Partnering Across Agencies: Systems of Care

Purpose of Presentation

- Acute Care Barriers to Transition in Minnesota
- How Systems of Care can Help
- Wraparound and Person-centered Practices
- Integrating SoC at Regional and Statewide Levels

Challenging Behavior

- We acknowledge that the term can be used place the blame for behavior on others (ASAN, 2024)
- We all engage in challenging behaviors that:
  - Interfere with quality of life
  - Can result in injury to self or others
- Avoiding using the word “behavior” makes it more difficult to find solutions
- We agree with ASAN that when talking about an individual avoiding generic terms by describing the specific behavior discussed is recommended

Why are Some Children & Adults Experiencing Barriers to Transition?

Acute Behavioral Needs

Defined: Behavioral needs that resulted in acute care

Elevated risk of:

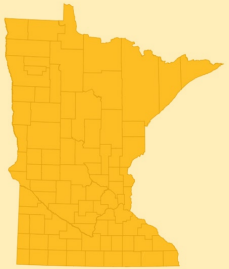
- Readmission,
- Persistence of challenging behavior over time,
- Worsened quality of life for self and family.

Allen, 2008; Cushing et al., 2022; Flood, 2009; Hawton & Harris, 2008

Barriers to Accessing Behavioral Support

Provider Shortages

- Crisis Level
- High turnover (training needs)
- Limited supervisory/licensed providers, thus, limited service areas



Providers and systems that do not adequately meet the needs of people in cultural, racial, linguistically diverse communities

Insufficient community services for people with needs that are deemed too “intensive,” including “stepped down” supports.

How many children were boarded at different Minnesota hospitals in 2023?

Total number of children who were boarded in hospitals in the Twin Cities and length of longest stay, by hospital.

Hospital	# of children boarded	Longest stay (days)
Allina Health	790	138
Children's Minnesota	254	123
M Health Fairview	164	81
HCMC	78	72

Note: Sahan Journal reached out to five health-care systems in the Twin Cities; four responded with data. HCMC stands for Hennepin County Medical Center.

Table: Cynthia Tu, Sahan Journal • Source: Reporting by Sahan Journal • Get the data • Created with Datawrapper

HEALTH

Why are kids of color in Minnesota spending days, weeks, and months in hospital emergency rooms that can't treat their problems?

Children with autism and mental illness find themselves "boarded"–even though doctors, families, and caregivers know it doesn't help. As one hospital service director says, "We are truly harming these children, and this is not OK."

by **Sheila Mulrooney Eldred** February 5, 2024

sahanjournal

https://sahanjournal.com/health/minnesota-autism-mental-illness-hospital-boarding/

Transitioning from Hospital Settings

Communication across services can break down…..

“Come to find out she’d left the _____ (out of home placement) six weeks ago. She’s been in our community for six weeks with absolutely no mental health support... [focus group participant].”

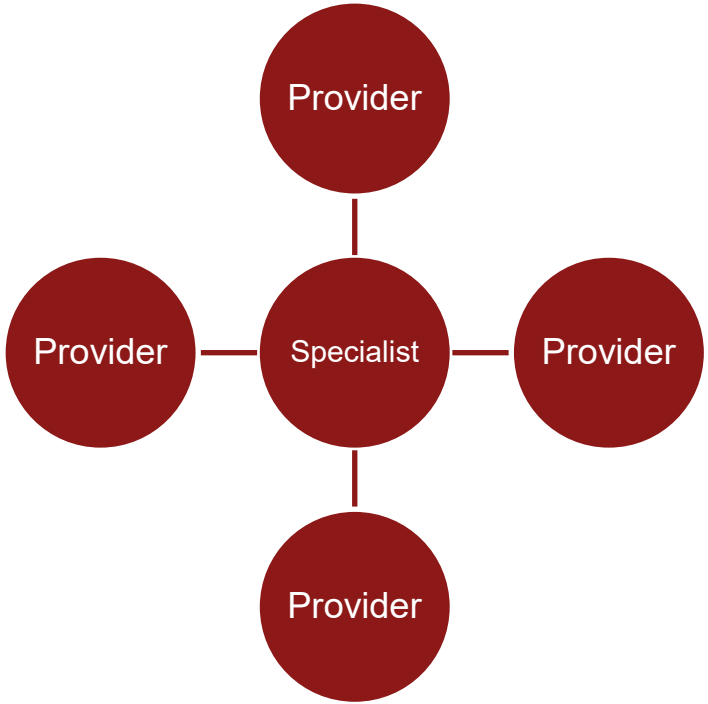
-Matthews et al., 2018

“...Sometimes, you know, we’ll get a heads-up that somebody’s coming home from the contractor, and sometimes we won’t.” –*[focus group participant]*.

