Minnesota Medical Association

Minnesota Chapter
American College of Emergency Physicians®

Emergency Department Boarding of Patients with Psychiatric Diagnoses (EDBPPD)

A Final Report from the MMA-MNACEP Taskforce to Reduce ED Boarding of Patients with Psychiatric Diagnoses (EDBPPD)

May 2023

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Executive Summary

Overview

Emergency departments (EDs) report alarming rates of ED boarding of patients with psychiatric diagnoses (EDBPPD), wherein patients wait days or weeks in EDs for an available hospital or residential treatment bed that meets patient needs. The complexity of the problem and the multitude of proposed solutions to solve the problem have hindered the MMA and MNACEP's ability to act. This report includes a positive description of the EDBPPD problem in Minnesota (pp. 6-37) and a normative list of recommendations intended to alleviate the problem (pp. 37-44).

Recommendations

Below is a summary of the Task Force's recommendations. Please note that full descriptions of these recommendations are provided on pp. 37-44. Recommendations noted with an asterisk (*) are those that the Task Force identifies as actions that the MMA and MNACEP, as medical associations, are uniquely positioned to leverage best.

1	**Recommendations Spanning the ED Boarding Continuum**
1.A	Publicize and Circulate this Report to Inform and Empower Leaders*
1.B	Support the Creation of a Minnesota ED Boarding Database*
1.C	Collaborate to Improve the Usefulness of Mental Healthcare Search Tools in Minnesota*
1.D	Strategize to Improve the Size, Distribution, and Diversity of the Mental Healthcare Workforce in Minnesota
1.E	Protect and Expand the Use of Telehealth for Mental Health Services*
2	**Recommendations for Inflow Factors**
2.A	Support the Financial Sustainability of 988 Call Centers in Minnesota
2.B	Explore Emergency Transport Diversion to EDs in Hospitals with Patient-Appropriate Inpatient Mental Health Beds
2.C	Leverage Healthcare Workers and Facilities to Educate the Public About Mental Health Resources*
2.D	Support Legislation to Require Minnesota Health Plans to Reimburse for Collaborative Care Model Services*
3	**Recommendations for Stalling Factors**
3.A	Support the Development and Evaluation of Alternative Emergency Facilities for Patients with Psychiatric Diagnoses Who Await Disposition
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4	**Recommendations for Outflow Factors**
4.A	Advocate for More Inpatient Mental Health Hospital Beds in Minnesota
4.B	Advocate for More Residential Treatment Beds in Minnesota
4.C	Monitor and Engage in the Development of Locked IRTS Facilities in Minnesota
4.D	Support Legislation to Require Minnesota Health Plans to Cover PRTF and IRTS Services*
4.E	Collaborate to Reduce the Burdens of Corporate Foster Care on ED Boarding

Introduction

Emergency department boarding (EDB), wherein patients are deemed ready for admission or transfer but remain in EDs for days or weeks awaiting an available bed, is an enduring problem with devastating impacts. Since the early 2000s, academic journals, newspapers, and advocacy organizations have lamented the growing incidence and duration of EDB, which is associated with "increased morbidity and mortality, delays in care, decreased patient satisfaction, longer inpatient stays, disparities in access to care for the poor and uninsured, lost hospital revenue, and missed opportunities to see additional ED patients" (Nolan et al., 2015, pp. 57-58). EDB has also exacerbated burnout among mental healthcare workers (American College of Emergency Physicians, 2022).

Twenty years later, the problem of EDB persists. Its flames, fanned by the COVID-19 pandemic, are palpable in our own backyard. The Star Tribune has published at least eight articles about EDB in Minnesota in the past seven years alone (Olson, 2015; Serres, 2016; Olson, 2020; Brooks, 2021; Serres, 2021; Van Berkel, 2022; Olson, 2022, a; Olson, 2022, b).

Recent physician outcry for action on the ED boarding of patients with psychiatric diagnoses (EDBPPD) led the MMA to convene this Task Force in 2019.[1] Since we began, the COVID-19 pandemic has exacerbated mental illness in our state, crowded our EDs, and strained our already insufficient healthcare and mental health workforces. The need for the Task Force to take meaningful action on EDBPPD is more dire than ever.

The Task Force has been humbled by its charge. After three years of consulting stakeholders, reviewing research, and strategizing action, we recognize that the persistence of the EDBPPD problem is rooted in its dispiriting complexity. In the absence of a coordinated and comprehensive American mental health system, a dizzying patchwork of solutions and services has been sewn by a dizzying array of health systems, governments, and advocacy organizations. To complicate matters further, boarded patients are not homogenous, and neither are the obstacles that stall ED throughput.

While the EDBPPD problem can prove to be a daunting rock face, this Task Force has found power in discerning those footholds that the MMA and MNACEP, as associations of physicians, are best positioned to secure. We cannot scale this rock face overnight, nor can we do it alone. We must scale the EDBPPD problem step by step, in concert with the proper stakeholders, if we are to approach the summit. It is our hope that the accompanying report will guide the MMA and MNACEP as they adopt strategies to (a) reduce the incidence and duration of EDBPPD and (b) improve the health outcomes of patients with psychiatric diagnoses who board in EDs in Minnesota.

[1] While ED boarding (EDB) is not exclusive to patients with psychiatric diagnoses, ED boarding of patients with psychiatric diagnoses (EDBBD) is the focus of this report.

Measuring the Problem

Defining ED Boarding

The Task Force has adopted the following definition of ED boarding (EDB):

> Boarding describes ED patients whose evaluation is complete and for whom the decision has been made to either admit or transfer, but for whom there is no available bed. (Nolan et al., 2015, p. 58)

Following this definition, EDB is best measured as the time difference between when a patient receives a disposition decision to admit or transfer and when said patient departs the ED. In reality, "capturing the time of this decision to admit or transfer is difficult, because emergency departments have differing practices, administrative systems, and documentation processes" (Nolan et al., 2015, p. 58). Therefore, most studies of EDB use a proxy measure of ED length of stay (ED LOS), or the time difference between a patient's arrival to, and departure from, an ED. By comparing ED LOS datapoints against an adopted threshold of appropriate ED throughput time (e.g., 6 hours is the maximum appropriate time to spend in an ED), researchers can discern both the incidence and duration of EDB.

Unless stated otherwise, this report will recognize an EDB case as an ED LOS that surpasses 6 hours and EDB duration as an ED LOS minus 6 hours. These definitions are consistent with several studies that examine EDB (Nash et al., 2021; Nolan et al., 2015; Pines et al., 2009).

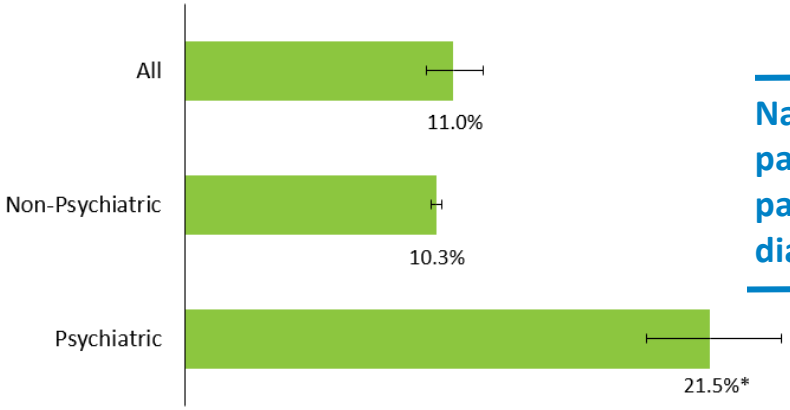
EDB Case Definition: An ED length of stay that surpasses 6 hours.

EDB Duration: ED length of stay minus 6 hours.

Incidence

One way to measure EDB is by estimating EDB incidence, or the proportion of all ED patients who board over a specified period of time. The most recently published national data on EDB incidence is from Nolan et al. (2015), who used a Centers for Disease Control and Prevention (CDC) dataset on ED visits from Calendar Year 2008 (Nolan et al., 2015). In addition to reporting EDB incidence for all ED patients, Nolan et al. report specific boarding incidences for ED patients with, and without, psychiatric diagnoses. These incidences are visualized in Figure 1. Note that Nolan et al. define patients with psychiatric diagnoses as those whose records indicate an International Classification of Diseases (ICD)-9 code for diagnosis. Reported psychiatric cases include patients with all classifications of psychiatric diagnoses, including substance use disorders.

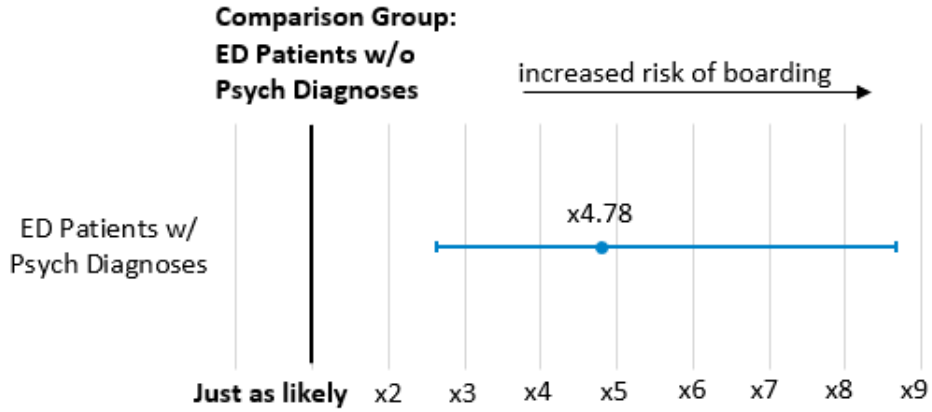
Figure 1. National incidences of ED boarding for all ED patients, ED patients without psychiatric diagnoses, and ED patients with psychiatric diagnoses (Nolan et al., 2015, p.59)



Nationally, while 11% of all ED patients board, 21.5% of ED patients with psychiatric diagnoses board.

The raw EDB incidences reported by Nolan et al. suggest that ED patients with psychiatric diagnoses are nearly twice as likely to board as ED patients without psychiatric diagnoses (10.3% and 21.5%, respectively) (Ibid, p. 59). However, Nolan et al. ran additional analyses which controlled for confounding variables of the patient (e.g., age, housing type, and insurance status) and of the hospital (e.g., region, metropolitan status, and ownership). When controlling for these variables, Nolan et al. estimate that ED patients with psychiatric diagnoses are 4.78 times as likely to board as ED patients without psychiatric diagnoses (Ibid, p. 60). This odds ratio is visualized in Figure 2.

Figure 2. Odds of boarding for ED patients with psychiatric diagnoses compared to ED patients without psychiatric diagnoses, 2008 (Nolan et al., 2015, p. 60)

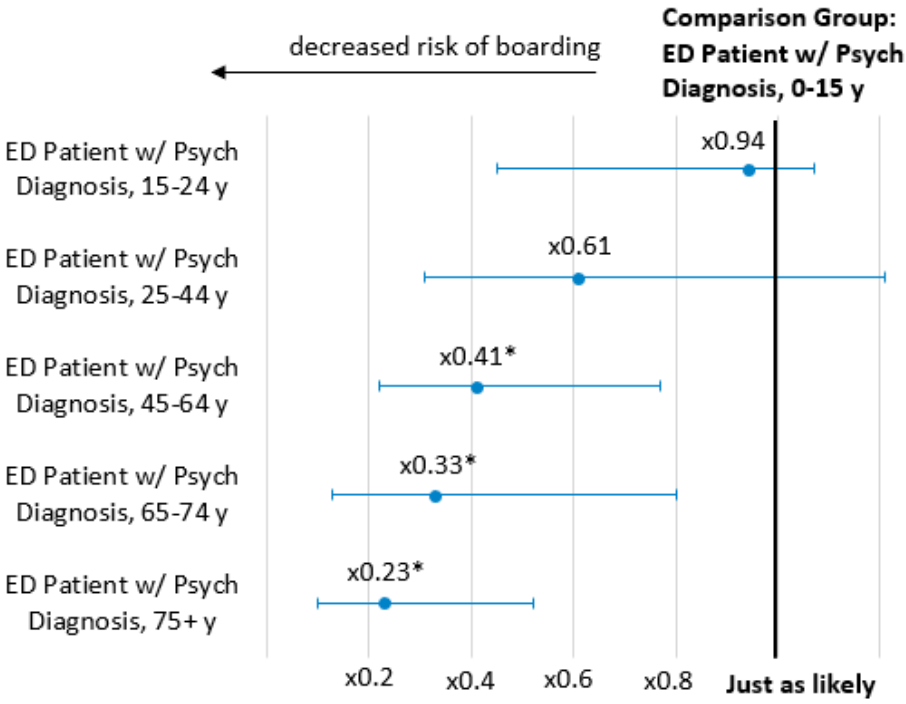


Likelihood of boarding compared to ED patients without psychiatric diagnoses.

When controlling for confounders, ED patients with psychiatric diagnoses board at almost 5 times the rate of ED patients without psychiatric diagnoses.

