients needing high-cost services in post-acute settings. Additionally, investigate how funding for these patients could be delivered in a more timely manner to reflect immediate need rather than a grant based process.
- Invest in capacity for short term crisis shelter options for patients to receive care in a more appropriate setting.
- Establish a mechanism for interim payment rates so that patients can start receiving timely services while rates are being negotiated.
- Ensure all parties are aware of accountability in providing appropriate services, including DHS creating a process map detailing county responsibility and policy. Such a map could help delineate where responsibility falls and how acute care providers can better navigate the complexities when working with DHS and Minnesota's 87 counties.

Allina Health remains committed to addressing barriers in acute care transitions and advocating for Minnesota's most vulnerable while ensuring our care team, resources and facilities are available in service of the most medically acute patients. We look forward to continued partnership with the state in addressing barriers to appropriate care.

Sincerely,

Kristen McHenry
Director, Public Affairs
Allina Health

ALZHEIMER'S ASSOCIATION®

October 29, 2024

Thank you for the opportunity to submit public comments on the Acute Care Transitions Advisory Council Report and Recommendations on behalf of the Minnesota Chapter of the Alzheimer's Association. We are a nonprofit organization that serves people living with Alzheimer's disease or another form of dementia and their caregivers.

Emergency room boarding and challenges transitioning people from inpatient to community-based treatment settings is a complex issue where there is no one solution. We appreciate that the recommendations center this complexity and acknowledge that narrowly focusing on one part of the acute care problem will likely just move the problem rather than solving it. Our core message for the Advisory Council is that dementia must be a part of the conversation.

While mental illness and substance use disorders are primary drivers of the acute care crisis in Minnesota, it is essential that any policy solution tackle this crisis comprehensively and reflect the unique needs of people living with Alzheimer's disease or another form of dementia. The Transfer and Discharge Delays for Behavioral Health Patients at Minnesota Hospitals report released this past July provides some important context.[1] While a history of behavioral issues or dysregulation and substance use accounts for 39% of inpatient discharge delays, dementia or another specific cognitive impairment drives 8% of discharge delays, with dementia patients having a longer median discharge delay of eleven days.

Given the significant role that people with dementia play in the acute care transition challenges facing hospitals, the Alzheimer's Association urges the Advisory Council to incorporate dementia specific information and supports into their recommendations such as expanded care navigation efforts and the statewide communication system. We also urge future advisory council recommendations to account for the discharge delays due to inadequate funding for community-based services. Scarce home-based care keeps people with dementia in the hospital longer than necessary and, as the acute care report acknowledges, pushes them into restrictive memory care settings when that level of care is not medically necessary.

Thank you for your time and support. We look forward to working with the Acute Care Transition Advisory Council going forward to meet the needs of people living with dementia and their caregivers.

Sincerely,

Robert Freeman
Vice President, Public Policy
Alzheimer's Association, MN-ND

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[1] Minnesota Department of Health, Wilder Foundation. *Transfer and Discharge Delays for Behavioral Health Patients at Minnesota Hospitals.* Retrieved from https://Rwww.health.state.mn.us/data/economics/docs/dischargedelays.pdf

alz.org/mnnd
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ARRM

October 30, 2024

Minnesota Department of Human Services
Transitions, Tribal & Transformations Division
TransitionsAdvisoryCouncil.DHS@state.mn.us

On behalf of our more than 200 member provider organizations, associated businesses and advocates, this letter is ARRM's response to the Acute Care Transitions Advisory Council's report and recommendations. We applaud the work done by the Council in the required timeframe, and are grateful to the Council participants for their contributions, especially co-chair Josh Berg, who is a member and officer of our Board of Directors.

We wholeheartedly support the recommendations of the Council. With all of the evidence and information gathering that went into them, it is absolutely correct that they are rooted in eliminating disparities and promoting equity in transitioning people from hospitals and emergency rooms back to the community. It is important that the work the Council started continue, that a standing workgroup focused on acute care transitions be as diverse as possible, and that it includes the voices of home and community-based services providers, as well as people who have gone through the transition process themselves. It is also imperative that systems of communication, service and discharge planning, and interagency coordination be improved. An improved transition process must be informed by reliable data, which can be evaluated in terms of race and ethnicity, age, gender, geography, disability status, physical and behavioral health needs, and other variables that may be identified.

Comments on the Specific Recommendations

I. The Council recommends that it become a standing unit within DHS, and that its membership include a diversity of representation to "ensure all Minnesotans have a voice in the system." This is an ambitious goal, and an overly large group could become unwieldy. We suggest a maximum number of members be established to ensure the group's effectiveness.

II. The recommendation calls for three initial regions to work together. We suggest adding guidance that the regions be chosen to represent different parts of the state, including urban/suburban/metro and rural. We also suggest that the list of partners represented in the work to assess the effectiveness of the transitions across the regions include managed care organizations and the healthcare administration division of DHS to capture the payer's perspective. And we suggest the addition of disability status to the list of variables for disaggregation of the data-based decision-making system.

III. We can't overstate the importance of applying adequate resources to the Council's ongoing work, and to the care system itself, to eliminate some of the barriers that impede smooth transitions. Such barriers include:

  - Inadequate and insufficiently-trained staff to accept people with high health and/or behavioral needs
  - Inadequate funding for housing
  - Shortage of home and community-based services
  - Insufficient numbers of inpatient and SUD beds to provide safe environments for people

IV. Integrating measurement and coordinating with existing health equity processes are important aspects of a successful care transition system, and must be included in the state's plan

V. Making changes to administrative policies and rules that create unnecessary barriers as quickly as possible will go a long way in improving the acute care transitions process. For example:

  - Create incentive programs, both short- and long-term, for direct support staff and supervisors in the home and community-based services sector, including the disability waivers
  - Avoid unnecessary terminations from, and delays in, enrollment in Minnesota Health Care Programs (including Medical Assistance, MinnesotaCare, Minnesota Senior Health Options, and Special Needs Basic Care) by approving service applications and renewals in a timely manner
  - Expedite MnCHOICES assessments and eliminate the requirement for full assessments if the individual's needs have not changed
  - Work with lead agencies to approve more rate exception requests, and approve them in a timely manner, under the Disability Waiver Rate System
  - Allow rate exceptions to remain in effect if the individual's Case Manager and support team determine that the removal of the rate exception will harm the individual's well-being
  - Allow providers to negotiate with their County for a higher Housing Support rate for individuals who cannot live with others.
  - Require collaboration between DHS and lead agencies on the processes and forms providers use in requesting rate exceptions
  - Expand respite access for children to unlicensed settings

We appreciate the opportunity to provide these comments on behalf of our members as part of this process. Please feel free to contact me if you have any questions. You can reach me at 612-464-3670 or email me at sschettle@arrm.org.

Sincerely,
Sue Schettle
Sue Schettle
Chief Executive Officer

Fairview

October 30, 2024

Re: Public Comment on Acute Care Transitions Advisory Council Task Force Report and Recommendations

On behalf of Fairview Health Services ("Fairview"), we appreciate the opportunity to provide comments on the recommendations from the Acute Care Transitions Advisory Council Report. Fairview is a nonprofit, integrated health system providing health care across the full spectrum of medical services through our 10 hospitals and 60 clinics. Fairview's broad continuum also includes senior and long-term care facilities through Ebenezer.