-Matthews et al., 2018

Meeting Children's Mental and Behavioral Health Needs in Rural Areas: When, How, and Where

- Care navigation across multiple systems and services
- Increasing pipeline of providers
- 'Hub and Spoke' models to increase generalist provider capacity
- Integration of services into primary care and other systems
- Telehealth, remote, and virtual care options



Richards, M. C., Benson, N. M., Kozloff, N., & Franklin, M. S. (2024). Remodeling broken systems: addressing the national emergency in child and adolescent mental health. *Psychiatric Services*, *75*, 291-293.

Acute Care Transitions Advisory Council (Report by October, 2024)

Acute Care Transitions Council Recommendations

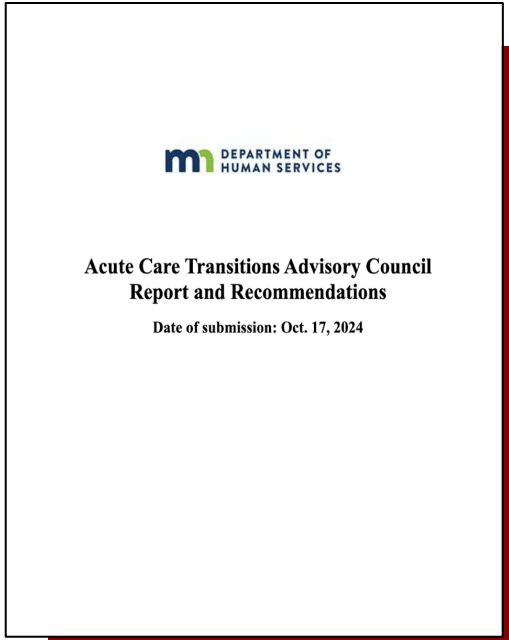
1. **Establish an ongoing council** to assist in long-term planning

2. **Expand regional capacity** for existing care navigation

3. Establish a **statewide infrastructure to improve communication systems**, provide coordination and support to regions, and monitor the development of **a unified measurement system**.

4. Integrate measurement systems to **monitor and evaluate geographic, racial, and ethnic disparities** and **coordinate with existing statewide health equity systems** on change efforts in Minnesota.

5. Begin long-term planning and **initiate short-term changes in administrative policy to improve transitions** for children and adults across the lifespan



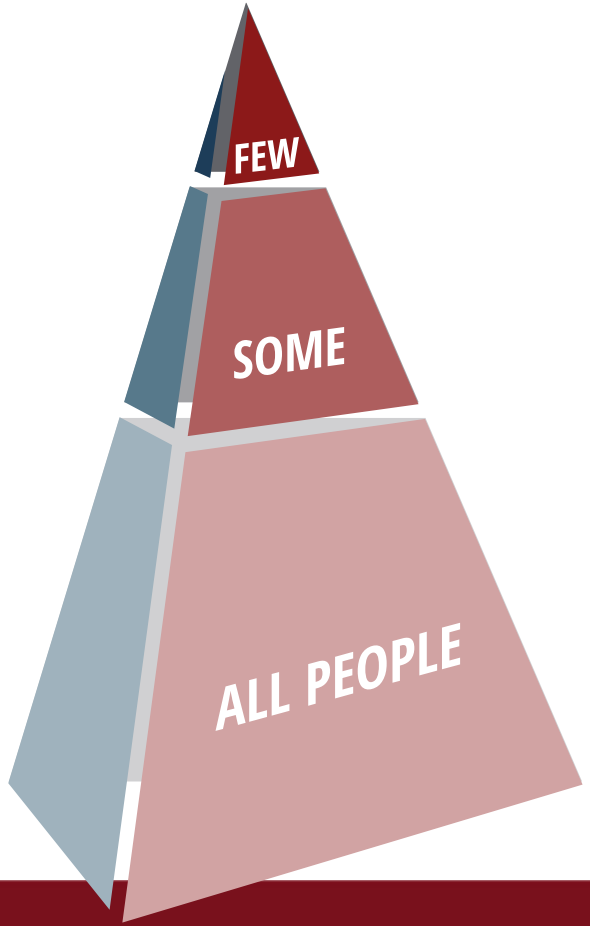
International Systematic Review of Discharge Delays from ED or Hospitals