Nolan et al. also explored how age might influence the odds of EDB among patients with psychiatric diagnoses, using patients ages 0 to 15 as the comparison group (Ibid, p. 60). These odds ratios are visualized in Figure 3. Generally, as the age of an ED patient with a psychiatric diagnosis increases, the odds that said patient will board decreases. Nolan et al. suggest that this may be due to the "particular difficulty in locating psychiatric services and securing placement for the pediatric population" (Nolan et al., 2015, p. 62).

Figure 3. Boarding odds of ED patients with psychiatric diagnoses by age compared to ED patients with psychiatric diagnoses ages 0 to 15 years old (Nolan et al., 2015, p. 60)



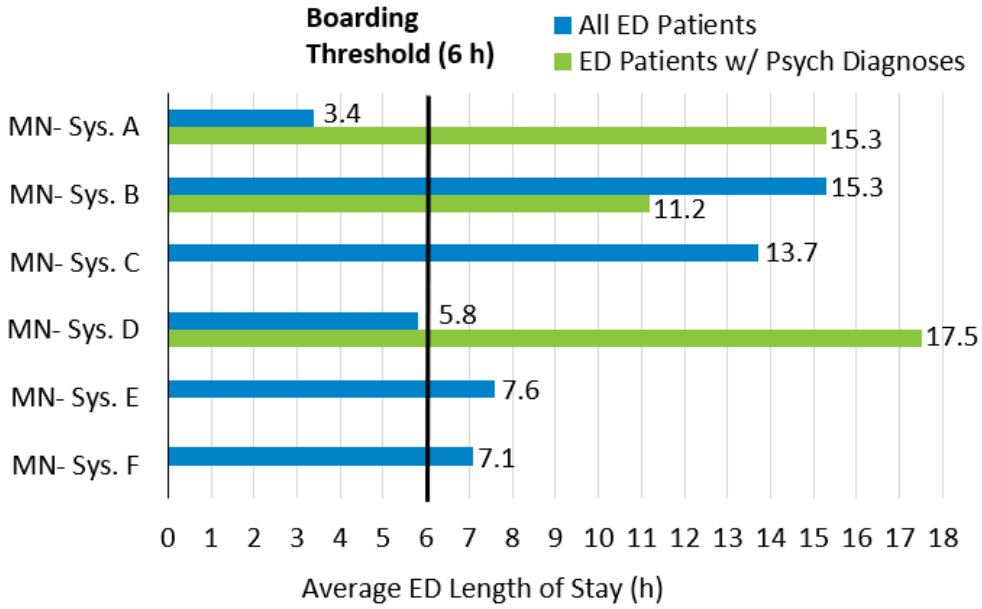
Likelihood of boarding compared to an ED patient with a psychiatric diagnosis who is younger than 15 y

Generally, the older an ED patient with a psychiatric diagnosis is, the lower their odds of boarding. This may be due to the difficulty of securing inpatient psychiatric services for children.

There also exist limited data on EDB incidence in Minnesota. In 2019, the Institute for Clinical Systems Improvement (ICSI) collected average ED LOS metrics from six of Minnesota's largest health systems between July and October of 2019.[2] Three systems reported additional data on the average ED LOSs for ED patients with psychiatric diagnoses. These ED LOS averages are visualized in Figure 4. The average ED LOSs at four large Minnesota health systems surpassed the boarding threshold of 6 hours (15.3, 13.7, 7.6, 7.1). Two systems reported average ED LOSs that did not surpass the boarding threshold but average ED LOSs for patients with psychiatric diagnoses that did. Note that variances in the way these systems measured and reported ED LOSs may weaken our ability to compare ED LOSs across systems.

[2] These 2019 data from ICSI are not published online but are available upon request of MMA staff.

Figure 4. Average ED LOSs of six large Minnesota health systems, July to October 2019 (ICSI, 2019)



At least two large MN systems have average ED LOSs that do not surpass the boarding threshold, but average ED LOSs for ED patients with psychiatric diagnoses that *do* (A and D).

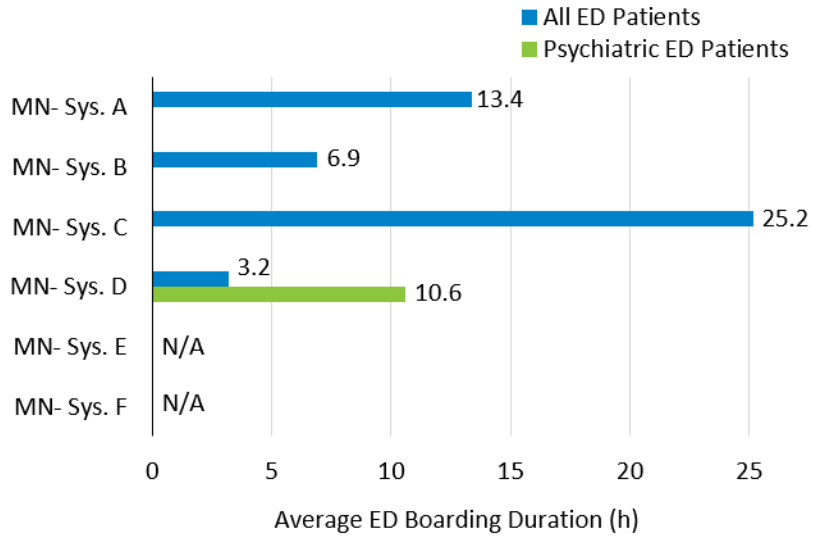
Duration

Another way to measure EDB is by duration, or how long boarded patients remain in EDs past the appropriate length-of-stay threshold of six hours. The most recent national data on EDB duration is from Nolan et al. (2015), who estimate an average national EDB duration of 3.3 hours (Nolan et al., 2015, p. 61). They also report that, on average, boarded ED patients with psychiatric diagnoses board for 2.78 hours longer than boarded ED patients who do not have psychiatric diagnoses (Ibid, p. 61). While no variable other than psychiatric status had a main effect on EDB duration, Nolan et al. estimate that, among boarded ED patients with psychiatric diagnoses, those with non-private residences boarded for an average of 2.09 hours longer than those with private residences (Ibid, p. 61). Unfortunately, the authors do not elaborate on their methodology for discerning private versus non-private housing.

There exist limited data on EDB duration in Minnesota. ICSI (2019) reports average EDB durations for four large Minnesota health systems between July and October of 2019.[3] These values are visualized in Figure 5. Maximum EDB duration times for these four systems ranged from 18 to 230 hours. Note that variances in the way these systems measured and reported ED boarding may weaken our ability to compare ED boarding durations across systems.

[3] These 2019 data from ICSI are not published online but are available upon request of MMA staff.

Figure 5. Average EDB durations of four large Minnesota health systems, July to October 2019 (ICSI, 2019)



Average ED boarding durations reported by four large MN health systems ranged from 3.2 to 25.2 hours.

Additionally, the Centers for Medicare and Medicaid Services (CMS) publishes annual data on the median ED LOS for patients with psychiatric diagnoses by state and by individual Medicare-certified hospitals (CMS, 2022, a; CMS, 2022, b; Measure ID: OP_18c). In 2021, the median ED LOS for patients with psychiatric diagnoses in Minnesota was 3.5 hours (Ibid, a). In 2021, the median ED LOS for patients with psychiatric diagnoses ranged from 1.46 to 10.45 hours across Minnesota hospitals (Ibid, b).

A Conceptual Model of EDBPPD – The Jammed Freeway

The problem of ED boarding of patients with psychiatric diagnoses (EDBPPD) can be conceptualized using the analogy of a jammed freeway (see Figure 6). The freeway itself is an ED. There are different types of commuters (patients in mental health crises or with psychiatric symptoms) each with their own destinations (appropriate facilities). However, the exit offramps (admit/transfer processes) that lead to the destinations are clogged. For example, popular destinations might have full parking lots (full beds), and lines are backed up to the freeway. We call reasons why patients with psychiatric diagnoses get stuck boarding in EDs "Outflow Factors."

The traffic jam spills back from each exit and into the lanes of the freeway. The longer commuters sit on the freeway, the more can go wrong. The constant stop-and-go, honking, and congestion (constant stimulation in busy EDs) may upset commuters (patients) and result in car accidents (exacerbated psychosis and violent behavior). Accidents can alter the commuter's destination to a more urgent exit (a higher acuity facility than needed when the patient arrived). To make the commuting (boarding) experience worse, many freeways don't have accessible roadside assistance services (psychiatric care). We call factors that potentially worsen the health of boarding patients "Stalling Factors."

The traffic jam spills back even further to the onramp of the freeway (the door of the ED). Even as the freeway is clogged, more commuters are merging on. While the freeway is still the best route for some commuters (patients experiencing severe psychosis, aggression, and/or co-occurring medical conditions), it may not be the best route for other commuters (patients with less acute symptoms) sitting on the onramp. Some of these commuters would be better off taking residential streets to their destination (non-ED crisis resources) but were too rushed (sudden psychosis) to study other routes (lay ignorance of non-ED crisis resources) or simply sucked onto the freeway by flow of traffic (conventional dispatch and emergency services protocol). Even still, for those commuters for which the jammed freeway is still the best route (patients with high-acuity symptoms), errands ran earlier in the day or week (access to outpatient, preventative mental health services) may have prevented the need for getting on the freeway during a jam (needing ED-level care due to a potentially preventable psychotic/aggressive episode). We call factors that lead to high ED utilization by patients in mental health crises "Inflow Factors."

Having established this conceptual model, the next three sections of this report will detail each of its components.

Figure 6. Conceptual model of ED boarding of patients with psychiatric diagnoses (EDBPPD)

Inflow Factors

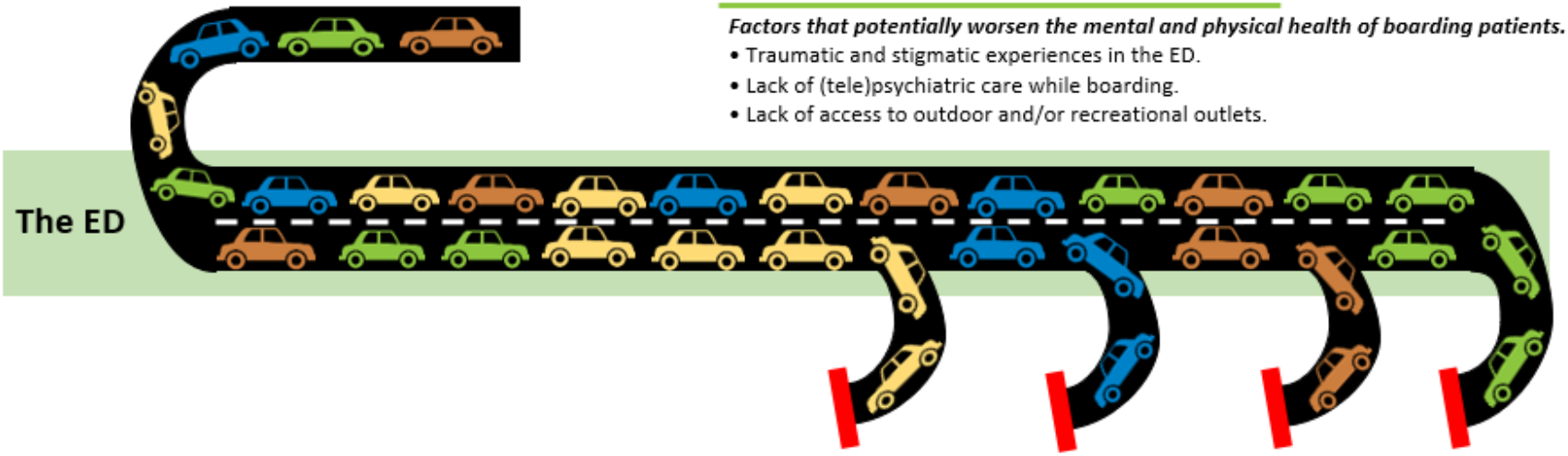
Factors that lead to high ED utilization by patients in mental health crises.

- Underlying prevalence of mental illness.
- Lack of patient access to preventative, outpatient mental health services.
- Protocol of conventional dispatch and emergency services during mental health crises.
- Lack of lay familiarity with mental health crisis resources.

Stalling Factors

Factors that potentially worsen the mental and physical health of boarding patients.

- Traumatic and stigmatic experiences in the ED.
- Lack of (tele)psychiatric care while boarding.
- Lack of access to outdoor and/or recreational outlets.



Outflow Factors

Reasons why mental health patients get stuck boarding in EDs.

- Shortages of psychiatric hospital beds for adults, children.
- Shortages of chemical dependency beds for adults, children.
- Shortages of residential (treatment) beds for adults, children.
- Distance of available beds from home, family, and community.
- Residential treatment admission criteria that preclude admission of people with a history of violence or violent criminal convictions.
- Inability of corporate foster care to welcome patients back.

Inflow Factors

Understanding the Mental Health Demand for EDs

To understand the mental health demand for EDs, one must have a basic understanding of mental health crises and the (sometimes limited) care options for people who experience them.