One of the most significant challenges we continue to face as a health system is helping our patients to find and secure an appropriate setting for discharge to the community once they no longer need an acute care hospital stay. Patients who we are unable to secure discharge plans for often end up staying in our hospitals for weeks and months past the time when they are medically ready to be discharged. In 2023, in our health system alone, we had over twenty-five thousand avoidable patient bed days due to discharge barriers and delays. These days also create a barrier to care for other patients needing acute hospital care and contribute to increased care costs for patients and hospitals.

We know these challenges are not unique to our health system and are impacting hospitals across Minnesota and the rest of the country. We appreciate the legislature acknowledging these challenges in the 2023 legislative session when they created the Advisory Council to identify discharge barriers and develop recommendations to address them. While much of the content of the Advisory Council's report lays out the research and data collection that has already taken place in many different settings, we are disappointed that the report only briefly discusses many of the known discharge barriers (Recommendation V) with action steps for solutions to resolve those barriers at the administrative or legislative level.

Discharges from Inpatient Settings versus Community Boarding in Emergency Departments

A good portion of the Advisory Council's report focuses on the entirety of the problem of discharge challenges, but it is important to differentiate between that challenges hospitals face with community boarding of adolescents and adults who do not have an acute medical need for being in the hospital, in Emergency Departments and the challenges with discharging individuals who continue to need medical intervention following an inpatient hospital stay. These are two distinct patient groups that require distinct solutions.

Discharge Barriers for Community Boarders from Emergency Departments

Barrier – Lack of Placement Options for Children/Adults Displaying Aggressive Behaviors

Solutions – Fairview urges the state and counties to focus on creating community placement options for children and adults whose behavioral issues are coupled with aggressive behaviors. There are simply too few places willing to accept children displaying any form of aggression resulting in lengthy stays in emergency rooms or juvenile detention facilities.

Barrier – Need for More Short-Term Crisis Respite/Shelter Options

Solutions – The state should invest in creating further capacity in short-term crisis stabilization, crisis respite or crisis shelter options for adolescents and adults. Oftentimes a long-term placement option is found, but the placement date is not available for several weeks. Additional short-term crisis settings will help to create more appropriate settings for managing behavioral conditions than an Emergency Department.

Discharge Barriers for Patients from Inpatient Settings

In reviewing our own data and in discussing with our care management teams at Fairview, we know there is a subset of individuals who are often experiencing the most significant barriers to discharge, resulting in them getting stuck in the hospital following their inpatient stay.

Barrier: Patients needing complex or expensive services in Post-Acute settings:

- High-cost treatments like chemotherapy or dialysis
- Expensive routine medications
- Expensive devices or special equipment – i.e. wound vacuum or complex wound care
- High staffing requirements or specialized skills – 1:1 sitters, specialized RNs for wound care, vent/trach management, and bariatric patients requiring specialized equipment

- Solutions: In order to rectify the cost barriers for these patients, the state should look at opportunities for creating a maximum spend by skilled nursing facilities (SNFs) on things like medications and supplies or segmented per diems for certain patient groups requiring specific skills. Any additional funding opportunities that would be available to manage these patients who require expensive medical interventions in post-acute settings would need to align with the real-time provision of clinical care instead of grant-based dollars that often take weeks or months to allocate.

Barrier: Patients with complex mental illness/behavioral/substance abuse issues

- Solutions: The state should create centers of excellence for SNFs and other post-acute settings for patients with these complex issues. The centers of excellence would be built on a different payment incentive model with greater regulatory flexibilities in order to create more access outside of hospitals for these individuals who cannot return to their home but no longer need hospital level care.

Barrier: State and/or County Eligibility Processes

- Scheduling and completion of MnCHOICES Assessments for waivered services can vary from anywhere from a week to several months
- MA Eligibility determinations extending to several months in many counties
- Rate Exception processes

- Solutions: The state should prioritize and create enforceable timelines for MnCHOICES assessments, Medical Assistance eligibility determinations, and other administrative processes to reduce the time people are stuck in inappropriate care settings. Additionally, the state should consider expanding the pool of individuals who can complete the assessments. For example, allowing hospitals or others to have certified MnCHOICES assessors on staff would reduce the significant backlog at the county level.

Barrier: Guardianship and Conservatorship Processes

- Post-acute and other settings requiring individuals to have guardianship or conservatorship in place before accepting into their facilities. The time from petitioning to completing guardianship proceeds can exceed six months

- Solutions: The state should implement presumptive eligibility for all settings in order to eliminate a desire to have restrictive guardianship in place for purposes of securing financial payment. In other situations where guardianship is appropriate and all other options have been exhausted, the state should incentivize a robust guardianship program including more appropriate timelines for completion of guardianship proceedings when individuals are stuck in hospitals or other facilities.

We do appreciate that some of these items were identified in the report as barriers, but unfortunately missing were actionable steps to be taken to rectify these barriers through policy changes in the short term. The intentions of the Acute Care Advisory Council Task Force in setting up new structures to gather data are laudable, but it is imperative that solutions are put in place in the short term while data collection and analysis are taking place. Without actionable solutions, patients will continue to face further delays in settings that are not appropriate for their condition.

On behalf of Fairview Health Services, we want to reiterate our appreciation for the Acute Care Transitions Advisory Council in starting to tackle this urgent issue. We look forward to working on behalf of our patients and care management staff in implementing new policies in the upcoming 2025 legislative session.

Regards,

Nate Mussell

Nate Mussell
Vice President of Public Policy
Fairview Health Services

Hennepin
Healthcare

October 30, 2024

Commissioner Jodi Harpstead
Minnesota Department of Human Services
444 Lafayette Road
St Paul, MN 55155

RE: Acute Care Transition Comments - Submitted via electronic submission

Dear Commissioner Harpstead,

Thank you for the opportunity to submit comments regarding the Acute Care Transitions Advisory Council recommendations. We appreciate the hard work this council has done in recent months and understand there is not a simple solution to meet the many-faceted challenges we face, and we appreciate your support and partnership to find solutions.

Hennepin Healthcare is the state safety-net health system. We are a Level 1 Trauma center, academic teaching hospital, regional burn center, and home to the Minnesota Poison Center. Hennepin Healthcare cares for the highest Medicaid population in the state and 70% of our patients use public programs.

Supporting our patients to transition to an appropriate level of care continues to be one of the largest challenges we face as a safety-net health system. Our focus should be supporting and creating the right resources at the right level of care in the community and preserving acute care for those who need it.

Guardianship
We strongly agree with the need to assess practices related to guardianship. Patients are frequently denied placements in long-term care due to the inappropriate requirement of facilities that an individual have a formalized guardian, when a much less restrictive option would support an individual's needs. These requirements should be prohibited as they are counter to federal law and often delay discharge for months, keeping individuals in beds they don't need. We encourage exploration of liability changes for long-term care settings when there is concern regarding accepting a patient.