"***Failing to invest in interventions that would build effective, well-paid community services for people with more complex needs has led to 'moving' the problem to hospital settings.***" **(Cadel et al., 2021).**

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

How Three-Tiered PBS Systems of Care can Help

Using Positive Behavior Support to Drive Change



Tier 3 - Individual Plan with Multiple Supports

Tier 2 – Group or Simple Problem Solving

Tier 1 – Home, Work, Community

Using Systems of Care to Address Challenges Addressing Transitions From Hospital Settings

Defining Systems of Care

“A coordinated effort to organize services and supports into a coordinated network that builds meaningful partnerships with people, their families and allies, and addresses their cultural and linguistic needs, in order to help them to achieve their dreams and goals at home, in school, in the community, and throughout life.”

Key Elements of Systems of Care

- State, regional, and local services create plans to improve communication & coordinate services more effectively
- Organizations and state systems leverage limited funds
- Decrease challenges associated with fragmentation and duplication of services
- People with lived experience with acute challenges, their families, allies and/or caregivers are full partners
- Accountability to people is demonstrated using data for monitoring, improving, and problem solving
- Use strengths-based wraparound planning/person-centered planning to improve social and emotional wellness

More details at Georgetown University Center for Child and Human Development

Serving children, youth, and adults via a continuum of care

Esler, A. (2022)