Mental Health Crises

Sometimes people experience mental health crises, or "situation[s] in which a person's behavior puts them at risk of hurting themselves or others and/or when they are not able to resolve the situation with the skills and resources available" (NAMI MN, 2018, p. 2). These crises can be triggered by a variety of reasons, including "increased stress, physical illness, problems at work or school, changes in family situations, trauma/ violence at home or in the community or substance use" (Ibid, p. 2). While anyone can experience a mental health crisis, they "can be especially hard for someone with a mental illness" (Ibid, p. 2).

Some people in mental health crises seek care voluntarily. Depending on crisis acuity, aggression level, and/or co-occurring medical conditions, the person may utilize a crisis response resource (e.g., crisis mobile unit, crisis hotlines), an urgent care, or an ED.

Other people in mental health crises refuse to seek care voluntarily. In these cases, the person in crisis may be subject to legal holds and commitments, which constrain care options.

Mobile Crisis Teams and Emergency Response

When a person in mental health crisis refuses to seek care voluntarily, bystanders may call for help. In most cases, the ideal responders are mobile crisis teams, or "teams of mental health professionals and practitioners who provide psychiatric services to individuals within their own homes and at sites outside of the traditional clinical setting" (MN Dept. of Human Services, 2018, p. 1). Mobile crisis teams operate 24/7 and "provide for a rapid response and will work to assess the individual, resolve crisis situations, and link people to needed services" (Ibid, p. 1).

Bystanders can contact the mobile crisis team of their respective county or tribe by calling the specific numbers listed on the Minnesota Department of Human Services (MNDHS) Website or by dialing 27474 (i.e., **CRISIS) (MN DHS, 2021). Alternatively, should bystanders call 911 in Minnesota, the 911 system must "include a referral to mental health crisis teams, where available" (MN Statutes Chapter 403.03, 2022). As of July 16, 2022, bystanders may call 988 to activate emergency services for those experiencing mental health crises.

Transport Holds

The first type of hold that can be imposed on a person in mental health crisis is called a transport hold. Transport holds can be initiated by police officers or health officers. Health

officers are defined by state law and include physicians, mental health professionals, social workers, ED nurses, advance practice nurses, physician assistants, and mental health practitioners who respond as part of a mobile crisis team (MN Statutes Chapter 253B.07, 2022).

If a responding police officer or health officer has reason to believe that a person "has a mental illness or developmental disability and is in danger of harming self or others if the officer does not immediately detain the patient," the officer can take said person into custody and transport them to a treatment facility (Minnesota Statutes Chapter 253B.051, 2022). This treatment facility is often an ED. The transport hold ends upon whichever occurs first: (1) the person's voluntary admission, (2) a physician or healthcare worker's decision to not admit the person, (3) 12 hours after arrival to the ED, or (4) once an emergency hold is initiated (Ibid).

Emergency Holds

When a person in mental health crisis arrives at an ED, either on their own volition or via a transport hold, sometimes they pose such a risk to themselves or others that a medical professional, acting as an "examiner," places them on an emergency hold (Minnesota Statutes, Chapter 253B.051, 2022). Under state law, the following professionals meet the definition of examiner:

> "Examiner" means a person who is knowledgeable, trained, and practicing in the diagnosis and assessment or in the treatment of the alleged impairment, and who is a licensed physician; a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6); a licensed physician assistant; or an advanced practice registered nurse (APRN) as defined in section 148.171, subdivision 3, who is practicing in the emergency room of a hospital, so long as the hospital has a process for credentialing and recredentialing any APRN acting as an examiner in an emergency room. (Minnesota Statutes Chapter 253B.02, 2022)

An examiner has 12 hours from the patient's arrival time to enact an emergency hold. During an emergency hold, a patient is confined in a secure treatment facility for up to 72 hours, not including weekends and holidays. Oftentimes, the secure treatment facility is the ED itself.

The examiner has the autonomy to discharge or transfer/admit the patient to an appropriate facility (at a hospital or residential treatment center) prior to the expiration of the emergency hold (Ibid).

District Court Holds and Civil Commitment

If the examiner deems that a patient under an emergency hold should be held and treated for more than 72 hours, they can file a petition for civil commitment with the county prior to the expiration of the emergency hold. A judge can then impose a district court hold on the patient, which goes into effect immediately after the expiration of the emergency hold (Minnesota Statutes, Chapter 253B.07, 2022). District court holds last until the end of the civil commitment process, which can take 14 to 44 days from the date the petition is filed (or up to 47 days from

the date the emergency hold is Imposed). If the judge commits the patient, the initial commitment cannot last more than 180 days from the ruling. In some cases, a commitment can continue per the recommendation of the patient's caseworker and/or a judge through another commitment proceeding.

Patients held under district court holds and civil commitments are typically committed to an inpatient hospital bed or an inpatient residential treatment bed depending on acuity and type of mental health issue. In the case that an appropriate facility is not available, patients board in the ED.

Drivers of Preventable Mental Health Crises

Some mental health crises are preventable. By preventing some mental health crises, we can decrease the utilization of EDs by people in mental health crises, and, in turn, reduce the incidence and duration of EDBPPD. There are several drivers of preventable mental health crises.

People with mental illnesses are particularly vulnerable to mental health crises. While most mental illnesses are not preventable, people with mental illness can sometimes avoid mental health crises if their symptoms are managed below a clinical threshold. Therefore, it is helpful to understand (a) the prevalence of mental illness in Minnesota and (b) the barriers this population faces in accessing preventative, outpatient mental health services.

Underlying Prevalence of Mental Illness

The Substance Abuse and Mental Health Services Administration (SAMHSA) collects data on several indicators related to mental health through the annual National Survey on Drug Use and Health (NSDUH). SAMHSA publishes annual state-by-state estimates using a combination of NSDUH results from the current and past year for statistical soundness (SAMHSA, 2022).

Depression in Minnesota

Figure 7 visualizes the percentage of Minnesota adults (teens) experiencing at least one major depressive episode (MDE) in the past year. Figure 8 visualizes the percentage of Minnesota teens experiencing at least one major depressive episode (MDE) in the past year. The estimated percentage of Minnesota adults experiencing an MDE in 2019-2020 was 9.3%, which is not statistically significant from the 2005-2006 estimate of 6.3% at the 95% confidence level (SAMHSA, 2022). The estimated percentage of Minnesota teens experiencing an MDE in 2019-2020 was 19.4%, which is statistically significant from the 2005-2006 estimate of 8.4% (Ibid). Additionally, the nonprofit Mental Health Minnesota reports that the number of Minnesota children screened online for mental health problems increased 373%, or 1,662 to 7,882, between 2019 and 2020 (Serres, 2021). The number of screenings provided by Mental Health Minnesota for all Minnesotans, regardless of age, increased 500% between January 2019 and January 2021. Of those screenings, 38% were for depression (Ibid).

Figure 7. Percentage of Minnesota adults experiencing at least one major depressive episode in the past year (SAMHSA, 2022)

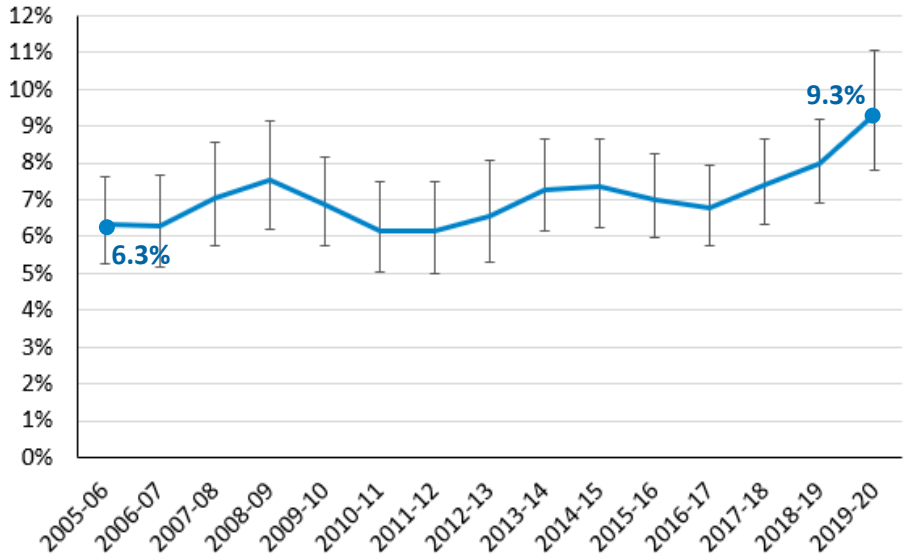
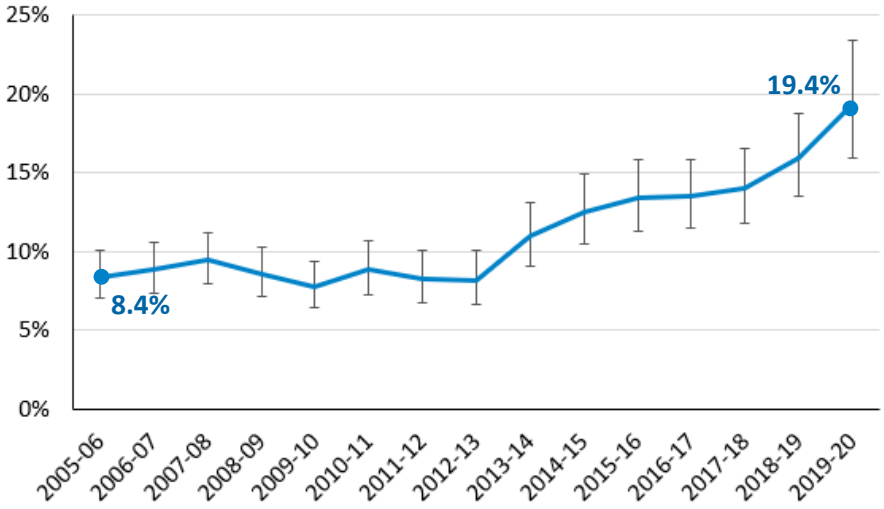


Figure 8. Percentage of Minnesota teens (ages 12-17) experiencing at least one major depressive episode in the past year (SAMHSA, 2022)



Substance Use Disorder in Minnesota

Figure 9 visualizes the percentage of Minnesota adults with substance use disorder (SUD) in the past year. Figure 10 visualizes the percentage of Minnesotan teens with substance use disorder (SUD) in the past year. The estimated prevalence of SUD for Minnesota adults in 2019-2020 was 17.3%, which is statistically significant from the 2015-2016 estimate of 8.0% at the 95% confidence level (SAMHSA, 2022). The estimated prevalence of depression for Minnesota teens in 2019-2020 was 5.7%, which is not statistically significant from the 2015-2016 estimate of 5.0% (Ibid). In addition, the Minnesota Department of Health (MDH) reports annual preventable deaths due to substance use and suicide (MDH, 2021). These MDH data for years 2000 through 2020, are visualized in Figure 11. While the incidences of alcohol- and drug-related deaths in Minnesota have been steadily climbing since 2007, these deaths grew exponentially in the wake of the COVID-19 pandemic. In 2020, 1,008 Minnesotans died from drug overdose, and 992 Minnesotans suffered alcohol-attributable deaths.