Emergency Medical Assistance
Emergency Medical Assistance (EMA) is not always accepted as patient's health needs may change, affecting EMA eligibility. This is especially true for new Americans who do not yet qualify for other coverage. When patients utilizing EMA no longer qualify for this coverage, the health systems who transferred the patient must often pay directly for the patient's care without other reimbursement. Funding should be provided to cover the ongoing costs of patients with EMA or criteria for EMA coverage should be changed for continuity of care.

Medical Assistance Eligibility and MnChoices Assessments
Medical Assistance determinations often take weeks to complete. For some patients, this leads to

delays in acute care transitions while the payer source is identified which must be completed before placement can be secured. Similar to expedited MnCHOICES assessments, a process for expediting or escalating patient cases that are causing acute care transition delays must be prioritized in the council's recommendations.

We strongly agree that we must identify strategies to expedite situations involving barriers to transition in the MnCHOICES Assessment process. We would recommend expanding this recommendation to include other processes that can cause significant delays in addition to the MnCHOICES assessment like the SMRT referral, OBRA II assessment and group home rate setting process.

We appreciate the recommendations to identify administrative policies that could have an immediate impact like working with counties to receive the resources they need to expedite approvals for equipment or rate exceptions. Similar to these recommendations, a process to escalate policies or processes within the agencies – like group home licensing or customized living approvals – when they are impacting a patient needing to transition out of an acute care setting would be an impactful short-term solution.

Youth specific challenges

We do not have specific pediatric or adolescent beds for behavioral health needs. In 2024, 82 youth have been seen in our Acute Psychiatric Services, 10% had already boarded this year in our emergency department. The six children who have boarded in our emergency department longer than seven days, were in our emergency department 119 days total. We sincerely request greater flexibility and increased services for families with wrap-around services to support young people to stay in their home environment to get the care they need.

Accountability

Transparency is needed to identify the challenging areas, and where resources are needed to meet the needs. A public dashboard including the numbers waiting, duration and type of care needed would brief the public and elected officials on if things are getting better or worse and hold all entities accountable.

Our teams are eager to support these newly formed workgroups to advance solutions and strongly encourage the inclusion of hospital care transition leadership in the ongoing committees to form the community measurements we need to use to show improvements.

Thank you for the opportunity to weigh in and for your continued commitment to helping address the challenges we face in discharge delays.

Sincerely,

Jennifer DeCubellis
Chief Executive Officer
Hennepin Healthcare

The
Long-Term Care
IMPERATIVE
A Minnesota Collaboration for Changes in Older Adult Services

Date: October 29, 2024
To: TransitionsAdvisoryCouncil.DHS@state.mn.us
From: Long-Term Care Imperative, Contacts:
Mark Schulz, VP of Policy, and Regulatory Affairs LeadingAge MN
Nicole Mattson, VP of Strategic Initiatives, Care Providers of MN
Comment period: October 15, 2024 – October 30, 2024
Re: DHS – Acute Care Transitions Advisory Council Report and Recommendations (PDF)

The Long-Term Care Imperative is a partnership of Care Providers of Minnesota and LeadingAge Minnesota, who together represent over 2,000 long-term care provider members. On behalf of our respective members please accept the following comments regarding the DHS-Acute Care Transitions Advisory Council Report and Recommendations.

First, we want to thank the advisory council members for their extensive work on the topic of acute care transition barriers and strategic solutions to ensure that Minnesotans can effectively transition to the most appropriate level of care. We wholeheartedly agree with the 2023 enabling statute goal of "establishing and implementing a statewide vision and systemic approach to acute care transitions in Minnesota."

We realize that the issues presented in the report are indicative of the entire healthcare continuum and not just confined to transitions between acute care and the post-acute or long-term care that our members provide. The omission of nursing facility and assisted living providers representation on the advisory council was a result of the enabling statute. The absence of our voice is demonstrable by the absence of discussing post-acute care, Medicare, care coordination, and the role of health plans in relation to transitions. We suggest amending the report's first recommendation to make permanent an advisory council, **to include** post-acute, nursing and assisted living facility representation **on any established advisory council, task force or acute care transitions working group**.

Often the next stop in the health care continuum, long-term care providers are trusted partners in providing safe, appropriate discharge locations for many older adults and others in need. Whether it be in a congregate living facility such as a post-acute facility, nursing home or assisted living or supported at home with home and community-based services these providers want to effectively serve their communities. For example, some of the potential issues we would like to see addressed include:

- **Funding and reimbursement** policies for prospective admissions have outsized implications for long-term care providers. We see potential solutions here including but not limited to:
    - Presumptive coverage for certain cases.
    - Expedited approval of Medicaid or hold-harmless for providers that accept certain Medicaid pending cases.
    - MN Choices assessments are timely and fully reflective of care needs.
    - Rate incentives for behaviorally complex individuals at the skilled nursing facility level.
    - Addressing the Elderly Waiver rate caps and its impact on more clinically/behaviorally challenging individuals at the assisted living level.

- **Guardianship/Conservatorship**. Often mischaracterized, provider requests for guardianship/conservatorship stem from their first-hand experiences, secondary to behavioral challenges or obligations to complete Medicaid applications. At the root cause is having a viable partner to make necessary decisions about care or follow through with Medicaid approval processes. There are no prohibitions within current law for using guardianship/conservatorship for a time-limited basis to complete the complex Medicaid application process—it is simply too long and complex a process to achieve.

- **Discharge/transfer:** The report alludes to behavioral challenges that can occur when individuals are not placed in the most appropriate setting—something our providers have faced repeatedly, particularly when accepting behaviorally complex individuals. These situations are often exacerbated by restrictive regulatory requirements that delay or prohibit moving individuals on to another, more appropriate, setting (federally licensed settings are obligated at https://www.revisor.mn.gov/statutes/cite/144A.135, https://www.ssa.gov/OP_Home/ssact/title18/1819.htm and https://www.ssa.gov/OP_Home/ssact/title19/1919.htm; and state licensed settings are obligated at https://www.revisor.mn.gov/statutes/cite/144G.) Thus, providers know that their only opportunity to ensure they can meet the care needs of an individual is prior to admission and furthermore, they must do what they can to anticipate any future changes or needs.
- **Care transitions:** Not all providers are functioning under the same set of regulatory standards or reimbursement methodologies, thus coordination of care and sharing of accurate clinical and behavioral health information assumes even greater importance when shared with other provider types. Additionally, understanding the constraints certain provider types are functioning under can be helpful to ensure that appropriate incentives are developed.
- **Workforce/funding**: Inability to accept prospective admissions is often a matter of inadequate workforce, particularly in rural communities. Our sector has over 15,000 caregiver openings. And providers are making choices about patient mix based upon their ability, and regulatory requirements, to meet the care needs given those staffing constraints. If we are to truly address years of systemic underinvestment in the long-term care sector, we must address the provision of adequate funding to support a thriving long-term care workforce.