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

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

Adults and examples of services and systems

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

Adults with Mental Illness and Behavioral Health Episodes

Adults with Substance Abuse Disorder

Adults with Complex Health Issues

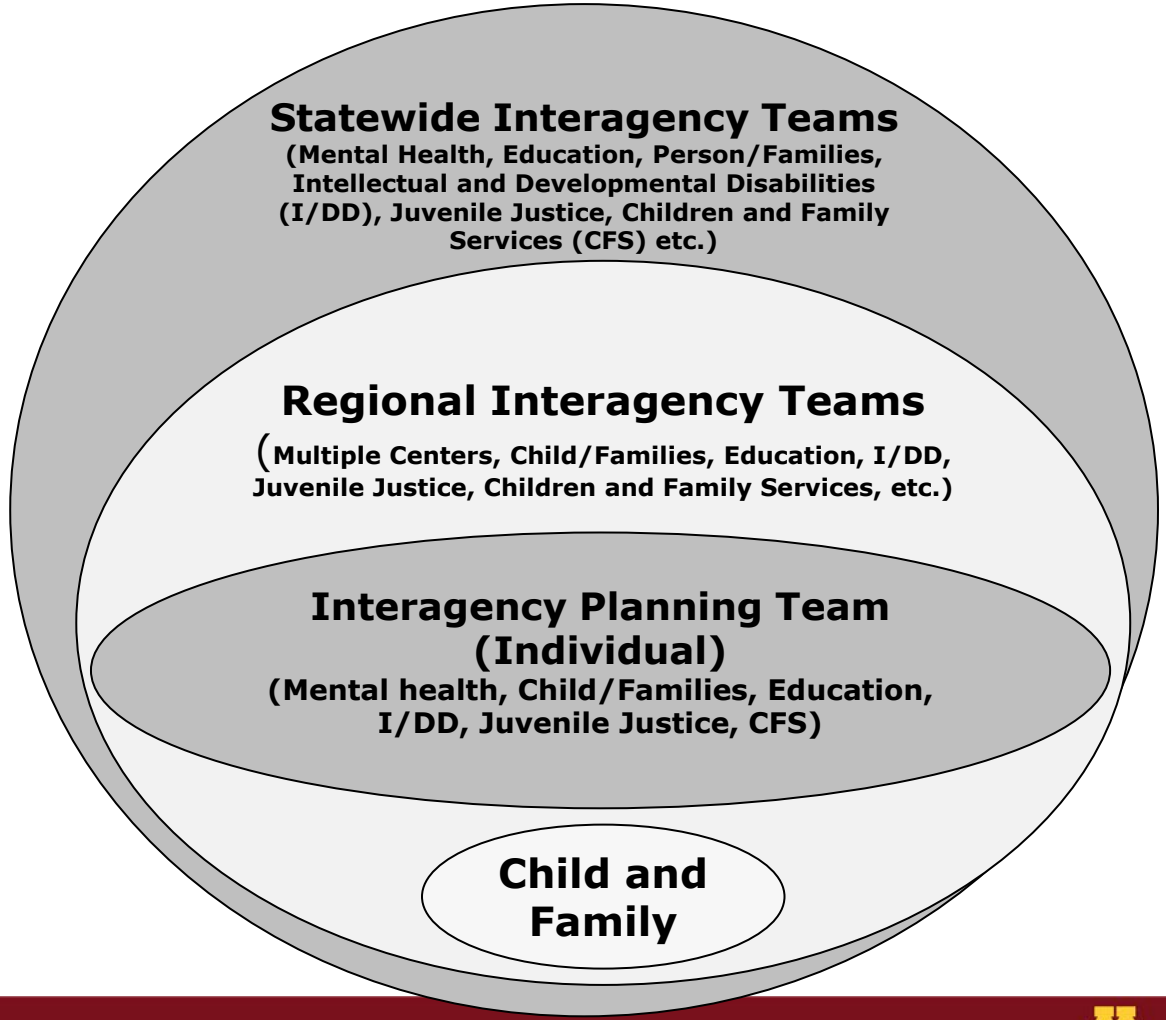
Adults Experiencing Systemic Barriers

Adults with Co-morbid Disorders & Multiple Challenges

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

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

Improving Transition Planning Using Systems of Care



Strategies for Improving Interagency Team Meetings

- Clarify roles and responsibilities of each person
- Spend time as a team understanding each service involved
- Work on establishing a common language
- Consider a glossary or simple list of acronyms and terms
- Make a list of the key steps needed for the transition
- Create an agreement that notification of submission to or from the hospital is immediately communicated with all key partners
- Write memorandums of agreement when communication barriers are encountered
- Adapt the way in which meetings are held when a person does not like meeting in large groups

Minnesota Systems of Care

Minnesota Systems of Care

Wraparound

Collaborative Intensive Bridging Services

Systems of Care in Hennepin County

Why are Some Children & Adults Experiencing Barriers to Transition?

Addressing The Challenges: Wraparound Planning

- **Community partnership**: Working together across partners
- **Collaborative action:** Create a unified plan
- **Planning for sustainability:** Develop long-term supports for a person
- **Access to supports and services:** Community works together to make sure people can access supports
- **Training and assistance:** Coaching and mentoring is provided
- **Accountability:** Wraparound plans are assessed and outcomes are measured

Phases & Activities of the Wraparound Process

1. Engagement and Team Preparation
2. Initial Plan Development
3. Implementation
4. Transition to Natural Supports

-National Wraparound Initiative

Person-Centered Planning

- Person leads their own meeting
- Team-based action planning
- Create plan for achieving a positive and meaningful life
- Help the person connect with their community
- Build a circle of support
- Balancing What is Important to and For a Person

Person-Centered Planning Models

- MAPs
- Personal Profiling
- Futures Planning
- PATH (Planning Alternative Tomorrows with Hope)
- Essential Lifestyle Planning
- Florida's Integrated Process

Learn More About Person-Centered Plans

Similarities and Strengths of Each Approach

Wraparound Key Features

- Team-based planning
- Focusing on the child or adult strengths & those close to them
- Action planning to improve social and emotional strengths and quality of life
- Coordinating services
- Connecting to natural supports
- Respecting the cultural values, beliefs, and preferences

Person-Centered Planning Key Features

- Team-based planning
- Build on strengths and talents
- Connect with the community
- Create meaningful relationships
- Treat everyone with dignity and respect
- Use active listening strategies
- Encourage empathy
- Seek to understand each person

Integrating Strengths of Planning Processes

Planning processes for building on strengths and improving lives should always be tailored…..