Figure 9. Percentage of Minnesota adults with substance use disorder in the past year (SAMHSA, 2022)

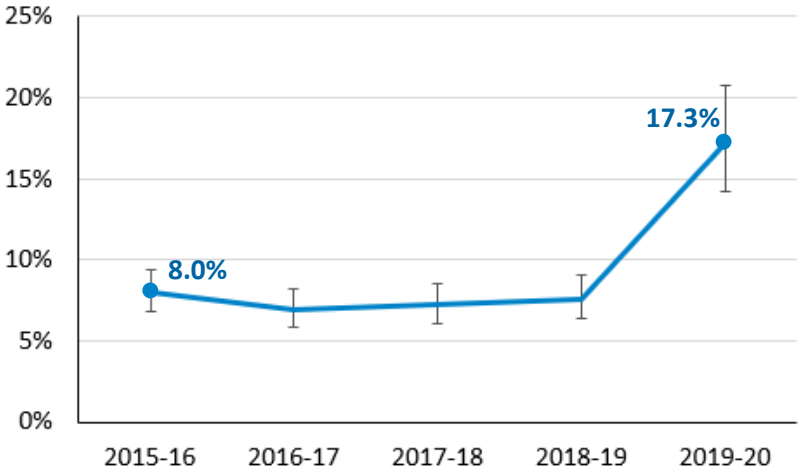


Figure 10. Percentage of Minnesota teens (ages 12-17) with substance use disorder in the past year (SAMHSA, 2022)

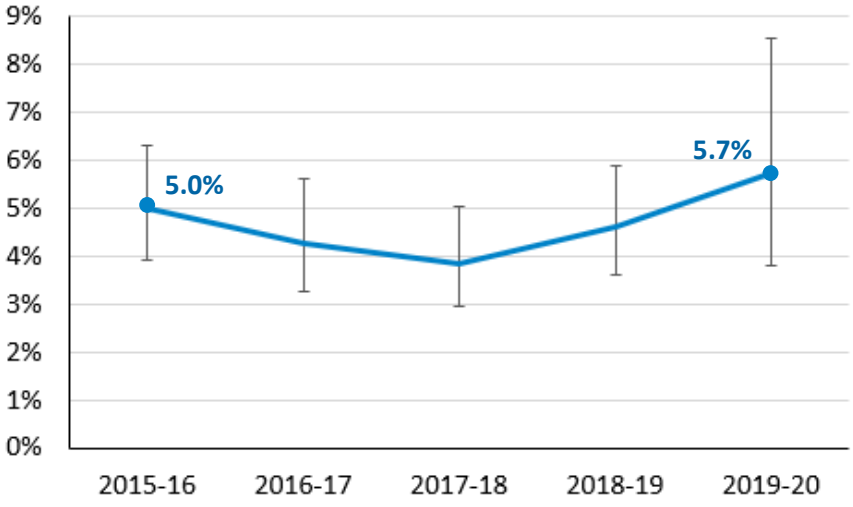
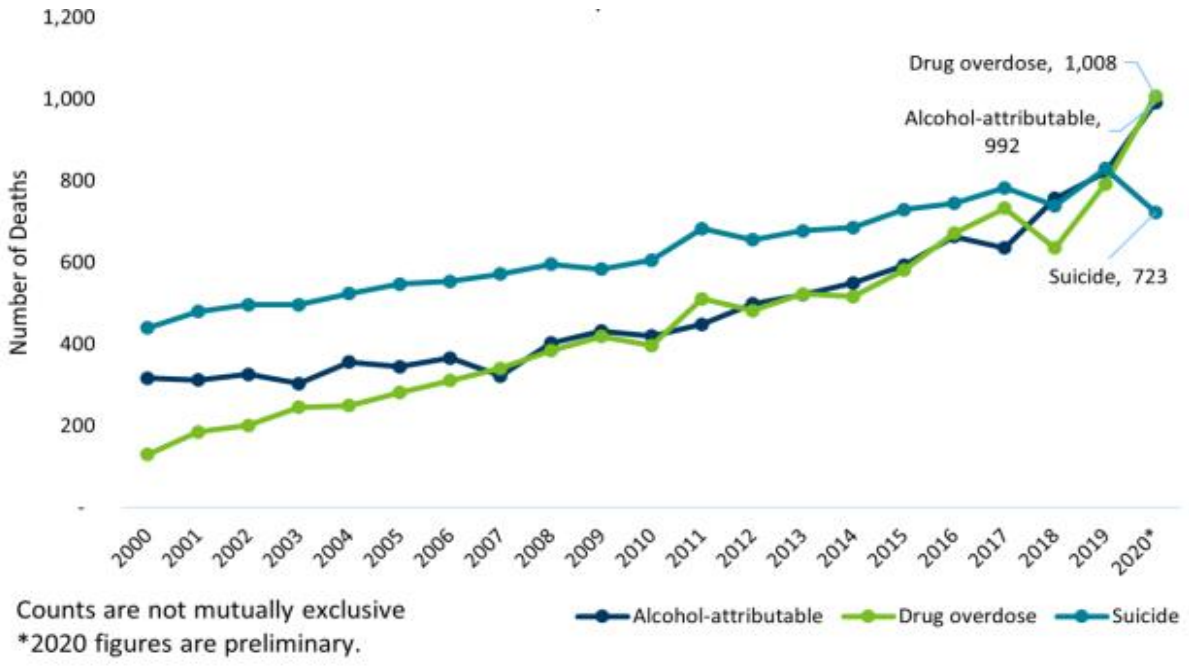


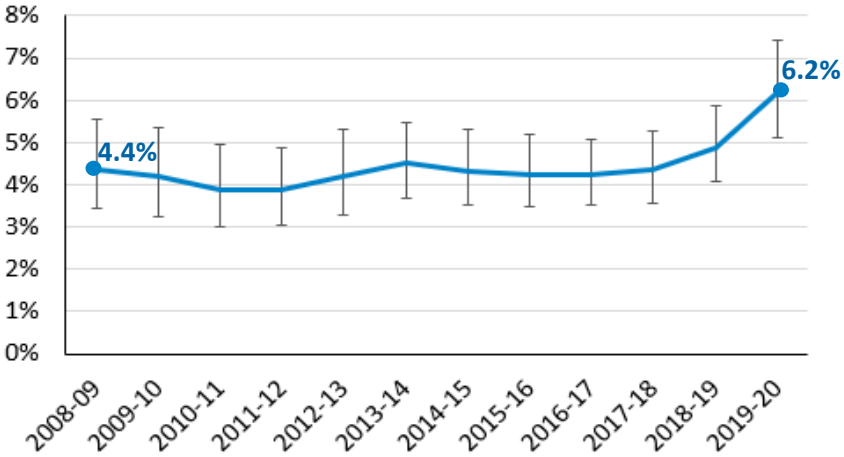
Figure 11. Preventable deaths of substance use and suicide in Minnesota, 2000-2020 (direct screenshot of MDH, 2021, p.1)



Serious Mental Illness in Minnesota

Figure 12 visualizes the percentage of Minnesota adults with serious mental illness (SMI) in the past year. SMI is defined by SAMHSA "as having at least one mental disorder, other than a developmental or substance-use disorder, in the past 12 months that resulted in serious impairment" (e.g., bipolar, schizophrenia) (SAMHSA, 2013). The estimated prevalence of SMI for Minnesota adults in 2019-2020 was 6.2%, which is not statistically significant from the 2008-2009 estimate of 4.4% at the 95% confidence level (SAMHSA, 2022). SAMHSA does not collect nor report data on the prevalence of SMI among minors.

Figure 12. Percentage of Minnesota adults with serious mental illness in the past year (SAMHSA, 2022)



Lack of Access to Preventative, Outpatient Mental Health Services

Within the context of increasing mental illness prevalence in Minnesota, especially in the wake of the COVID-19 pandemic, it is crucial to understand barriers patients face in accessing preventative, outpatient mental health services, including mental health evaluation, psychotherapy, and medication. Access to said services assist Minnesotans in managing their mental health disorders in ways that reduce the likelihood of mental health crises.

To assess patient access to preventative, outpatient mental health services in Minnesota, it is helpful to use Saurman's (2015) modification of Penchansky and Thomas's (1981) theory of access. Access to healthcare is not only a matter of affordability, but also availability, accessibility, accommodation, acceptability, and awareness. Table 2 applies Saurman's (2015) theory of access to outpatient mental health services. The following subsections detail each of these dimensions.

Affordability

Uninsured. In 2021, 4.0% of Minnesotans (228K) were uninsured (MDH, 2022, "Uninsurance Rates"). Uninsured individuals who cannot secure outpatient mental health services at free clinics end up paying the full cost of care themselves. According to MNHealthScores, in 2020, the average cost for a psychiatric diagnostic evaluation across 60 reporting Minnesota medical groups was $241 (range $130-$481), and the average cost for 60 minutes of psychotherapy across 69 Minnesota medical groups was $135 (range $99-$432) (MNHealthScores, 2021). Calculated out, the average annual cost of therapy sessions every other week was an estimated $3,240 (range $2,376-$10,368) in 2019.

Uninsured individuals also end up paying the full cost of prescription drugs. Table 1 lists daily dosage examples, estimated monthly prices, and estimated annual prices for the top six most-prescribed psychiatric drugs (and their generic forms) in 2018 (Drugs.com, 2021; PsychCentral, 2019). Annual price estimates range from $72 to $648 for generic drugs and $2,976 to $21,552 for brand drugs.

Table 1. Estimated monthly and annual prices for the top six most prescribed psychiatric drugs in 2018 (Drugs.com, 2021)

Medication	Daily Dosage Example	Monthly Price Estimate	Annual Price Estimate
Zoloft	50mg	$269	$3,228
Generic Sertaline	50mg	$20 to $54	$240 to $648
Xanax	1mg	$731	$8,772
Generic Alprazolam	1mg	$23	$276
Lexapro	10mg	$248	$2,976
Generic Escitalopram	10mg	$19 to $36	$228 to $432
Desyrel	150mg	N/A	N/A
Generic Trazodone	150mg	$55	$660
Welbutrin XL	150mg	$1,796	$21,552
Generic Bupropion	150mg	$17 to $45	$204 to $540
Adderall	20mg	$284	$3,408
Generic Amph/Dextro	20mg	$6 to $18	$72 to $216

Table 2. Considerations of access to outpatient mental health services

Dimenson of Access	Considerations
Affordability *Can patients afford care?*	• How many Minnesotans are uninsured? What prices do they pay for services? • How many Minnesotans are underinsured? What prices do they pay for services?
Availability *Is there adequete supply in a given area?*	• How many mental healthcare workers are there per capita? • How long are wait-times for outpatient mental health services? • How many (in-network) mental healthcare workers are accepting new patients?
Accessibility *Are patients physically able to access services?*	• How far must patients travel to receive outpatient mental health services? • What transportation barriers do patients face in traveling to said services?
Accommodation *Can patients be seen and treated as needed?*	• How many mental health clinics offer walk-ins or appointments after business hours? • How many mental healthcare workers offer remote telemedicine/telepsychiatry?
Acceptability *Will the patient accept a specific service from a specific provider at a specific location?*	• Are patients more willing to receive care from someone of the same race, gender, etc.? • Do services challenge cultural or spiritual beliefs of patients? • Do services have stigma attached to them? • Are waiting rooms confidential?
Awareness *Are patients aware of care options to which they are entitled?*	• Are patients aware of their eligibility for public healthcare programs? • Are patients aware of their coverage and benefits for outpatient mental health services?

In 2022, 57.5% of uninsured Minnesotans were potentially eligible for Medical Assistance or MinnesotaCare but did not enroll (MDH, 2022, "Potential Sources of Health Insurance Coverage"). The other half of uninsured Minnesotans chose not to enroll in an employer-sponsored plan or an individual plan, likely due to high premium costs and personal risk tolerance (Ibid).

Medical Assistance (Medicaid). In February 2022, 17.3% of Minnesotans (990K) had Medical Assistance (MA), or Medicaid, insurance (MN Dept. of Human Services, 2022, a.). MA enrollees pay a $3.55 monthly deductible and no copays for mental health visits. Calculated out, MA enrollees can expect to pay no more than $42.60 per year for therapy sessions every other week (MN Dept. of Human Services, 2022, b.).

There is no MA copay for some mental health drugs (Ibid). For other mental health drugs, MA enrollees pay a $1-$3 copay per prescription, up to $12 per month. Calculated out, MA enrollees can expect to pay no more than $36 for a one-year supply of psychiatric medication.

MinnesotaCare. In February 2022, 1.8% of Minnesotans (107K) had MinnesotaCare coverage (MN Dept. of Human Services, 2022, a.). MinnesotaCare is a public insurance program for Minnesotans who earn too much for MA but too little to afford employer-sponsored or individual insurance. MinnesotaCare enrollees pay no deductible and no copays for mental health visits (MN Dept. of Human Services, 2022, b.).

There is no MinnesotaCare copay for some mental health drugs (Ibid). For other mental health drugs, MinnesotaCare enrollees pay a $7 copay per generic prescription and a $25 copay per brand prescription, up to $70 per month. Calculated out, MinnesotaCare enrollees can expect to pay no more than $300 for a one-year supply of psychiatric medication.

Employer Sponsored Insurance. In 2022, 52% of Minnesotans (2.97M) had employer-sponsored insurance (ESI) coverage (MDH, 2022, "Sources of Health Insurance Coverage"). In 2019, the average annual deductible for a single person (family) enrolled in an ESI plan was $2,227 ($4,160) (Kaiser Family Foundation, 2022). Cost-sharing for mental health services and prescriptions, before and after deductibles are met, vary across ESI plans. Before meeting a deductible, ESI enrollees are sometimes allowed one to three complimentary outpatient mental health visits. As of 2019, Minnesota law requires health plans to recognize mental health therapy visits as primary care visits with respect to cost-sharing obligations, including complimentary visits, deductibles, co-insurance, and copayments (Minnesota Statutes Chapter 62Q.47, 2022).

Once complimentary mental health visits are expended (if offered), some ESI plans require enrollees to pay the full cost of care themselves before surpassing the deductible, while others require enrollees to pay relatively high copays or coinsurance. Once an enrollee surpasses their deductible, ESI plans will typically impose relatively low copays or coinsurance until an out-of-pocket maximum is reached. In 2019, 1 in 5 Minnesotans with ESI coverage reported delaying or forgoing care due to cost sharing (MDH, 2021, b., p. 5).