Lutheran
Social Service
of Minnesota

October 30, 2024

Minnesota Department of Human Services
Transitions Division, Tribal & Transformations Division, Aging and Adult Services Division, and Disability Services Division
Sent electronically to TransitionsAdvisoryCouncil.DHS@state.mn.us

Re: Acute Care Transitions Advisory Council Report and Recommendations

Dear Minnesota Department of Human Services,

Thank you for the opportunity to provide public comment on the Acute Care Transitions Advisory Council Report and Recommendations. We are thankful for the state's efforts to develop an action plan to improve systems and create support for Minnesotans who are facing barriers to move from hospital and return to their community. We understand this is significantly impacting our neighbors with highly complex needs and often at the intersection of intellectual and developmental disability and mental health disorders.

Lutheran Social Service of Minnesota has over 45 years of experience supporting our neighbors with disabilities to live full and abundant lives. Last year, we served 10,671 individuals and families through care coordination services, employment services, self-direct care options, life sharing, and residential and in-home support. LSS is deeply committed to providing person-centered support which means our wide array of services are specifically designed to meet the unique needs of individuals in a variety of settings statewide. Our innovative service delivery design is focused on ensuring people with disabilities have meaningful relationships and opportunity to contribute to community.

While the Department of Human Services has been coordinating a response to complex transitions, LSS has steadily engaged with partners including DHS, counties, hospitals, and other community providers. We have also collaborated internally within our organization to strategize pro-active, person-centered responses that increase service options. This includes growing LSS Specialized Community Supports statewide as it is integral to our work to provide community-based services in the most integrated setting possible.

As we have responded to this community need, we have also experienced barriers and lack of resources within the existing home and community-based system that has prevented or significantly delayed accessibility to the appropriate level of care in the most community-integrated setting within an individual's community of choice. We write to you today to share our insights on how recommendations in the report will address these barriers and lack of resources as well as additional recommendations for DHS to consider.

The following report recommendations align with LSS' recommendations to the council:

Improving Systems for Transition Planning and Care Coordination (p. 51). LSS strongly supports this and encourages funding be added to this recommendation to ensure sustainability. Funding transitional supports will incentivize collaborative care between health care and home and community-based providers when supporting individuals discharging or admitting to a hospital setting. Transitions are more successful when the community-based provider receives initial (pre-discharge) and ongoing (30-days post charge) training from medical staff. This reduces health care incidences, such as infections, and readmittance to hospital. Additionally, when skilled workers from in-patient psychiatric settings provide coaching, training, and de-escalation support to the community-based provider it promotes a smooth, successful transition designed to support the unique needs of an individual with complex behavioral support needs. This is equally effective when people supported in community-based settings require hospital stays. When direct support professionals remain a continuous support for individuals there are overwhelming benefits, including but not limited to more successful hospital stays, successful transitions to home, and decreased fear and stress for patients.

Initiate Short-Term Administrative Policy Changes (p. 76). This aligns with LSS recommendations to the council to create responsive systems that expedite community options. When responding to a complex transitions case, we recommend establishing a new administrative framework that expediates licensing, Unique Minnesota Provider Identifier approval, and the rate exception process. This will significantly shorten the length of time to establish a licensed site and begin to serve people in the community of their choice at the most appropriate level of care. Within the current system, the average timeframe to respond and develop an LSS Specialized Community Supports home is 5-6 months. If there were a mechanism to expediate these processes, we anticipate this timeframe could be shortened to 2-3 months (notwithstanding delays to workforce recruitment and hiring).

We hope you will consider the following additional recommendations:

Develop a 245D crisis residential model. Within the current system of service options, community residential providers do not receive funding when there are openings or service interruptions. This presents significant challenges to maintaining a licensed site with full-time, highly-skilled professionals. It also prevents continuity of care when an acute care hospital stay is necessary for an individual's health and well-being. Creating a waiver service to provide crisis stabilization services in a residential setting would provide sustainability and thereby incentivize providers. The crisis model must be responsive to incidents experienced when supporting people with complex needs including acute care hospital stays, transition to long-term community-based or independent living, post-arrest detention, and higher impact to property repair costs, insurance claims, and premium increases.

Increase caregiver respite opportunities. Increasing licensed capacity and respite reimbursement will help more people and their caregivers access respite and prevent hospital admissions. Ensuring that the providers of a new crisis model can provide preventative respite care for children and adults with complex needs will allow those settings to be utilized when crisis stabilization services are not needed.

Invest in home and community-based services (HCBS) and the direct support professional workforce. Continue to refine the disability waiver rate system by implementing wage increases that close the wage gap between direct support professionals (DSPs) and comparable occupations. DSPs are on the frontline of delivering services to support people to remain healthy and living as independently as possible in their home and community. The workforce shortage coupled with a high demand for caregiving professionals has exacerbated the challenges to recruit and retain highly-skilled direct care and supervisory staff. It is critical that the full HCBS continuum is adequately and responsibly funded to sustain competitive wages and benefits that reflect the professionalism and importance of services provided and to ensure our neighbors are supported when, where, and how they need it.

Invest in mental health. Community-based mental health is critical to preventing admission and readmission to hospital level of care. In 2023, LSS Behavioral Health supported more than 3,500 people through in-person and telehealth therapy visits as well as employer, school, and shelter-linked mental health partnerships. Integrating behavioral health supports in LSS' SCS service model has also been an effective tool to stabilize behavior and increase staff retention. Implementing the rate increases as recommended in DHS' recent Medicaid Outpatient Mental Health Rate Study is critical to preserving and growing access to community-based mental health.

Expand access to supported decision-making. As people have experienced complex transitions from hospital to community, guardianship has been utilized as a discharge tool. While guardianship is appropriate in some instances, it is best practice to promote and utilize less restrictive alternatives including supported decision-making. We recommend prioritizing supported decision-making services, education and outreach, and increased legal support so that hospitals and caregivers utilize alternatives to guardianship. We also recommend establishing ongoing funding for supported decision-making services including waiver reimbursement.

Leverage Minnesota State-Operated Community Services (MSOCS). MSOCS has unique ability and access to resources, including employees with higher training and pay, to accommodate the immediate needs to support people in need of complex transitions. MSOCS can also strategically transition people served to community-based providers following stabilization.

Thank you, again, for the opportunity to share LSS' experience and recommendations. We remain committed to supporting a coordinated, person-centered, and community-based response to complex transitions. Please contact Erin Sutton, Senior Director of Advocacy, at erin.sutton@lssmn.org if we may provide additional information.

Sincerely,

Alexis Oberdorfer
Senior Vice President, Services
Lutheran Social Service of Minnesota

Minnesota Hospital Association

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Minnesota Department of Human Services
Attn: Acute Care Transitions Advisory Council
540 Cedar St
P.O. Box 64987
Saint Paul, Minnesota, 55164

October 30, 2024

Subject: Public Comment on Acute Care Transition Advisory Council Report and Recommendations

To the Acute Care Transitions Advisory Council,

We are writing to you today on behalf of the Minnesota Hospital Association (MHA) and Minnesota's hospitals and health systems in response to the Council's recent report and recommendations published on acute care transitions in Minnesota.

We would like to thank all the members who served on this Council. In particular, we would like to acknowledge Dr. Susan Pleasants with M Health Fairview and Cindy St. George with Allina Health for representing MHA, and their respective health systems.