- **Wraparound includes service coordination focus**
  - tools for improving communication
  - Measurement strategies for tracking strengths
- **Person-centered methods don't rely on verbal and written words**
  - Drawing pictures
  - Images from the internet
- **Both methods encourage community natural supports and mapping**

Adapting Positive Supports to Each Cultural Context

Culturally responsive transition planning involves…

- Understanding the cultural values and beliefs of the child or adult receiving support
- Dedicating time in team meetings to learn more about each other
- Teaching people to recognize deeply held viewpoints
- Encouraging dialogue, reflection, and respect for others when disagreements arise
- Creating an atmosphere of trust where people feel safe to raise concerns
- Considering whether bias is impacting how data are being collected and interpreted

Integrating Systems of Care at the State, Regional, and Local Levels

Statewide Approach:
Regional Network Meetings in Statewide Planning
Data & Communication Pathways Overview

Statewide Leadership Oversight Team

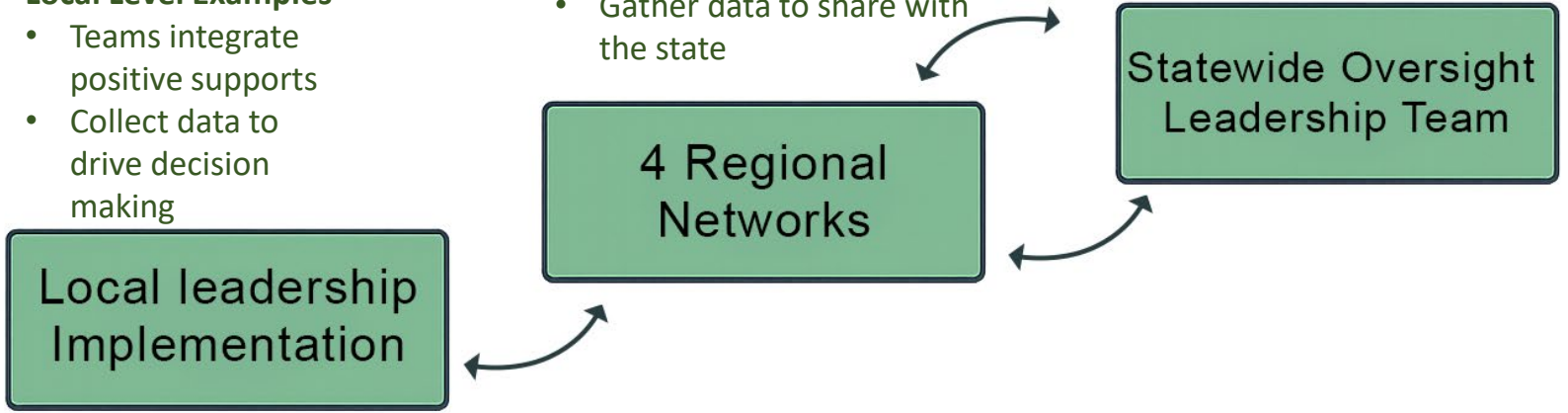
- *State meetings focus on understanding needs in unique regions*
- *Summary of statewide data helps drive decision making*

Regional Level Examples

- Networks meet to discuss what is needed in region
- Create communication about services
- Gather data to share with the state