To make sense of why Minnesotans with ESI might forgo care due to cost, it is useful to use an example. Let's say an enrollee needs one 60-minute psychotherapy session every two weeks (26 sessions per year). The enrollee has 3 complimentary mental health visits per year (must pay for 23 sessions per year). The enrollee must pay the full cost of therapy (average $135/session) up to their annual deductible (average $2,227). The deductible amount in this case pays for 16.49 therapy sessions. The enrollee must then pay 30% coinsurance ($40.50/session) for the remaining 6.51 sessions. In total, this Minnesotan with ESI coverage must pay $2,490.65 per year just for therapy every other week. This cost does not include the cost of ESI premiums nor cost-sharing for other medical services and prescriptions.

Cost-sharing for prescription drugs tend not to vary before and after a deductible is met. Instead, cost-sharing amounts depend on whether the drug in question is generic or brand, on the ESI plan's formulary (preferred drug list), and/or excessively expensive. ESI plans impose lowest cost-sharing for generic drugs on the formulary (e.g., $5-$25 copay per 30-day supply), higher cost-sharing for brand drugs on the formulary (e.g., $50+ copay), and even higher cost-sharing for drugs off the formulary (e.g., $150+ copay).

Individual Insurance. Minnesotans under 65 who earn too much for MA or MinnesotaCare and who are not offered ESI by an employer must purchase health plans on the individual market. In 2022, 2.8% of Minnesotans (160K) had individual market coverage (MDH, 2022, "Sources of Health Insurance Coverage").

While employees typically take whichever singular ESI plan is offered by their employer, Minnesotans purchasing plans on the individual market can chose from a selection of plans with different premium costs and coverage. Purchasers on the individual market often select plans that have the lowest up-front premium costs. Unfortunately, plans with lower premiums impose higher cost-sharing (e.g., deductibles, copays, and coinsurance) once insured. One way to measure cost-sharing imposed by a plan is by actuarial value (AV), or the percentage of healthcare costs you can expect your plan to pay, on average; the lower the premium, the lower the AV, and the higher the cost-sharing. In 2021, 53% of enrollees on the individual market selected Bronze-tier plans—plans with the lowest possible premiums but also the lowest possible AV of 60%-69% (MN Commerce Dept., 2021, p. 5). These individuals are largely underinsured, or have health insurance but face such high cost-sharing that they cannot afford care. In 2019, 1 in 4 Minnesotans with individual coverage reported delaying or forgoing care due to cost sharing (MDH, 2021, b., p. 5).

Individual plans, once purchased, function similarly to the design of ESI plans detailed above. Deductibles and cost-sharing depend on the actuarial value of the plan purchased.

Medicare, Medicare Part D and Medicare Advantage. In 2020, 18% of Minnesotans had some form of Medicare coverage (1M) (Centers for Medicare and Medicaid Services, a., 2022). Medicare is a public insurance program for people older than 65 and for some non-elderly adults with disabilities. Those who are eligible for Medicare can either enroll in what is called

original Medicare, through the federal government, or a Medicare Advantage plan, through a private insurance company.

Original Medicare enrollees face no cost-sharing for their first psychiatric diagnostic evaluations each year but are responsible for the full cost of psychotherapy until they meet their annual Medicare Part B deductible of $233 (Medicare.gov, 2022). Given that the average cost of a 60-minute psychotherapy session in Minnesota is $135, this deductible is likely met after one or two sessions. After the deductible is met, enrollees pay 20% coinsurance on the Medicare approved amount for psychotherapy. In 2022, the Medicare approved amount for a 60-minute psychotherapy session in Minnesota is $148.84 (Centers for Medicare and Medicaid Services, b., 2022). Calculated out, original Medicare beneficiaries can expect to pay approximately $1,758 per year for 60-minute psychotherapy sessions every other week. Prescription drug coverage for original Medicare is covered through Medicare Part D, which is offered by private insurance companies. Part D imposes its own deductibles and cost-sharing for medications but varies from plan to plan, similarly to individual plans.

Individuals who want better coverage than what is offered by original Medicare can choose to purchase Medicare Advantage Plans, which are offered by private insurance companies. Oftentimes, people who chose this coverage will purchase a Medicare Advantage + Part D plan, which covers health services and prescription medications. Medicare Advantage + Part D plans have varied deductibles and cost-sharing.

Availability

Mental Healthcare Workforce Supply and Distribution. Table 3 lists the types of mental healthcare workforce licenses in Minnesota and their respective scopes of practice.

Table 3. Mental healthcare workforce licenses and their respective scopes of practice

License	Prescribe	Diagnose	Provide Therapy
Physician (MD, DO, MBBS) Physician Assistant (PA) Adv. Practice Registered Nurse (APRN)	✓	✓	✓
Lic. psychologist (LP) Lic. indept. clinical social worker (LICSW) Lic. marriage and family therapist (LMFT) Lic. professional clinical counselor (LPCC) Lic. professional counselor (LPC)	X	✓	✓
Lic. alcohol and drug counselor (LADC)	X	X	✓

The Minnesota Department of Health offers comprehensive data on the workforce supply and distribution of each of these licensed mental healthcare workers (MHWs) at the county and statewide levels (MDH Office of Rural Health & Primary Care, 2021). Table 4 lists the total counts, and per-capita rates, of active licenses in Minnesota in 2021. Note that some licensed MHWs have business addresses outside of Minnesota but may be practicing in Minnesota on a part-time or seasonal basis, or even via telehealth across state lines.

Table 4. Total counts and per-capita rates of active mental healthcare workforce licenses in Minnesota, August 2021 (MDH, 2021)

	MN Business Address		Total	
License	Count	Per 10K pop.	Count	Per 10K pop.
Physician	19,183	33.4	26,108	45.5
Psychiatrist*	-	-	569	1.0
Physician Assistant	3,216	5.6	3,655	6.4
Adv. Practice Registered Nurse (APRN)**	9,681	16.9	9,845	17.1
Lic. psychologist (LP)	3,241	5.6	3,683	6.4
Lic. alcohol and drug counselor (LADC)	3,450	6.0	3,710	6.5
Lic. indept. clinical social worker (LICSW)	5,172	9.0	6,150	10.7
Lic. marriage and family therapist (LMFT)	2,616	4.6	2,817	4.9
Lic. professional clinical counselor (LPCC)	2,391	4.2	2,582	4.5
Lic. professional counselor (LPC)	272	0.5	362	0.6

*Data on actively licensed psychiatrists are from 2019 (MDH, 2019; p. 19)
**Data on actively licensed APRNs are from March 2022 (MN Board of Nursing, 2022; p. 9)

Mental Healthcare Worker Network Restrictions. While total counts and per-capita rates of licensed MHWs offer upper-bound estimates of mental health care supply, they do not accurately reflect the supply of mental healthcare in any given patient's health plan network. Due to the exorbitantly high cost-sharing patients face when seeking out-of-network care, the effective healthcare supply for any given patient is lower than what is reported by the state.

Mental Healthcare Worker Credential Restrictions. Even if a patient identifies an available, in-network MHW, health plan coverage for services rendered by the worker may be contingent on the worker's credentials. For example, Medicare will only cover psychotherapy rendered by physicians, physician assistants, advanced practice registered nurses, licensed psychologists, and licensed independent clinical social workers (Medicare.gov, 2022). When health plans refuse to cover services rendered by certain MHWs, the effective healthcare supply for any given patient is lower than what is reported by the state.

Appointment Availability and Wait Times. Even if patients are able to find in-network MHWs, the MHWs may not be accepting new patients, or may have appointments booked out for weeks to months.

Accessibility

Travel Distance to Available Outpatient Mental Health Services. The distribution of licensed mental healthcare workers (MHWs) is not geographically equitable throughout the state of Minnesota. The Minnesota Department of Health visualizes comprehensive data on the density of actively licensed MHWs per county (MDH Office of Rural Health & Primary Care, 2021). This data reported at the county level abstracts away the distance patients may need to drive within their own counties. For example, patients living in northern St. Louis County may need to drive two to three hours to see MHWs in Duluth. Depending on care needs, insurance networks, and availability, Minnesotans may need to drive across one or multiple county lines to receive in-person care. At an even more granular level, available MHWs who live across town, or across the metropolitan area, may not be accessible to patients who lack affordable, reliable transportation.

While not appropriate for all patients, evaluation and psychotherapy rendered via telehealth is a much more accessible option for patients who live far from available MHWs. Access to telehealth could improve with greater investment in broadband services in rural areas.

Accommodation

Walk-In, After-Hours, and Weekend Appointments. It may be particularly hard for lower-income, working-class patients to take time off work, or to schedule leave in advance, for mental health appointments during the traditional 9:00AM-5:00PM workday. When mental healthcare workers only offer appointments during typical business hours on weekdays, they fail to accommodate a large subset of individuals living with mental health disorders, resulting in increased utilization of EDs.

Acceptability

Patient-Mental Healthcare Worker Concordance. Sometimes patients are more willing to see and/or actively engage with mental healthcare workers (MHWs) with whom they share a social identity, such as race, gender, or sexual orientation. The Minnesota Department of Health reports data on the race, ethnicity, and gender distribution for each mental healthcare workforce (MDH Office of Rural Health & Primary Care, 2021). One potential way to increase the acceptability of mental health services by Minnesotans is to build a mental health workforce that more closely reflects the demographics of the patients it serves. In the interim, MHWs should take extra care when rendering care to racially discordant patients, including "focusing on improving patient-centeredness, information-giving, partnership building, and patient engagement in communication processes" (Johnson Shen et al., 2017).

Stigma Associated with Seeking Mental Health Services. According to one HealthPartners survey of adults in select Minnesota and Wisconsin communities, 50% of respondents were reluctant to seek help for their mental illness and one in three respondents were not comfortable talking with someone about their mental illness (HealthPartners, 2020). Stigma

associated with seeking mental health services seeps from broader society to the clinic itself. Patients may be less willing to seek care at mental health clinics if sitting in conspicuous, non-confidential waiting rooms signals their mental illness to others.

Awareness

Awareness of Public Health Insurance, or Health Insurance Subsidy, Eligibility. Not all Minnesotans who are eligible for Medical Assistance, MinnesotaCare, or individual market subsidies and cost-sharing reductions via the Affordable Care Act (ACA) are aware of their eligibility. In 2019, nearly one in two uninsured Minnesotans were eligible for Medical Assistance or MinnesotaCare but not enrolled (MDH, 2021, "Potential Sources of Health Insurance Coverage").

Awareness of Benefits and Coverage Offered by Health Plans. While health insurance plans are required to distribute a summary of benefits and coverage (SBC) to their enrollees every enrollment period, enrollees may not be fully aware of the benefits and coverage which their plan covers (and does not cover), including limitations on the type of facility or mental healthcare worker through which services are rendered.

Awareness of In-Network Mental Healthcare Worker Availability. It can be a daunting task for patients to gain awareness of which mental healthcare workers (MHWs) are in-network and taking new patients. "FastTracker MN," run by the Minnesota Psychiatric Society, the Minnesota Department of Human Services, and the Minnesota Mental Health Community Foundation, is a publicly accessible search tool which shows the availability of an array of inpatient and outpatient mental healthcare services (FastTracker MN, 2022).

Drivers of Unnecessary ED Utilization by People in Mental Health Crises

Access to outpatient mental health services is not a fail-safe against mental health crises. However, when people experience mental health crises, ED-level care is not always necessary or appropriate. By diverting people in crisis who do not need ED-level care away from EDs, advocates can decrease the utilization of EDs by people in low-acuity mental health crises, and, in turn, reduce the incidence and duration of EDB. There are several drivers of unnecessary ED utilization by people in mental health crises.

Police Engagement During Mental Health Crises

As detailed earlier in this report, prior to July 2022, 911 systems in Minnesota were required to dispatch mobile crisis teams when appropriate, subject to availability. If mobile crisis units are unavailable, 911 systems will dispatch police officers. The manner in which a police officer engages with a person in a mental health crisis can alter the course of the crisis. When a police officer engages poorly, they can escalate the situation and exacerbate the mental health crisis to a point in which the person may now need ED-level care. When a police officer engages well,

they can de-escalate the situation and connect the person with lower-acuity resources when appropriate.

Between 2017 and 2020, the Minnesota Legislature passed laws that now require police officers to receive at least six hours of training for crisis intervention and mental illness crises (CIMIC) every three years (2021 Minnesota Statutes, Chapter 626.8468). This training must be delivered by a third-party training entity approved by the Minnesota Board of Peace Officer Standards and Training (POST). The learning objectives for this training can be found on the POST website (MN POST, 2021).

Lack of Lay Familiarity with Mental Health Crisis Resources

Most Minnesotans are not familiar with the mental health crisis resources available to them. This unfamiliarity can, in some instances, lead to the unnecessary ED admission of people experiencing mental health crises.

In addition to national toll-free mental health and suicide prevention hotlines, Minnesotans can call their county- or tribe-based mobile crisis teams, which are detailed earlier in this report. Mobile crisis services are proven to decrease the hospitalization rate of patients in mental health crises. One meta-analysis conducted by the Washington State Institute for Public Policy (WSIPP) suggests that people in mental health crisis who received mobile crisis services were 42% less likely to be hospitalized compared to those who did not receive said services (WSIPP, 2019, p. 1). According to the Minnesota Department of Human Services, in 2016, 60% of adults using mobile crisis services were able to remain at their residence, only 4% went to an ED, and only 11% were ultimately admitted to an inpatient psychiatric unit (MN Dept. of Human Services, 2018, p. 1).