Minnesota's hospitals and health systems and the patients they serve continue to face persistent, ongoing delays in hospital discharges. A comprehensive survey conducted by MHA found that Minnesota's hospitals experienced nearly 195,000 patient days of avoidable care in 2023. As a result of these avoidable care days, Minnesota's hospitals and health systems incurred an estimated $487 million in unpaid care costs in 2023. This is demoralizing for our caregivers, harmful for the patients we serve, and unsustainable for our healthcare system.

The five broad recommendations offered in the report provide a sound launching pad for the much needed and anticipated work to continue addressing acute care transitions during the next legislative biennium. We are encouraged that the report takes a comprehensive approach to the nature of the problem and that it recognizes that the problem should not simply be "moved" from provider type to provider type, but rather that it is shared across the care continuum.

We appreciate ideas included in Recommendation V on identifying the barriers that exist and acting in the short and long term to address them via administrative action and legislation. We specifically support including workforce incentives for direct support staff, funding community services in acute care settings, for HCBS providers supporting the transition process in acute care settings, addressing ongoing issues with guardianship, and expediting MnCHOICES assessments.

We encourage the Council to continue work towards solutions on the dual challenge uniquely faced by hospitals and their patients needing acute care transition. The first of which involves individuals who are boarding in emergency departments without acute medical needs that require admission for inpatient care. The second involving those who were admitted to the hospital for necessary inpatient services but no longer have acute medical needs and who still need services at a lower level of acuity.

MHA continues to gather input from our member hospitals and health systems with regard to possible solutions. Some concrete ideas that we have heard include:

- Create enforceable timetables for administrative processes including MnCHOICES assessments and MA eligibility determination.
- Provide additional funding to help support patients needing high-cost services in post-acute settings. Additionally, investigate how funding for these patients could be delivered in a more timely manner to reflect immediate need rather than a grant based process.
- Invest in capacity for short term crisis shelter options for patients to receive care in a more appropriate setting.
- Establish a mechanism for interim payment rates so that patients can start receiving timely services while rates are being negotiated.
- We encourage the Council and the Department of Human Services (DHS) to create a thorough process map detailing county responsibility and policy. Such a map could help delineate where responsibility falls and how acute care providers can better navigate the complexities when working with DHS and Minnesota's 87 counties.

There is an urgent need for permanent, long-term solutions and legislative action. However, in the interim we encourage DHS to take administrative steps to help address this crisis. MHA remains committed to working with the Council, DHS, and the legislature to advance solutions to address acute care transitions in Minnesota. Thank you for your consideration.

Sincerely,

Mary Krinkie

Mary Krinkie
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NAMI
National Alliance on Mental Illness
MINNESOTA

October 28, 2024

Thank you for the opportunity to share comments concerning acute care transitions in Minnesota. As the Acute Care Transitions Advisory Council (ACTAC) report repeatedly noted, people with mental illnesses and mental health concerns are a significant portion of the people experiencing delays in transitions. After reading the report, we think it is important to call out the urgency of this issue and the need for targeted funding and tangible support as soon as possible.

We would urge state leaders, both executive and legislative, to act quickly and to prioritize funding and policies that will have the greatest impact on the people experiencing delays in transitions, and frontline workers and providers. While data collection and analysis are crucial to respond to these issues, we would assert that the broad solutions to the stated problems have not changed significantly over time. We need to build our mental health system to be equitable and accessible for all Minnesotans, at the right time, and in the right place.

Recommendations:

- **Increase Medicaid Reimbursement Rates**: The ACTAC report acknowledges in several places the need to bolster services and capacity while also incentivizing providers in difficult positions. Raising Medicaid rates is the quickest way to achieve both of these goals. With increased rates, providers can maintain stability, pay workers adequate wages, and provide higher quality services, ultimately improving care for Minnesotans and contributing to intervention and prevention to decrease transition challenges.
- **Build on What Works**: Currently, the Mental Health Collaboration Hub works to find the right provider to transition children into the community. The Minnesota Hospital Association's bed tracker helps to find open psych beds without needing to call all the hospitals in the state. Fasttracker also works to connect people to openings within their insurance network. Programs like these could use increased support from the state, and we should be careful not to duplicate ideas like regional hubs. We have Adult Mental Health Initiatives and Children's Mental Health Collaboratives which do work on a regional level so we should not duplicate these efforts, but build on them. Additionally, the state held a systems of care grant previously and it did not help to develop the needed infrastructure.
- **Invest in Intensive In-Home Services:** The ACTAC report mentions several Home and Community Based Services as well as care models like wraparound. Children with mental illnesses must have access to services that are not covered by HCBS Waivers like In-Home Children's Therapeutic Services and Supports (CTSS), Children's Intensive Behavioral Health Services and Bridging Services (CIBS), and aftercare. It is also important to clarify that wraparound services must be High Fidelity Wraparound which is an evidence-based model. These services need adequate and stable funding streams to be the bridge for children and families over gaps in transition care.
- **Build Residential and Crisis Stabilization Capacity:** In addition to appropriate in-home services, the state must build capacity for community services. Children's crisis stabilization was authorized in 2022, and this year the legislature directed the Minnesota Department of Human Services (DHS) to develop a Medical Assistance (MA) benefit, but that will take some time. The state must invest in

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funding specialized residential settings and crisis stabilization beds to provide the exact placements that are needed to relieve boarding.