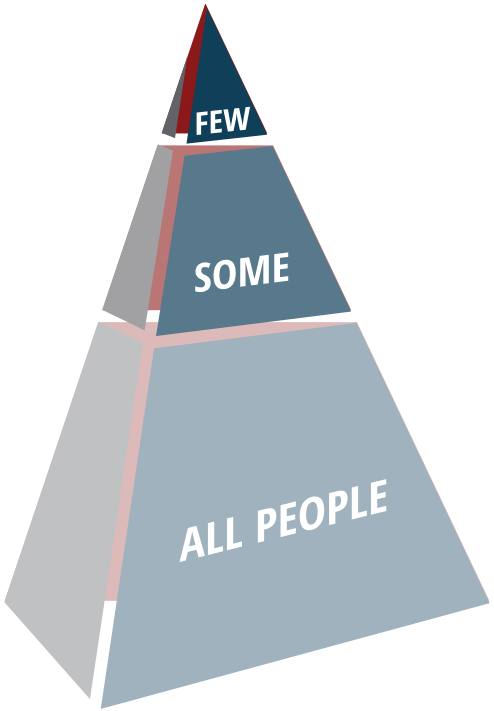
Local Level Examples

- Teams integrate positive supports
- Collect data to drive decision making

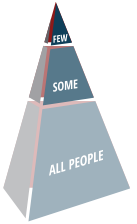


Addressing Acute Care Challenge Across Tiers

Tier 3 (Interventions, Systems and Supports for a Few People)
Temporary acute care placements when no other options are available
Coordination of funds and communication across state departments and divisions
Flexible funding for transition planning
Point of contact navigator or facilitator during transition
Funding for individualized planning
Systems for encouraging memoranda of agreement between organizations to improve communication
Ensuring training and clinical support is available prior to transitions
Team-based individualized planning includes one or more positive supports
Evaluation & measurement systems in place for statewide monitoring of acute care transitions
Tier 2 (Interventions, Systems, and Supports Needed for Some People)
Regional teams monitor signs families and communities may need support
Regional referral system for anyone wanting additional support is offered
Access to function-based targeted and group interventions is available
Communication systems across local, regional, and state teams is used for coordination
Evaluation system at regional and state levels for monitoring Tier 2
Tier 1 (Interventions, Systems, and Support for All People)
Incentives for providers accepting people who require more flexible tailor services
Endorsement systems for organizations implementing PBS and/or other positive supports across data systems and practices
Increases in salary for staff directly supporting people who require more flexible and tailored supports
Promotion path for staff providing direct support in organizations
Training and technical assistance systems for ongoing expansion of PBS for families and providers
Evaluation system for monitoring prevention-based efforts



Statewide Interventions Across Tiers



Tier 1	Tier 2	Tier 3
• Training for PBS and EBPs in layers for all partners • Incentives for providers accepting people who require more flexible tailor services • Endorsement systems for organizations • Increase salaries working with EBPs • Staff promotion pathways • Evaluation systems for Tier 1	• Monitoring and screening at a regional level • Referral system for people to seek support for minor challenges • Memoranda of agreement taught and encouraged at regional level • Evaluation of Tier 2	• Transition planning related to barriers to acute care • Policies and statues driving individualized FBA and EBPs • Care Navigator to assist coordination • Coordination of funds across departments/divisions • Funds dedicated to expanding Tier 3 training systems linked to HCBS funds • Tier 3 & acute care evaluation systems • Memoranda of agreement for Tier 3 communication