Stalling Factors

Identifying the Most Frequent Road Hazards

When people in mental health crises receive care at EDs, their experiences, from arrival to departure, can negatively affect the course of their illness. In some cases, prolonged negative stimuli and lack of psychiatric care in EDs can exacerbate a patient's mental illness to a point that they now need higher-acuity care.

Traumatic and Stigmatic Experiences in the ED

Busy, noisy, and bright EDs can heighten the anxiety and agitation of, and even increase the risk of elopement for, ED patients in mental health crisis (Nicks & Manthey, 2012). In crowded waiting rooms, and in semi-private exam rooms, ED patients in mental health crisis are immersed in one of the most traumatizing environments possible. The manner in which ED patients in mental health crisis are treated can also be extremely stigmatizing. Some EDs place

patients with psychiatric diagnoses in conspicuously colored gowns. It is not uncommon for these patients to be locked in rooms and subject to restrictions on their personal property and movement.

Some hospitals have implemented new facilities and processes to mitigate the risk of traumatizing and stigmatizing ED patients with psychiatric diagnoses. Some hospitals have distinct psychiatric EDs, which provide a quieter, separate space where mental healthcare workers can care for ED patients in mental health crises. Other hospitals have invested in more recent innovations, like emergency Psychiatric Assessment, Treatment, & Healing units, or "EmPATH" units (Zeller, 2017). After brief evaluations in EDs, patients with psychiatric diagnoses are brought to a calming, open-floor unit with comfortable chairs, lighting, and music (MHealth Fairview, 2021). Patients have the option to enter quiet, private rooms should they need to remove themselves from stimuli. In EmPATH units, a multidisciplinary mental health team renders assessments, evaluations, and care plans for patients. There are currently two EmPATH units in the state of Minnesota: one at M Health Fairview Southdale, in Edina, which opened in March of 2021, and one at CentraCare in St. Cloud, which opened in August of 2021. M Health Fairview at the University of Minnesota, Twin Cities, will be opening an EmPATH unit in the near future (date to be determined). Short of comprehensive EmPATH units, some hospitals have opened observation rooms, ED extensions, and designated psychiatric EDs to "provide a therapeutic environment more conducive to caring for patients with psychiatric illness" (Nordstrom et al., 2019).

Lack of (Tele)Psychiatric Care While Boarding

There is no guarantee that patients with psychiatric diagnoses will receive psychiatric care during their time in the ED. According to one 2008 survey of 328 ED directors nationwide, 62% "indicated there are no psychiatric services involved with patient care while patients are being boarded in the emergency department prior to admission or transfer" and 52% "had no substance abuse or dual diagnosis patient services available" (ACEP, 2008).

In addition to hiring psychiatrists and advanced mental health practitioners on-site, EDs might also explore telepsychiatry as a means to actively treat ED patients for their psychiatric illness. Telepsychiatry is becoming an increasingly popular way for a scarce psychiatric workforce to render care across the state, sometimes via 24-hour remote servicing contracts. In the past few years, the State of Minnesota has passed robust telehealth parity laws that protect mental healthcare worker payment and patient affordability (MN House Research, 2020).

Outflow Factors

Identifying the Sticking Points

Fortunately, there exist useful data that can be used to identify the most highly demanded facilities for ED patients with psychiatric diagnoses and the type of obstacles present in the admission and transferring processes. In 2019, the Minnesota Hospital Association (MHA) and the Wilder Foundation published a study of 22 hospitals on reasons for potentially avoidable days (PADs), or "reasons for days in inpatient mental health hospital care when a patient is stabilized and ready to be discharged but is unable to be discharged" (MHA and Wilder Research, 2016, p. 2).

Two of the participating hospitals did not have inpatient psychiatric units and reported reasons for PADs for patients with psychiatric diagnoses across their medical units (see Table 5). The remainder of this section will examine each of these factors.

Table 5. Reasons for potentially avoidable days for hospitals without inpatient psychiatric units (MHA and Wilder Research, 2016)

Reason	% of PADs
Inpatient behavioral health unit bed not available	48%
Delay due to patient legal involvement, including civil commitment	23%
State psychiatric hospital bed unavailable at AMRTC	9%
Crisis home/crisis bed not available	8%
Chemical dependency treatment bed not available	7%
Waiting for a social service or government agency to identify an IRTS placement	6%

Hospital Bed Shortages

The most frequently cited reason for EDBPPD is a shortage of available hospital beds. The MHA-Wilder study reports that, of mental health PADs at hospitals without inpatient psychiatric units, 57% were due to unavailable mental health (psychiatric or chemical dependency) hospital beds at another hospital or at the Anoka Metro Regional Treatment Center (AMRTC) (MHA and Wilder Research, 2016, p. 2).

The MDH health Economics Program publishes annual data on the number of available psychiatric and chemical dependency hospital beds in Minnesota for both adult and pediatric patients (MDH, 2022). Hospitals are required to report these data under state law (MDH, 2022). Summary statistics from 2020, the most recent dataset, are provided in Table 6.

Table 6. Available psychiatric and chemical dependency hospital beds in Minnesota, 2020 (MDH, 2022)

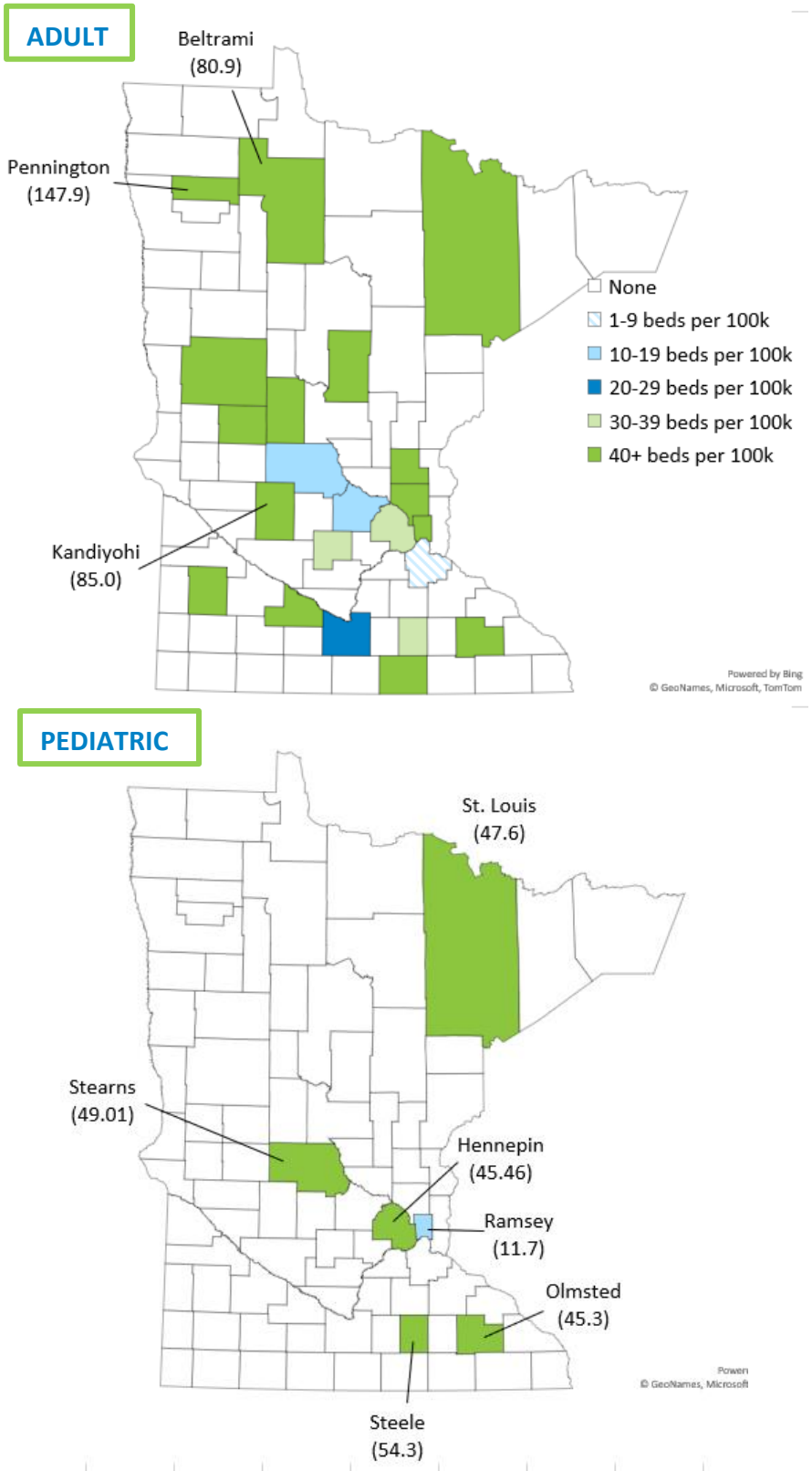
Hospital Bed Type	Count	Per 100K pop.	Add'l Beds to Meet Rec. (50 per 100K pop.)	% Increase to Meet Rec. (50 per 100K pop.)
Adult				
Psychiatric Beds	1,128	25.7	1,066	95%
Chemical Depdendency Beds	51	1.2	--	--
Pediatric				
Psychiatric Beds	183	13.9	476	260%
Chemical Dependency Beds	20	1.5	--	--
Total				
Psychiatric Beds	1,341	23.5	1,512	113%
Chemical Dependency Beds	71	1.2	--	--

The most commonly cited psychiatric bed target in the United States, 40-60 per 100,000 people, was published by the Treatment Advocacy Center (TAC) in 2008 (Treatment Advocacy Center, 2016). While the methodology used for discerning this range is subject to continued scrutiny, the Task Force emphasizes that, by any measure, Minnesota is lacking in psychiatric hospital beds. The fourth and fifth columns of Table 6 compare Minnesota hospital bed data against the center of the TAC recommended range, or 50 psychiatric beds per 100,000 population.

The maps provided in Figure 13 visualize the number of available adult and pediatric psychiatric hospital beds per capita by county in 2020. While there are 25.7 adult psychiatric hospital beds per 100K adults statewide, regional beds-per-capita vary. Only 6 of Minnesota's 87 counties have pediatric psychiatric beds. While there are 13.9 pediatric psychiatric hospital beds statewide, regional beds-per-capita vary.

It should be stressed that the MDH (2022) dataset and the ATC recommendation are by no means comprehensive measures of hospital bed availability. First, MDH (2022) data is from a point-in-time study that does not capture constant fluctuations in counts of available beds. Second, current MDH data collection does not distinguish geriatric psychiatric beds from adult ones. Third, not all beds are homogenous; a bed that may be appropriate for a patient with a given mental illness, illness acuity, and/or a co-occurring condition may not be appropriate for the next patient.

Figure 13. Number of psychiatric hospital beds per 100,00 residents by county, 2020 (MDH, 2022)



While there are 25.7 adult psychiatric hospital beds per 100K adults statewide, regional beds-per-capita vary.

Only 6 of Minnesota's 87 counties have pediatric psychiatric hospital beds.

While there are 13.9 pediatric psychiatric hospital beds per 100K children statewide, regional beds-per-capita vary.

Obstacles to Building More Hospital Beds

There exist both statutory and financial reasons as to why there are too few psychiatric and chemical dependency hospital beds per capita in Minnesota.

Statutorily, no licensed hospital beds can be built in Minnesota without approval from the state government. In 1984, the State passed a moratorium, or freeze, on the number of licensed hospital beds as a means to curb excessive hospital capacity and spending (Gildemeister, 2021, p. 5). In 2004, the State has eased the moratorium through what is known as a "Public Interest Review Process" (MDH, 2022, b.). This process involves the submission of a plan by a hospital, review of the plan by MDH to discern whether the new beds serve the public interest, and legislative approval of the plan. There is limited reason to suspect that new psychiatric and chemical dependency beds would induce demand or exacerbate excessive hospital spending. The MHA-Wilder study of 20 hospitals with inpatient psychiatric units reported that 94% of patients in psychiatric hospital beds met the criteria for admission (MHA and Wilder Research, 2016, p. 3). While the case can be made that most plans for new psychiatric and chemical dependency beds promote the public interest, the Public Interest Review Process is cumbersome, lengthy, and site-specific, without a "systematic consideration for how capacity aligns with inpatient needs and public policy goals" statewide (Gildemeister, 2021, p. 12).

In recognition of the need for psychiatric hospital beds, the State has adopted an exception to the hospital bed moratorium, through July 31, 2027, for any hospital that increases its beds for mental health services and meets several other criteria, including, but not limited to, the acceptance of Medical Assistance and MinnesotaCare and arrangement with a tertiary care facility to treat physical medical conditions (Minnesota Statutes Chapter 144.551 Subdiv. 1a, 2022).