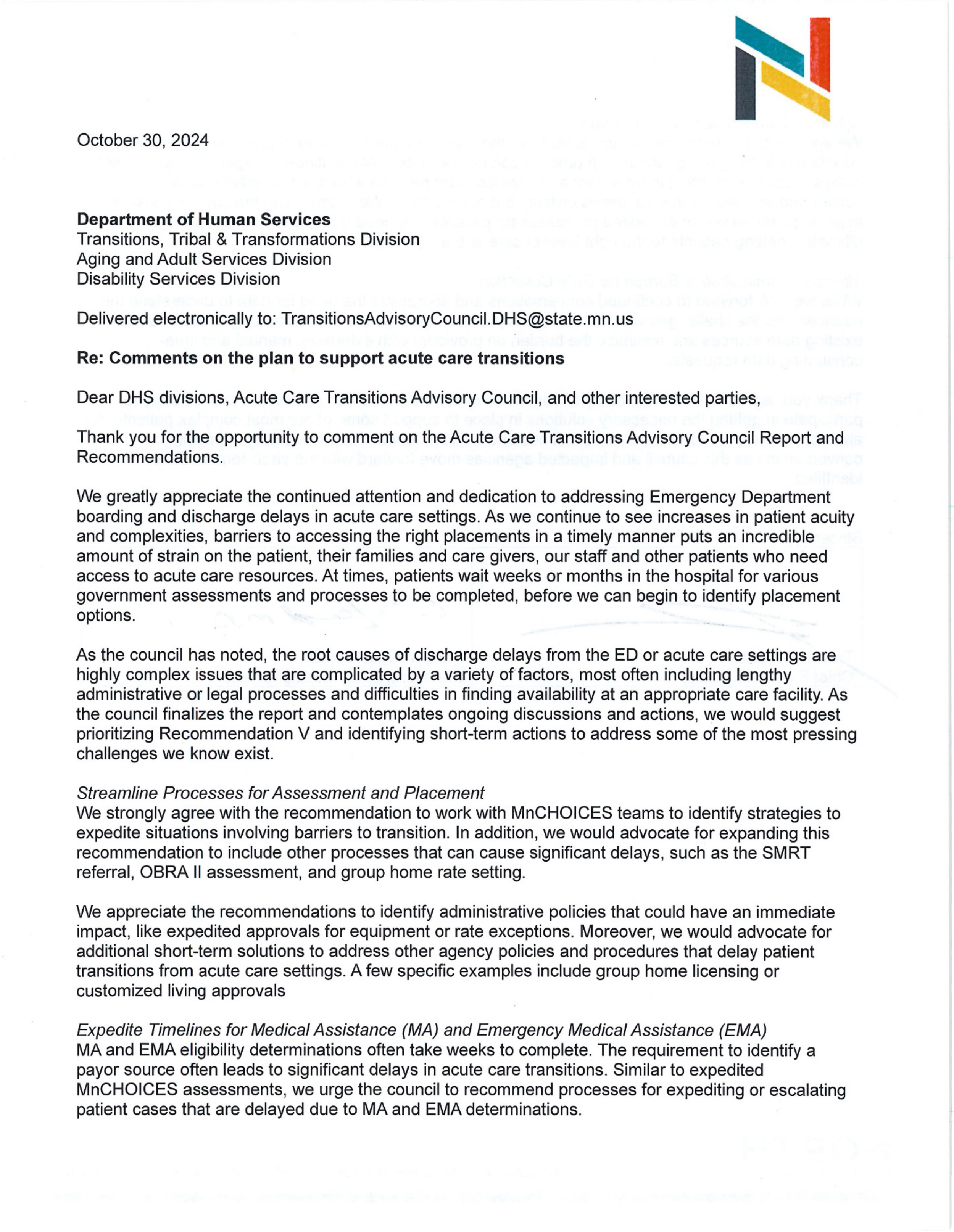
- **Crisis Response and Prevention:** With adequate crisis response and prevention, we can reduce the number of crises that snowball into causing transition care problems later on. We must fully fund our mobile crisis teams and move away from grants and on to formula-based allocations to equitably meet needs across the state. We must ensure that 988 and 911 call centers are equipped with the knowledge and partnerships to avoid criminalizing mental illnesses and exacerbating crises. Other important preventative measures also need deeper investments like voluntary engagement, school-linked mental health, and First Episodes programs. There are also policy changes like expanding eligibility criteria for case management to increase prevention of more serious crises.
- **Private Public Partnership:** We believe it is appropriate for people in crisis to go to the emergency room. However, seeking help at the ER should not turn into a boarding crisis. The fact of the matter is that community hospitals must invest in inpatient beds. Contrary to the needs, inpatient capacity has shrunk over the last several years, and despite historic investments to other parts of hospital infrastructure, mental health has not been prioritized. Raising Medicaid rates is an essential first step, but profitable hospitable systems must find ways to increase inpatient bed capacity for the good of the community, as well as psych ERs which provide actual treatment and triage, not boarding. Additionally, private insurance providers must expand coverage to services like the ones mentioned above. Mental illnesses do not discriminate by income. It is hard enough to meet the needs of Medicaid patients, but it is also a great disservice to everyone when families with adequate private coverage cannot access necessary services.
- **State Medical Review Team (SMRT):** The state must invest in the SMRT to provide disability determinations in a timely fashion. It is unacceptable when the main reason for boarding is waiting months for a determination. SMRT needs increased staff and resources to prioritize expedited determinations for children boarding.
- **Workforce:** With increased capacity comes increased workforce needs. Private and public entities must work together to provide loan forgiveness, paid supervision hours, alternative licensure, and viable career paths for mental health professionals and peer specialists. Turnover and burnout rates are also high for case managers. These types of frontline workers need stability in caseloads, support in vicarious trauma, and living wages. The state should prioritize these workers in need, over more administrative care coordination positions. Addressing workforce issues is also one of the most important ways to reduce racial and cultural disparities that were highlighted in the report.

Please reach out to us with any questions or to continue this conversation.

Sincerely,

Sue Abderholden, MPH
Executive Director

Elliot Butay
Senior Policy Coordinator



October 30, 2024

Department of Human Services
Transitions, Tribal & Transformations Division
Aging and Adult Services Division
Disability Services Division

Delivered electronically to: TransitionsAdvisoryCouncil.DHS@state.mn.us

Re: Comments on the plan to support acute care transitions

Dear DHS divisions, Acute Care Transitions Advisory Council, and other interested parties,

Thank you for the opportunity to comment on the Acute Care Transitions Advisory Council Report and Recommendations.

We greatly appreciate the continued attention and dedication to addressing Emergency Department boarding and discharge delays in acute care settings. As we continue to see increases in patient acuity and complexities, barriers to accessing the right placements in a timely manner puts an incredible amount of strain on the patient, their families and care givers, our staff and other patients who need access to acute care resources. At times, patients wait weeks or months in the hospital for various government assessments and processes to be completed, before we can begin to identify placement options.

As the council has noted, the root causes of discharge delays from the ED or acute care settings are highly complex issues that are complicated by a variety of factors, most often including lengthy administrative or legal processes and difficulties in finding availability at an appropriate care facility. As the council finalizes the report and contemplates ongoing discussions and actions, we would suggest prioritizing Recommendation V and identifying short-term actions to address some of the most pressing challenges we know exist.

Streamline Processes for Assessment and Placement
We strongly agree with the recommendation to work with MnCHOICES teams to identify strategies to expedite situations involving barriers to transition. In addition, we would advocate for expanding this recommendation to include other processes that can cause significant delays, such as the SMRT referral, OBRA II assessment, and group home rate setting.

We appreciate the recommendations to identify administrative policies that could have an immediate impact, like expedited approvals for equipment or rate exceptions. Moreover, we would advocate for additional short-term solutions to address other agency policies and procedures that delay patient transitions from acute care settings. A few specific examples include group home licensing or customized living approvals

Expedite Timelines for Medical Assistance (MA) and Emergency Medical Assistance (EMA)
MA and EMA eligibility determinations often take weeks to complete. The requirement to identify a payor source often leads to significant delays in acute care transitions. Similar to expedited MnCHOICES assessments, we urge the council to recommend processes for expediting or escalating patient cases that are delayed due to MA and EMA determinations.

Address Court Processes and Delays
We agree with the recommendation to address the rights of individuals and families and appreciate the council highlighting the guardianship process can be a variable. We continue to experience significant delays (weeks or months) in treatment and transitions for patients who need guardianship or conservatorship appointments, Jarvis orders, and commitment. We recommend the council consider exploring alternatives or expedited processes for patients that need guardianship or conservatorship, ultimately getting patients to the right level of care at the right time.