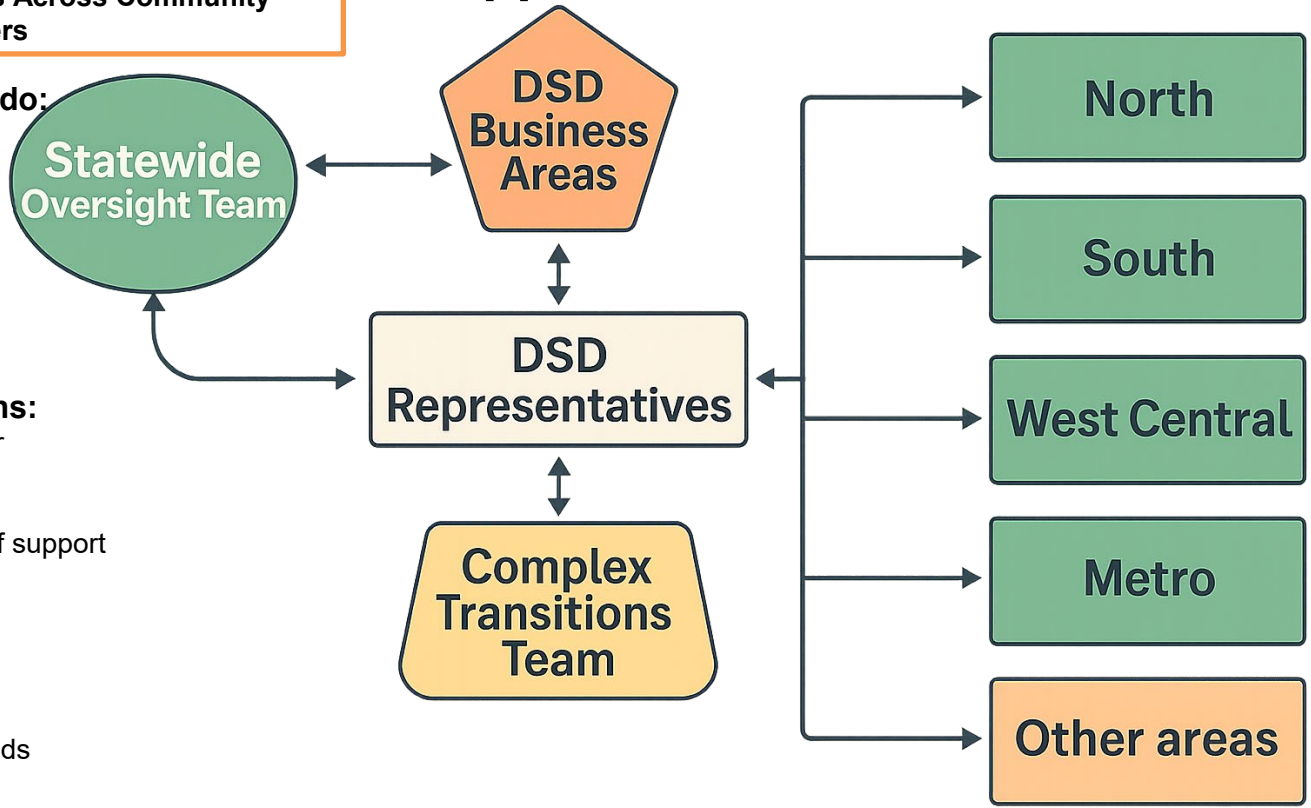
Communication Feedback Loop Systems for Addressing Positive Supports

Representation in Teams Across Community Partners

Getting better at what we do:
- Annual Conference
- Cohort Training
- Person-centered practices
- Positive behavior support
- Trauma-informed
- Culture of Safety
- ECHOs

Statewide Communications:
- Where training should occur
- Marketing and recruitment
- Resource investment
- Developing areas in need of support

Information Sharing:
- Regional Data
- Cohorts
- Trainers available
- Regions' Strengths and needs