Financially, even if a hospital can weather a Public Interest Review Process, there is little incentive to invest in psychiatric and chemical dependency beds compared to other types of beds. Cognitive services (e.g., mental health evaluation/management, assessment, and psychotherapy) are not as profitable as other medical services, especially those in certain procedure-heavy specialties (e.g., orthopedic, neurological, and oncological services). Additionally, patients who need psychiatric and chemical dependency beds, especially those with severe mental illness, are disproportionately uninsured or insured by public plans (e.g., Medical Assistance, MinnesotaCare), which pay hospitals less compared to private plans (Reisinger Walker et al., 2015).

The financial disincentives for operating psychiatric and chemical dependency beds contribute to a phenomenon known as "bed banking," wherein hospitals operate fewer beds than the number for which they have licenses. According to the Minnesota Department of Health, in 2020, only 70% of licensed hospital beds were in operation and available (MDH, 2022). Hospital systems with banked beds can bring beds online, for any specialty, at any time, without a Public Interest Review Process. Reasons for bed banking vary but include workforce capacity.

Obstacles to Hospital Bed Throughput

The availability of psychiatric and chemical dependency hospital beds is not just a matter of the number of hospital beds in operation, but the speed with which patients are discharged from said hospital beds. Fortunately, we have useful data for identifying the sticking points of psychiatric hospital bed throughput in Minnesota. In 2019, the Minnesota Hospital Association and the Wilder Foundation published a study of 22 hospitals which reported reasons for potentially avoidable days (PADs), or "reasons for days in inpatient mental health hospital care when a patient is stabilized and ready to be discharged but is unable to be discharged" (MHA and Wilder Research, 2016, p. 2). Of the participating hospitals, 20 reported reasons for PADs in their psychiatric units. The top eight reasons, together comprising 69% of PADs, are provided in Table 3.

It is beyond the scope of this report to examine the issue of hospital bed throughput further. However, note that 32% of PADs were attributed to unavailable psychiatric and chemical dependency hospital beds elsewhere. Moreover, several obstacles to hospital bed throughput are also obstacles to ED throughput (compare Tables 5 and 7).

Table 7. Reasons for potentially avoidable days for hospitals with inpatient psychiatric units (MHA and Wilder Research, 2016)

Reason	% of PADs
State psychiatric hospital bed unavailable at a Community Behavioral Health Hospital (CBHH)	14%
Chemical dependency treatment bed not available	11%
Intensive Residential Treatment Services (IRTS) bed not available	10%
Delay due to patient legal involvement, including civil commitment	8%
State psychiatric hospital bed unavailable at Anoka Metro Regional Treatment Center (AMRTC)	7%
Group home bed not available	7%
Awaiting Community Access for Disability Inclusion (CADI) Waiver approval	6%
Waiting for a social service or government agency to identify an IRTS placement	6%

Criminal History as a Barrier to Residential Treatment Center Admission

The MHA-Wilder study reports that 23% of mental health PADs at hospitals without inpatient psychiatric units were attributed to delays due to "patient legal involvement, including civil commitment," with a particular emphasis on the "difficulty of placing patients in community-based settings because of criminal histories" (MHA and Wilder Research, 2016, p.6). Community-based settings here mean inpatient facilities that serve patients with psychiatric

diagnoses who do not need hospital-level care but are too unwell for discharge and outpatient treatment.

All residential treatment centers have a responsibility to ensure the safety of their residents. To that end, many of these facilities preclude admission of prospective residents with violent criminal histories. To be clear, this practice is based on facilities' inability to provide the security and services necessary for patients with a history of violence. When a significant proportion of boarded patients with psychiatric diagnoses have violent criminal histories and need residential treatment, but are barred by residential treatment centers, it contributes to EDBPPD incidence and duration. The Task Force recognizes the significance of this outflow factor but is not in a position to make a normative statement about the trade-off between resident safety and access to residential treatment for people with criminal histories.

Residential Treatment Bed Shortages

Psychiatric Residential Treatment Shortage

The MHA-Wilder study reports that 8% of mental health PADs at hospitals without inpatient psychiatric units were attributed to an unavailability of psychiatric residential treatment beds (MHA and Wilder Research, 2016, p.2). An additional 6% of PADs were attributed to waiting for a county to identify one type of residential treatment bed, Intensive Residential Treatment Services (IRTS) (Ibid, p. 2).

In Minnesota, there are two types of residential treatment beds for adults with mental illness. Residential Crisis Stabilization (RCS) services are "intended for very short-term crisis stabilization of up to 10 days" (MDH, 2019). Intensive Residential Treatment Services (IRTS) "provides stays usually less than 90 days, allowing individuals time to develop skills needed for successful transition to outpatient services and supports in their home communities" (Ibid). As of March 2022, there are a total of 828 licensed residential treatment beds for adults with mental illness in Minnesota, or 18.9 per 100,000 population (MN Dept. of Human Services, 2022).

There are also two types of residential treatment beds for children with mental illness. Children's Residential Facilities (CRFs) are 24/7 programs wherein "care and treatment are designed to help the child improve family living and social interaction skills and/or gain skills to return to the community" (MN Dept of Human Services, 2016). Psychiatric Residential Treatment Facilities (PRTFs) "provide inpatient treatment, such as therapeutic services and discharge planning to children and youth under age 21 with complex mental health conditions in a residential facility rather than a hospital" (Ibid). PRTFs are required to have nurses on staff 24/7 (MN DHS, 2018, p. 11, p. 20). As of March 2022, there are a total of 682 licensed residential treatment beds for children in Minnesota, or 26.5 per 100,000 population (MNDHS, 2022). It is common for private health plans to refuse coverage for PRTFs.

It is worth noting that not all mental health treatment beds can accommodate high-acuity, behaviorally complex patients, whose care may require additional security measures and staff with specialized training. At present, none of these facilities are locked. However, in 2022, the Minnesota Legislature appropriated roughly $3.1 million dollars for the creation of locked IRTS

facilities across fiscal years 2023 and 2024 (MN Session Laws Chapter 99, Article 3, Section 7). Locked IRTS facilities will be reserved for "patients who have been transferred from a jail or who have been deemed incompetent to stand trial and a judge has determined that the patient needs to be in a secure facility" (Ibid).

The Minnesota Department of Human Services (MNDHS) publishes real-time data on the number of actively licensed residential mental health treatment beds in Minnesota for both adult and pediatric patients. Summary statistics from March of 2022 are provided in Table 8.

Table 8. Licensed residential treatment beds for mental illness in MN (MNDHS, 2021)

Residential Treatment Type	Bed Count	Per 100K pop.
Adult	**828**	**18.9**
Residential Crisis Stabilization (RCS)	201	4.6
Intensive Residential Treatment Services (IRTS)	627	14.3
Pediatric	**682**	**51.7**
Children's Residential Facilities - Mental Health Treatment	594	45.1
Psychiatric Residential Treatment Facilities (PRTF)	88	6.7
Total	**1,510**	**26.5**

Chemical Dependency Residential Treatment Shortage

The MHA (2016) study reports that 7% of mental health PADs at hospitals without inpatient psychiatric units were attributed to an unavailability of chemical dependency residential treatment beds.

In Minnesota, there are three types of residential treatment beds for people with chemical dependency. Detox Services are "sub-acute medical [facilities] that safely monitor persons admitted under the influence of alcohol and/or drugs or assist clients through a safe withdrawal" (Central Minnesota Mental Health Center, 2021). Some Substance Use Disorder Treatment facilities offer residential services and "provide treatment services to assist and support a person's efforts to recover from a substance use disorder" (MNDHS, 2022). Finally, some Children's Residential Facilities specialize in chemical dependency treatment.

MNDHS publishes real-time data on the number of actively licensed residential chemical dependency treatment beds in Minnesota for both adult and pediatric patients. Summary statistics from March of 2022 are provided in Table 9.

Table 9. Licensed residential treatment beds for chemical dependency in MN (MNDHS,

Residential Treatment Type	Bed Count	Per 100K pop.
Detox Services	**317**	**6.3**
Serves Adults Only	135	3.1
Serves Adults and Teens	182	3.2
Substance Use Disorder Treatment - Residential	**3,742**	**84.4**
Serves Adults Only	3,575	81.5
Serves Adults and Teens (16+), Specializes in Teens	167	2.9
Children's Residential Facilities - Chemical Dependency	254	19.3
Total	**4,059**	**71.1**

Other Outflow Factors

Inability of Corporate Foster Care to Welcome Patients Back

Members of this Task Force have frequently heard or experienced an issue wherein ED patients with psychiatric diagnoses board because the corporate foster care facility from which they came refuses to welcome the patient back. Corporate foster care is a licensed residential setting that serves adults or children in foster care and where the license holder does not reside (MNDHS, 2020). These facilities often use a shift-staff mode of support.

Recommendations

As made evident in this report, the problem of ED boarding of patients with psychiatric diagnoses (EDBPPD) is complex and requires a multitude of interventions from various stakeholders. The Task Force makes the following recommendations as to how the MMA and MNACEP might alleviate the EDBPPD problem in Minnesota. Recommendations noted with an asterisk (*) are those which the Task Force identifies as an action which the MMA and MNACEP, as medical associations, are uniquely positioned to leverage best.

1) Recommendations Spanning the ED Boarding Continuum

*1.A. Publicize and Circulate this Report to Inform and Empower Leaders**

We believe that the complexity of the ED boarding problem makes it difficult for leaders in government and healthcare to understand and act on the problem. There are upstream, immediate, and downstream factors that worsen ED demand for crisis care, quality of care for boarded patients, and access to beds when patients are ready for disposition, respectively. Moreover, certain beds can only accommodate certain patients. These compounding complexities are difficult to piece together clearly and can quickly overwhelm leaders into inaction.

We recommend that the MMA and MNACEP publicize and circulate this report to inform and empower leaders in government and healthcare. We recommend that this full report be published online via a publicly accessible link, and that the MMA and MNACEP actively share the link with a strategic list of stakeholder organizations. Additionally, we recommend that MMA and MNACEP consider the creation of smaller, more succinct deliverables as needed (e.g., “Figure 6. Conceptual model…”, one-pagers, etc.)

*1.B. Support the Creation of a Minnesota ED Boarding Database**

It is our conclusion that current data do not describe the ED boarding (EDB) problem well enough for us to act strategically. The insufficiencies of current data, listed below, should be corrected for through the creation of a Minnesota ED Boarding database.

First, current data on EDBPPD incidence and duration are not standardized enough for meaningful analysis. As stated by Nolan et al. (2015), "the US lacks a standard [case] definition for ED boarding" and "emergency departments have differing practices, administrative systems, and documentation processes" (p. 58). When individual EDs are burdened with adopting their own case definitions of ED boarding and favor definitions which are compatible with site-specific practices, any estimates reported by one ED are incompatible with estimates reported by other EDs. Such is the case with the voluntarily reported, system-level estimates from ICSI (2019). We need Minnesota EDs to adopt a standardized case definition of ED boarding to ensure that the data we are acting on is accurate.

Second, current data on EDBPPD incidence and duration are not granular enough for strategic resource allocation. National estimates from Nolan et al. (2015) and system-level estimates from ICSI (2019) conceal the distribution of ED boarding burden across specific types of patients and EDs. The EDBPPD crisis is not one homogenous problem solvable with one silver bullet. It is an amalgam of component problems tied to specific patient and ED characteristics. We need to know which types of patients and EDs experience the highest burden of EDBPPD to strategize which solutions to prioritize. Our report highlights patient variables (e.g., ZIP code of residence; insurance status; previous psychiatric evaluation, psychotherapy utilization, and psychiatric medication adherence; method of ED arrival; type of facility or bed requested; foster care status, etc.) and ED variables (e.g., ZIP code of ED; ED-dedicated psychiatric specialist availability; dedicated space for patients in psychosis, etc.) of particular importance.

Third, current data on EDBPPD incidence and duration are insufficient in describing patient experience and quality of care while boarding. It is our goal not only to reduce EDBPPD incidence and duration, but to also improve the care and experience of patients who board. We need data on EDBPPD quality metrics (e.g., whether, and how quickly, the patient received psychiatric care in the ED; whether the patient was in a hallway, a separate space for patients experiencing psychosis, or an EmPATH unit, etc.) to indicate which types of patients and EDs are experiencing the worst boarding quality.

Finally, current data is not collected frequently enough to monitor the problem or to evaluate solutions. In the absence of a centralized data collection system with regular reporting periods, the only ED boarding data we obtain is from ad hoc analyses by academics, like Nolan et al. (2015), or by non-profits, like ICSI (2019). We need regularly reported ED boarding data to monitor the problem and evaluate the efficacy of proposed solutions.

We recommend that the MMA and MNACEP prioritize the creation of a Minnesota EDBPPD database that can correct for these data limitations and empower stakeholders to be more strategic and impactful in tackling the EDBPPD crisis.