Minimize Administrative Burden for Data Collection
While we look forward to continued conversations and appreciate the need for data to understand the nuances and the challenges with this patient population, we urge the council and agencies to utilize existing data sources and minimize the burden on providers with extensive, manual and time-consuming data requests.

Thank you, again, for the opportunity to comment on this extensive body of work. We are happy to participate in getting the necessary solutions in place to support some of our most complex patients. As always, we are available to answer questions and will look forward to participating in ongoing conversations as this council and impacted agencies move forward with the short-term actions identified.

Sincerely,

Trevor Sawallish Chief Executive Officer	C. Ogland m.D. Carolyn Ogland, MD President, Chief Medical Officer

Appendix G: Glossary

Note: Visit the CBSM Glossary of Terms for more Minnesota Department of Human Services glossary terms.*

Acute care
Medical care for an episode of injury or an illness.

Assertive community treatment
Assertive community treatment (ACT) improves outcomes for people with severe mental illness and may be more likely to be at-risk of hospitalization and other negative life outcomes including involvement in the criminal justice system. The practice involves forming a multidisciplinary team including community outreach and action planning.

Boarding
Refers to the time when patients are in the emergency department waiting for a hospital bed to become available.

Challenging behaviors
Behavior that are of concern by the people who are living and working with a person. Everyone engages in behaviors that are problematic at some point in life. A behavior becomes challenging if it interferes with quality of life, health and wellness or safety.

Community Access for Disability Inclusion (CADI) Waiver
Program that provides home and community-based services to children and adults with disabilities who require the level of care provided in a nursing facility. These services are an alternative to institutionalization. They help a person live as independently as possible in community settings and promote optimal health, independence, safety and community integration.

Community Alternative Care (CAC) Waiver
Program that provides home and community-based services to children and adults who are chronically ill or medically fragile and require the level of care provided in a hospital. These services are an alternative to institutionalization. They help a person live as independently as possible in community settings and promote optimal health, independence, safety and community integration.

Community First Services and Supports (CFSS)
Refers to the DHS transition from personal care assistance (PCA) to CFSS. The terms PCA and CFSS refer to supports people receive to help them remain independent in the community.

Competency-based assessment
A model that is focused on identifying the skills needed for a position, determining a plan to build these skills and designing strategies to evaluate the effectiveness of that plan. The goal is for a person to demonstrate mastery of a skill before moving on to the next competency to be taught. Once they demonstrate the skill, they move to the next skill to acquire. This approach means that time is not wasted on teaching skills a person already knows.

Competency drivers
The strategies, systems and resources that are used to improve knowledge and skills within an organization or group is referred to as the competency drivers within an implementation effort. Four major elements of competency drivers include assessing performance, selecting trainers, content taught (curricula) and how coaching and mentoring is provided on an ongoing basis.

Culture of safety
Providers who provide a culture of safety acknowledge that the work carries some high risk in the tasks the employee does. They also provide a culture that is blame-free, where people can report errors or near misses with our fear of reprimand or punishment. It encourages people across the organization to collaborate and seek solutions together in the spirit of safety for everyone. Organizations who are committed to a culture of safety commit resources to address safety concerns.

Dementia
A term used to describe an impairment in a person's ability to remember, make decisions and think that interferes with everyday tasks and activities. Dementia is more common in older adults but it is not a part of the aging process.

Discharge delays
Refers to situations where patients in the hospital no longer need medical services and could leave the hospital but are unable to do so for non-medical reasons.

Evaluation plan
An approach to organizing the ongoing assessment of practices by explaining what is being evaluated, describing evaluation questions that identify measures and create a plan to collect, summarize and use data to improve HCBS outcomes. The evaluation plan addresses how data are used for decision making in meetings throughout the year and as part of an annual evaluation.

Feedback loops
A term used in an organization to 1) gather information, 2) assess the data, 3) make changes based on what has been learned and 4) meeting again to follow progress and make changes.

Fetal alcohol syndrome (FASD)
Refers to a condition resulting from alcohol exposure during a mother's pregnancy. Drinking alcohol while pregnant can cause a woman's child to be born with disabilities. These disabilities can impact the child's behavior and physical development, as well as their learning and cognitive processes. Symptoms of fetal alcohol syndrome vary across children and impact the child for their entire life.

Leadership drivers
There are two different kinds of leadership skills referred to in implementation science. *Technical* challenges are the types of management-related problems that can be solved easily using basic management and administrative strategies used to coordinate trainings. *Adaptive* challenges are more complex and require more advanced skills such as active listening, empathy and the ability to help groups work through larger and contextual problems. For example, adaptive challenges may arise when there are people feeling unheard or

there is a perception that some people are being treated unfairly. Adaptive leaders have the skills to help a group of people navigate these larger social challenges and arrive at potential solutions together.

Group residential housing (GRH)
A state-funded income supplement program that pays for room and board costs for low-income adults who have been placed in a licensed or registered setting with which a county human service agency has negotiated a monthly.

Home and Community-Based Services (HCBS) Waiver
Services not normally covered by Medical Assistance that are covered under a 1915(c) federally funded waiver program or through state funds. HCBS waivers allow states flexibility to cover virtually all long-term care services that people with disabilities need to live independently in home and community settings. States may operate several 1915 (c) HCBS waiver programs at once, each offering a distinct package of services and supports to different groups of people.

Home health agency services
Services delivered by a home health agency to a person with medical needs due to illness, disability or physical conditions in the person's place of residence or in the community where normal life activities occur.

Hospital
An acute care institution licensed under Minn. Stat. §144.50 to 144.58.

Institutional review board (IRB)
Refers to a group formally designated to review and monitor research involving human subjects in accordance with U.S. Federal Food and Drug Administration (FDA). An has the authority to approve, require modifications or reject research proposed within an organization or system. The IRB process is meant to protect the rights and welfare of human research participants.

Juvenile detention center
A secure facility providing 24-hour treatment, education, housing and transition services for children and youth who are placed in this setting either as a condition of court-ordered probation or as the result of having been committed to the commissioner of corrections.

Lead agency
A county, tribal nation or managed care organization (MCO).

Logic model
Refers to a model used to visually describe the relationship between an organization’s resources, activities and the impacts that are sought. A logic model provides a roadmap for a group interested in implementing interventions and/or providing services. The major elements include defining 1) inputs, 2) activities and 3) outcomes.

Managed care
Health care delivery system that includes pre-established provider networks and reimbursement arrangements, administration and clinical systems.

Managed care organization (MCO)
An organization certified by the Minnesota Department of Health to provide all defined health care benefits to people enrolled in a Minnesota Health Care Program (MHCP) in return for a capitated payment. MCOs are also referred to as health plans or prepaid health plans.

Medical transportation management (MTM)
Coordinates non-emergency medical transportation (NEMT) for fee for service Medical Assistance recipients in the Twin Cities metro area through a contract with the Metro County Consortium (MCC).

Medical Assistance (MA)
Minnesota's name for the federal Medicaid program that provides medical care for people with low incomes.

Medicaid
A jointly funded, federal-state health insurance program for people who have a low income or other needs. It covers children, people who are older, people who have disabilities and others who are eligible to receive federally assisted income maintenance payments. Minnesota's Medicaid program is called Medical Assistance. See also Medical Assistance.