Community Partners Involved in Regional Planning

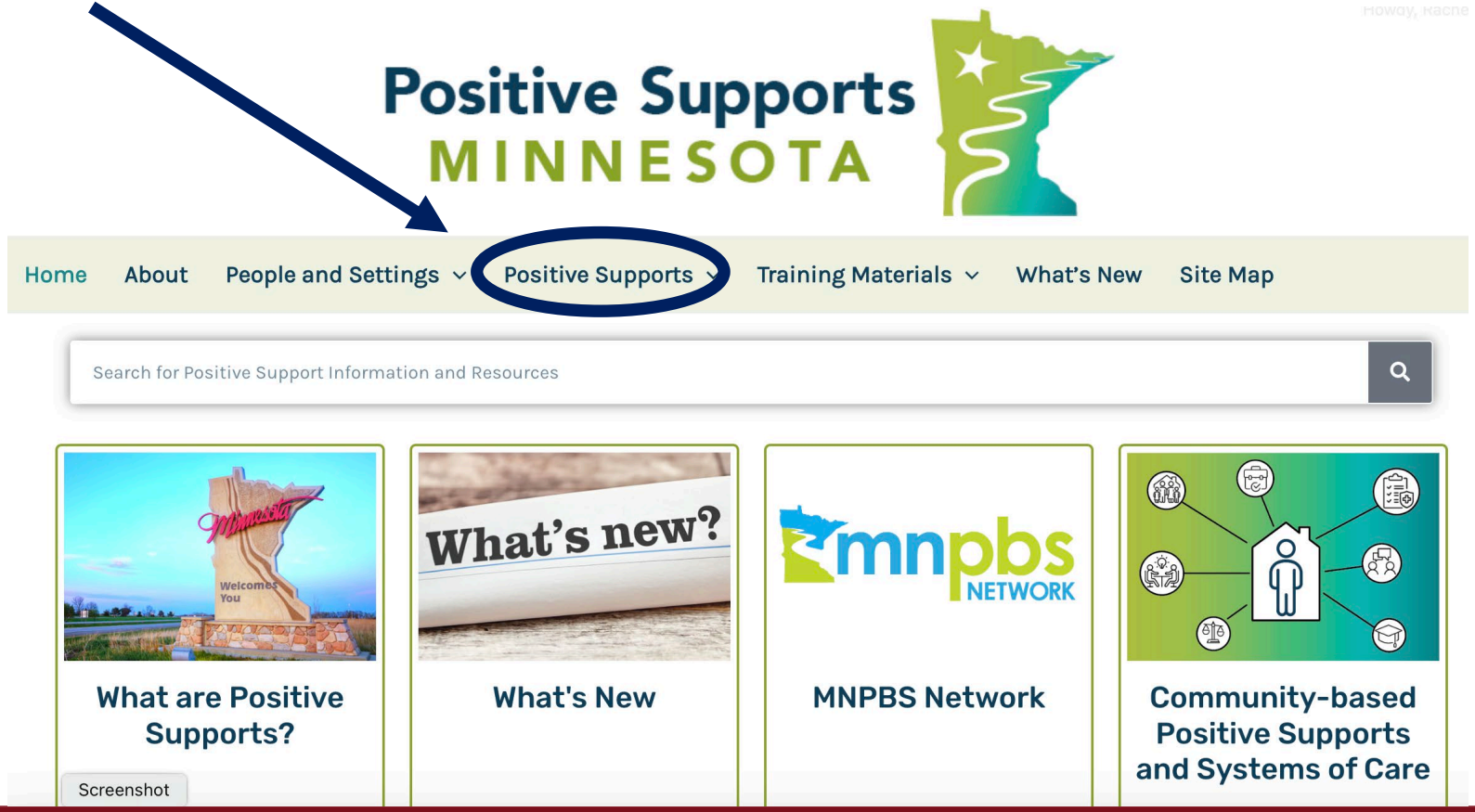
- People with lived experience with positive supports
- Family members/guardians
- Advocacy organizations
- Providers
- County representatives
- State professionals
  - Disability Services/ ADSA
  - General Councils Office
  - Direct Care and Treatment
    - Mental Health and Substance Abuse Treatment Services (MHSATS)
    - Community Supports and Services
- University partners

Regional Data-based Decision Making

- Evaluation Questions (Examples)
  - What positive supports are used in regions
  - Are there trainers available for key positive supports
  - Etc.
- Regional Checklist for Teams
- PATH action planning and data
- Tiered Onsite Evaluation Tool (Cohort Teams)
- Outcome Data (Examples)
  - Number of trainers in area
  - Training events in region
  - Counties involved
  - Regional team representation
  - Community mapping information
- Website stats

Systems of Care Resources

Find More Systems of Care Information at MNPSP.ORG



Free Resources Online

- Systems of Care Definition
- History of Systems of Care
- MNPSP Systems of Care Site
- Georgetown University Toolkit
- Child Welfare and Systems of Care
- National Technical Assistance & Training Assistance Center
- Standards for Systems of Care
- National Wraparound Initiative
- Research on Wraparound
- Wraparound and Story

Youth Mental Health:
Where Rural Families can Find Help Now

1. Education on mental health, illness, risk, protective factors
   - 988 Suicide and Crisis Lifeline
   - MN Dept Health mental health resources
   - NAMI resources
2. Integration of mental health into primary care settings
3. School-linked services and supports

Developed by

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