*1.C. Collaborate to Improve the Usefulness of Mental Healthcare Search Tools in Minnesota**

Access to outpatient and inpatient mental healthcare is limited by the awareness of available services among the public and mental healthcare workers. In Minnesota, there are several mental healthcare search tools. "FastTracker MN," run by the Minnesota Psychiatric Society, the Minnesota Department of Human Services, and the Minnesota Mental Health Community Foundation, is a publicly accessible search tool which shows the availability of an array of inpatient and outpatient mental healthcare services (FastTracker MN, 2022). The Minnesota Department of Human Services' (MN DHS) "Licensing Lookup" is a publicly accessible search tool which shows the license type, bed count, and care accommodations of residential treatment facilities (MN DHS, 2022). "Bed Tracker," run by the Minnesota Department of Health and the Minnesota Hospital Association, is a search tool only accessible by mental healthcare workers and shows the availability of an array of inpatient mental healthcare services (e.g., hospital beds, residential treatment beds) (Minnesota Hospital Association, 2022).

While these tools hold great promise in improving access to mental healthcare, this Task Force has heard from multiple stakeholders that these search tools are not always user-friendly, provide data that is untimely (i.e., the data on available beds is often stale and inaccurate), and/or provide data that is not relevant (i.e., there is not enough information on the specific bed type—pediatric vs. adult, chemical dependency vs. psychiatric, capacity to serve behaviorally complex patients, capacity to serve patients with developmental disabilities or physical comorbidities; etc.).

We recommend that the MMA and MNACEP collaborate with the appropriate stakeholders to improve the usefulness of mental healthcare search tools in Minnesota.

1.D. Strategize to Improve the Size, Distribution, and Diversity of the Mental Healthcare Workforce in Minnesota

The availability, accessibility, and acceptability of mental health services are constrained by the size, distribution, and the diversity of the mental healthcare workforce at every stage of the ED boarding continuum (i.e., outpatient/preventative care, emergency care, and hospital/residential bed care). We need enough workers to meet demand, we need them distributed equitably across the state, and we need them to reflect the diversity of communities they serve.

For these reasons, it is our recommendation that the MMA and MNACEP strategize to improve the size, distribution, and diversity of Minnesota's mental healthcare workforce. While we acknowledge and applaud efforts currently underway to improve the size, distribution, and

diversity of the general healthcare workforce, we encourage the MMA and MNACEP to strategize a distinct campaign to address barriers unique to improving the *mental healthcare* workforce in Minnesota. We encourage the MMA and MNACEP to collaborate with efforts already underway by statewide task forces and committees.

*1.E. Protect and Expand the Use of Telehealth for Mental Health Services**

The use of telehealth can improve access to timely and appropriate mental health services across the ED boarding continuum (i.e., outpatient/preventative care, emergency care, and hospital/residential bed care) in several ways. First, telehealth can increase the availability of mental healthcare workers (MHWs) by expanding their geographic reach. Second, telehealth can increase the accessibility of MHWs by removing transportation barriers for workers and patients. Third, telehealth can increase the acceptability of mental health services by allowing patients to receive care in the privacy of their own home, as opposed to conspicuous clinics with non-confidential waiting rooms.

We recommend that the MMA and MNACEP work to protect and expand the use of telehealth for mental health services by advocating for parity in healthcare worker payment, and patient cost-sharing, between services provided in-person and identical services provided remotely. We urge that parity be extended to audio-only services, which may serve to increase access for patients with technological limitations or domestic violence concerns. We limit these recommendations to those mental health services which are appropriate for the use of telehealth with respect to concerns of quality and patient outcomes (i.e., as to not supplant, nor deter, use of in-person mental health services when needed).

2) Recommendations for Inflow Factors

2.A. Support the Financial Sustainability of 988 Call Centers in Minnesota

The 988 mental health crisis hotline will continue to be a crucial tool for connecting people experiencing mental health crises with appropriate resources, emergency response, and/or medical treatment. Through 988-prompted resources (e.g., 24/7 hotlines and mobile crisis teams), many people experiencing mental health crises will get the help they need without visiting an ED and thus avoid the risk of boarding.

We recommend that the MMA and MNACEP take action to support the long-term financial stability of 988 call centers in Minnesota. This may include, but is not limited to, supporting state legislation that would allow the state to collect a telecommunication fee from phone service subscribers to support costs associated with 988 operations. As of November 2022, 4 states (CO, NV, VA, and WA) have imposed such fees (National Academy for State Health Policy, 2022).

2.B. Explore Emergency Transport Diversion to EDs in Hospitals with Patient-Appropriate Inpatient Mental Health Beds

Most emergency transport will drive a person experiencing a mental health crisis to the nearest available ED, regardless of whether that ED is adjacent to an inpatient psychiatric unit suitable for that patient's needs (e.g., age-appropriate, condition-appropriate, security-appropriate). Depending on the acuity of the mental health crisis, the patient may have been better off being driven to an ED that was further away but had an adjacent inpatient unit suited for their needs. Strategic emergency transport diversions may reduce EDBPPD incidence and improve continuity of care for patients experiencing mental health crises.

We recommend that the MMA and MNACEP explore the legal, political, and practical feasibility of strategic emergency transport diversion of patients in mental health crises to EDs in hospitals with patient-appropriate inpatient beds.

*2.C. Leverage Healthcare Workers and Facilities to Educate the Public About Mental Health Resources**

Access to mental health resources is limited by the awareness of said resources among the public. People who are unaware of their insurance coverage for mental health services, or of FastTracker, Minnesota's search engine for local, in-network mental health service availability, may be less likely to get connected to preventative mental health services. People who are unaware of mental health crisis resources (e.g., crisis hotlines, 988, mobile crisis teams, local urgent cares and EDs) may experience a worse care journey if a mental health crisis arises. Additionally, a lack of public awareness as to when to seek outpatient care at clinics, moderate-acuity care at urgent cares, or high-acuity care at EDs may also worsen care journeys for individuals and their neighbors. These resources can reduce EDBPPD incidence, but only if the public is made aware of them.

We recommend that the MMA and MNACEP support campaigns to educate the public about the aforementioned mental health resources. Given our roles as physician associations, we encourage campaign strategies that leverage healthcare workers and facilities as disseminators of information. For example, one strategy may involve the education of primary care providers, who would then disseminate information to their patients orally, through posted literature, and/or through distributable literature. Another strategy may involve educating patients as they leave EDs after experiencing mental health crises. This latter strategy may serve to reduce repeated, inappropriate use of EDs among patients with lower-acuity mental health needs.

*2.D. Support Legislation to Require Minnesota Health Plans to Reimburse for Collaborative Care Model Services**

The lack of integration between preventative physical and mental health services hinders the ability of primary care providers (PCPs) to connect patients to appropriate mental health services. Typically, if a PCP finds that their patient screens positive for depression or anxiety,

the PCP can either attempt treatment on their own or refer the patient elsewhere. To ensure optimal care, it is common for the PCP to refer the patient to a specialist. This referral process can be time-consuming. Additionally, even if a referral is secured, the patient may not be accepting of the additional appointment due to time, duration, location, and/or conspicuous nature of the clinic as providing mental health services (i.e., the patient is fearful of stigma).

An alternative approach, called the Collaborative Care Model (CoCM), significantly improves the ability of primary care clinics to ensure that patients receive timely mental health services (AIMS Center, 2022). CoCM is a team-based model of care in which PCPs can call on an on-site behavioral health care manager (BHCM) to further assess and treat a patient who screens positive for depression or anxiety. The BHCM has remote access to a psychiatric consultant, who provides expertise and offers extra support if needed. An electronic registry, through which the BHCM and the psychiatric consultant monitor patient care, is central to CoCM. Despite the strong evidence basis of CoCM, many public and private plans in Minnesota do not reimburse for CoCM billing codes.

We recommend that the MMA and MNACEP support legislation to require Minnesota health plans to reimburse for CoCM services. We encourage collaboration with the Minnesota Psychiatric Society, which has indicated this legislation as a recent priority.

3) Recommendations for Stalling Factors

3.A. Support the Development and Evaluation of Alternative Emergency Facilities for Patients with Psychiatric Diagnoses Who Await Disposition

People experiencing mental health crises deserve access to emergency facilities that offer quality care experiences and treatment outcomes. Unfortunately, standard EDs may not be the best means toward those ends. Standard EDs are often filled with busy, noisy, and bright stimuli which may agitate patients who are experiencing mental health crises. Moreover, standard EDs are often ill-staffed to provide patients with mental healthcare treatment while they await disposition.

Alternative emergency facilities, distinctly designed to calm and treat patients in mental health crises as they await disposition, can improve care experience and quality. These alternative emergency facilities can range in complexity, from retrofitted rooms or extensions in standard EDs, to the creation of designated psychiatric EDs or EmPATH units.

We recommend that the MMA and MNACEP support the development and evaluation of alternative emergency facilities, strictly adjacent to hospitals, for patients with psychiatric diagnoses who await disposition. The Task Force emphasizes the need to support and evaluate a variety of alternative emergency facilities, ranging in cost and complexity, to provide communities and systems fiscally reasonable alternatives (i.e., not just costlier EmPATH units or designated psychiatric EDs, but also ways to retrofit existing ED spaces).

*3.B. Advocate for an Increase in ED-Designated Mental Healthcare Workers**

We have heard from many emergency physicians that, due to inadequate staffing, it is common for patients with psychiatric diagnoses to not receive any, or sufficient, mental healthcare treatment while boarding in the ED. Delayed mental healthcare treatment can lead to poorer care experiences and treatment outcomes for patients who board.

We recommend that the MMA and MNACEP identify strategies to increase the number of ED-designated mental healthcare workers in Minnesota, including, but not limited to, ED-assigned psychiatrists, mental health practitioners, mental health professionals, and peer support specialists.

4) Recommendations for Outflow Factors

4.A. Advocate for More Inpatient Mental Health Hospital Beds in Minnesota

The number, regional distribution, and bed type distribution (e.g., adult vs. pediatric, psychiatric vs. chemical dependency, capacity to serve high acuity/behaviorally complex patients securely, capacity to serve patients with developmental disabilities, etc.) of inpatient mental health hospital beds in Minnesota continues to fall short of the leading national recommendation. This shortage continues to serve as a primary driver of ED boarding by clogging ED throughput of patients experiencing mental health crises.

We recommend that the MMA and MNACEP advocate for a supply of inpatient mental health hospital beds to better accommodate the needs of Minnesotans. The Task Force urges that new hospital beds should be distributed equitably across bed types and geographic regions.

4.B. Advocate for More Residential Treatment Beds in Minnesota

The Task Force has heard from multiple stakeholders that the number, regional distribution, and bed type distribution (e.g., adult vs. pediatric, psychiatric vs. chemical dependency, capacity to serve high acuity/behaviorally complex patients securely, capacity to serve patients with developmental disabilities, etc.) of mental health residential treatment beds in Minnesota are inadequate. This shortage continues to serve as a primary driver of ED boarding by clogging ED and hospital bed throughput of patients experiencing mental health crises.

We recommend that the MMA and MNACEP advocate for a supply of mental health residential treatment beds that better accommodates the needs of Minnesotans. The Task Force urges that new residential treatment beds should be distributed equitably across bed types and geographic regions.

4.C. Monitor and Engage in the Development of Locked IRTS Facilities in Minnesota

The ability of Intensive Residential Treatment Services (IRTS) facilities to take behaviorally complex patients with psychiatric diagnoses is limited by the facilities' security measures and

specialized staffing. When IRTS facilities can't welcome behaviorally complex patients ready for discharge, said patients wait longer in EDs and hospital beds, which clogs throughput. The Minnesota Legislature recently acknowledged this problem by appropriating $3.1 million dollars for the creation of locked IRTS facilities across fiscal years 2023 and 2024 (MN Session Laws Chapter 99, Article 3, Section 7).

We recommend that the MMA and MNACEP monitor, and support the development of, locked IRTS facilities in Minnesota. It is crucial that these locked facilities be brought online as quickly as possible and in a way that is equitably distributed.

*4.D. Support Legislation to Require Minnesota Health Plans to Cover PRTF and IRTS Services**

Access to residential treatment services is limited by the affordability of said services under various Minnesota health plans. When residential treatment services are not covered, or not covered adequately, by Minnesota health plans, it can stall the discharge of patients with mental health diagnoses in EDs and in hospitals.

We recommend that the MMA and MNACEP support state legislation to require all health plans in Minnesota to offer meaningful coverage for Psychiatric Residential Treatment Facilities (PRTFs) for children and Intensive Residential Treatment Services (IRTS) for adults.

4.E. Collaborate to Reduce the Burdens of Corporate Foster Care on ED Boarding

The Task Force has heard from multiple stakeholders that the practices of some corporate foster care facilities, or licensed residential settings that serve adults or children in foster care and where the license holder does not reside, exacerbate the EDBPPD problem. One such practice is the use of emergency departments as respite care for corporate foster care staff. Another such practice is the inability of corporate foster care to welcome patients back upon discharge.

We recommend that the MMA and MNACEP collaborate with the appropriate stakeholders to reduce corporate foster care's contributions to the ED boarding problem while still ensuring access to appropriate care for residents of corporate foster care.

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