Medicaid Management Information System (MMIS)
A mechanized claims-processing and information-retrieval system for Medicaid. The federal government requires all states operate an MMIS to support Medicaid business functions and maintain information in several areas (e.g., provider enrollment, eligibility, benefit package maintenance, managed care enrollment, claims processing, prior authorization).

MnCHOICES
A web-based application tool for conducting and creating person-centered assessments and support plans. It helps people with long-term or chronic-care needs make decisions about their care. MnCHOICES includes two electronic tools: assessment and support plan.

Organizational drivers
Refers to the way an agency designs the systems that are used in training an evidence-based practice (positive support). Organizational drivers include the way data is collected and summarized to monitor progress, how meetings are structured to encourage feedback and ensure communication is shared across an organization. The problem-solving systems within an organization that helps make sure barriers are removed and solutions to challenges are found quickly are also part of organizational drivers.

Personal care attendant (PCA)
A term used to describe a position involving a staff person trained to provide HCBS services to people who are living in homes in the community. PCAs support people with physical, mental health related or intellectual and developmental disabilities with the everyday tasks that help them to live in the community.

Positive behavior support
A framework used to improve the quality of a person’s life and prevent or decrease challenging social interactions. The tools and strategies used in positive behavior support encourage social and communication skills and involve changing social settings to prevent challenging behaviors. Positive behavior support is based on

research from areas including biomedical and behavioral science. Research also guides how positive behavior support is implemented in education and human service settings using a tiered model with interventions that gradually increase based on each person's unique needs. The universal level, or Tier 1, includes interventions for improving the quality of life and social interactions for everyone within a provider setting. The second tier involves monitoring HCBS data to identify problems that a person might have as early as possible and to intervene when challenges are still minor. The third tier is used to create individualized plans for each person who needs more intense supports.

Positive support practices
The term positive support refers to practices that are: a) person-centered, family-centered, student-centered and community-centered; b) evidence-based with research studies that show how effective an approach is and who benefits from the practice; c) sensitive and respectful to the unique culture of each person involved; d) adapted and improved over time using data to guide use and e) often implemented with other practices within complex everyday settings.

Positive support services
Refers to services that involve developing, implementing and monitoring a person-centered and individually designed plan to improve quality of life while also addressing behaviors that interfere in a person’s life. There are three levels of staff involved. A positive support professional develops a plan with the child or adult and their team to enhance a person’s quality of life and focusing on emotional and skill development. Analysts provide support to staff implementing the plan and direct support staff provide specialist services by implementing key elements of the plan.

Private pay
Paying for long-term care with your personal finances, such as savings and investments, long-term care insurance, home equity, certain life insurance benefits and/or options, certain annuity contracts and trusts.

Qualitative data
Information that is used to better understand the perceptions and emotional states of people and that seeks to capture the details of something that is being evaluated. Examples of qualitative measures include interviews with one person or groups, reviewing documents to assess whether changes have occurred, written descriptions of a situation or setting that occur in rich detail or case studies and stories used to assess organize what is being learned by grouping into categories or codes and looking for themes.

Quality of life
This is a common term used to describe how a person experiences their standard of health and wellbeing. Quality of life can be broken down into domains: emotional wellness, social interactions, work and employment, financial status, living environment, physical health, intellectual stimulation and spiritual growth.

Quantitative data
Information that is measured and results are shown using numbers to assess the amount of quantity of something. Examples of quantitative data include staff attrition numbers in a given year, the frequency of incidents that represent challenging social interactions or how many people report improved quality of life scores using measures that define important quality of life domains (physical health, wellness, finances).

Scoping review
Used by groups of people to learn more about a topic of interest by reviewing publications, reports and other communications. A scoping review is often used in situations where a more formal systematic review of the literature is not possible. Scoping reviews are used to identify knowledge gaps, assess the scope of a body of literature, clarify concepts and/or to assess how research is being conducted in an area. Although not as formal as other methods, scoping reviews must employ valid and transparent research methods that can be reproduced by other researchers.

Social Services Information System (SSIS)
Case management and data collection application for foster care, out-of-home placement, children's mental health, adoption information and vulnerable adult tracking.

State Medical Review Team (SMRT)
Division of the DHS that makes disability determinations using criteria defined by the Social Security Administration.

Systems of care
A system of care is a coordinated network of community-based services and supports designed to meet the challenges of children and youth with serious mental health needs and their families. These partnerships of families, youth, public organizations and private service providers address challenging behavior by addressing the mental health services and support needs and building on the strengths of a child, young person or adult. These systems are also developed around the principles of being child-centered, family-driven, strength-based and culturally competent.

Three-tiered model of positive behavior support
A framework for implementing universal strategies for all people in a home, work or other setting and by providing a continuum of interventions that increase in intensity based on the unique needs of each person. This framework is applied to positive behavior support and other practices that improve quality of life.

Tier 1 universal
Strategies for practicing and learning social and emotional skills that everyone can benefit from learning including people receiving support, staff, supervisors, human resource professionals, leaders, family and community members. Tier 1 also includes recognizing and celebrating positive social interactions, responding in a consistent manner to challenges and using data to assess progress over time.

Tier 2
Monitoring for changes in quality of life or challenges that might be occurring in social interactions and intervening as early as possible to prevent an escalation of interfering behavior. Examples of Tier 2 includes simple function-based strategies and group interventions that provide more opportunities to practice skills and receive positive feedback.

Transitional care unit (TCU)
A short-term care placement that provides a person recovering from an illness, injury or surgery with a place to recover and regain strength and independence. A TCU is best for patients who need short-term care.

Trauma-informed support
Traumatic life experiences such as child or domestic abuse, natural disasters or other negative life events can have a lasting impact on a person's health and emotional wellbeing. Trauma-informed support refers to the core values and messages that describe why it is important for organizations to be sensitive to the past trauma most people have in their lives. Organizations that are committed to trauma-informed supports change policies and procedures, introduce training to help staff understand how to avoid re-traumatizing people, create ways to monitor the impact of universal training efforts and build expertise within the organization to provide people access to evidence-based practices (e.g. Psychological First Aid, Trauma-focused Cognitive Behavior Therapy, etc.).

Wraparound Planning
A process created to support children, young people and adults with mental health needs and challenging behavior and coordinating the different service systems involved. Each of these services require parents/caregivers to complete forms, attend meetings and respond to requests related to services. Juvenile justice, children and family services, special education, mental health and developmental disabilities are all examples of these different services. The wraparound plan is mean to help youth and their parents by improving service coordination. Wraparound planning is a team-based approach that is child and family driven. Team members include natural supports (friends, family members and people who know the child or young person well). Individuals from formal supports might include a parole officer, counselor, psychiatrist or special education teacher. The goal of wraparound is to assess the child and family strengths to build a plan of support that will improve quality of life.

* These glossary terms have been taken from existing definitions in different resources including the Minnesota DHS CBSM Glossary of Terms and the Home and Community-based The Minnesota Home and Community-Based Services (HCBS) Modules for Person-Centered Organizations.