

# Understanding State Hospital Utilization & Rising Costs in Ramsey County

AM Workshop





## Presenters

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# Why Are We Here?

# Goals for AM & PM Workshops

1. Understanding State Operated Services (Direct Care and Treatment) and the complexities of those using these services
2. Recognize the multiple systems and partners that must work together for treatment and stabilization of our most vulnerable residents
3. Why utilization and costs are rising
4. County role and limitations
5. Where future policy and investment decisions are needed

# Agenda: AM Board Workshop

1. Overview of Direct Care and Treatment (DCT) - Erik Adolphson, Transitions and Liaison Director
2. Who is Using the State Hospital System?
  - A resident's journey through Ramsey County's Direct Care and Treatment Utilization Process
  - Complex scenarios and high acuity
3. Ramsey County Role in Utilization and Discharge
  - Weekly Utilization review process
  - Client voice and discharge planning
4. Barriers to Discharge

The background of the slide is a scenic landscape. On the left, there is a dense forest of trees with autumn foliage in shades of yellow, orange, and green. On the right, a wide river flows through a valley, with a town or city visible in the distance under a bright, hazy sky. A horizontal bar with a dark red segment on the left and a grey segment on the right is positioned above the main text area.

## Section #1

# Overview of Direct Care and Treatment

# What is Direct Care and Treatment?

Minnesota's State-Operated Behavioral Health System

Serves **12,000+** individuals annually

Provides:

- Inpatient psychiatric hospitals
- Forensic (Mentally Ill and Dangerous – “MI&D”) treatment services
- Residential and step-down care
- Community-based and outpatient services

Serves individuals with **complex needs that exceed community capacity**

Admission is **referral-based** (counties, courts, hospitals)

Statewide system:

- **150+** sites
- **5,500** staff
- **\$786M** annual budget

# Why DCT Matters for Ramsey County

## Where State System Meets Local Impact

- Individuals served often have:
  - MI&D commitments
  - Co-occurring mental health & substance use
  - Developmental disabilities
  - Justice system involvement
- Community system limitations:
  - Limited high-acuity placements
  - Provider refusal due to complexity
  - Housing instability
  - Workforce shortages
- When community options are unavailable:
  - **State hospital becomes the default placement**
- When discharge is delayed:
  - Longer lengths of stay
  - Increased system costs
  - Ongoing strain on county and state resources

## Statutory Framework

# **253B.10 PROCEDURES UPON COMMITMENT**

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Section #2

# Who is Using the State Hospital System?

# Who is Using the State Hospital System



While patient numbers may be smaller, the complexity and intensity of needs are significantly higher.

64%

## Serious and Persistent Mental Illness (SPMI)

- High prevalence of conditions like schizophrenia and bipolar disorder.

46%

## Co-occurring Substance Use Disorders (SUD)

- Frequent dual diagnosis complicating treatment and recovery.

85%

## Justice System Involvement

- History of interactions with law enforcement and courts, including competency evaluations.

49%

## Housing Instability

- Significant rates of homelessness or unstable living situations.

77%

## Long Histories in Public Systems

- Extensive experience with multiple public services, including repeated hospitalizations.

# How Complexity Impacts State Hospital Utilization



Higher patient complexity requires more specialized care and staffing in community placements



Complex cases involve multifaceted needs, extending the time and effort required for safe and effective discharge planning



The specialized needs of complex patients limit the pool of community providers, creating placement challenges



Intensive resource needs and discharge complexities directly contribute to patients remaining in state hospitals for extended periods

**The combination of increased acuity, prolonged discharge planning, and reduced community provider availability leads to longer lengths of stay and drives up overall healthcare costs in state hospitals.**

# Jordan's Journey Through Ramsey County's DCT Utilization Process

- 29-year-old male with Unspecified Schizophrenia, Fetal Alcohol Spectrum Disorder, and substance use history
- Multiple civil commitments (2021, 2022, 2023, 2025) with five provisional discharge revocations due to failure to adhere with conditions
- History of aggression and assaults toward staff, shelter residents, and police when psychotic or noncompliant with treatment
- Repeated difficulty maintaining placements and treatment adherence; extensive program denials due to complexity of needs
- Currently engaged through the Innovations Grant Bed-Hold Program, partnering with a provider and navigating a moratorium exception to develop a specialized, structured discharge plan for stability and community safety



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## Section #3

# Ramsey County's Role in Utilization and Discharge

# State Operated Services: Utilization Review Process

## Internal Coordination Meeting

- MN Choices, Financial Assistance Services (FAS), Prepetition Screening Supervisor, Targeted Case Management (TCM) Supervisors, Innovations Grant Project Manager

## Key Focus Areas

- Each client receiving treatment in a state operated hospital or Direct Care and Treatment facility is reviewed individually
- Full group evaluates discharge plans and identifies financial or service eligibility barriers
- Work to resolve internal processing issues to advance Medical Assistance and waiver funding applications, ensuring timely authorization and continuity of services

## Identify Actionable Items to Report Back to External Partners

# Weekly Utilization Review Process: Afternoon Coordination with System Partners

- Multi Disciplinary Treatment Team Meeting
  - State Hospital Supervisors, Case Management, Direct Care and Treatment, Targeted Case Management Supervisors, Prepetition Screening Supervisor
- Review barriers to discharge
- Identify follow up actions
- Diversions and coordination of remote provisional discharge
- Barriers that contribute to delays
- Discharge planning process continues throughout the week

# Why Client Voice Matters in Discharge Planning

“It helped me start advocating for myself.”

-Utilization Client

- Discharge planning starts at the time of admission
- Successful placements are more likely when clients understand and support the plan
- Clinical treatment teams may recommend more structured care than the client prefers
- Discharge decisions require balancing client choice, clinical judgement, and safety considerations

“It is a bit of a culture shock...to be trusted. I don't ever take the freedom for granted.”

-Utilization Client

A portrait of a middle-aged man with a receding hairline, wearing black-rimmed glasses and a light blue button-down shirt. He is looking directly at the camera with a slight smile. The background is a blurred outdoor setting with trees and a building.

## Derrick's Journey Through Ramsey County's Direct Care and Treatment Utilization

- Adult male with serious and persistent mental illness and co-occurring substance use disorder involved in county services for over 15 years
- History of numerous hospitalization, homelessness and involvement with the criminal justice system
- Received multiple levels of care including case management, Assertive Community Treatment (ACT), residential services, supportive housing and state hospital treatment
- Repeated difficulty maintaining housing placements due to symptoms, substance use, and behavioral concerns, requiring high level of coordination
- Case required use of specialized placement resources and cross-system collaboration to address mental health, legal, and housing needs
- Pending indeterminate commitment hearing scheduled for April 2026

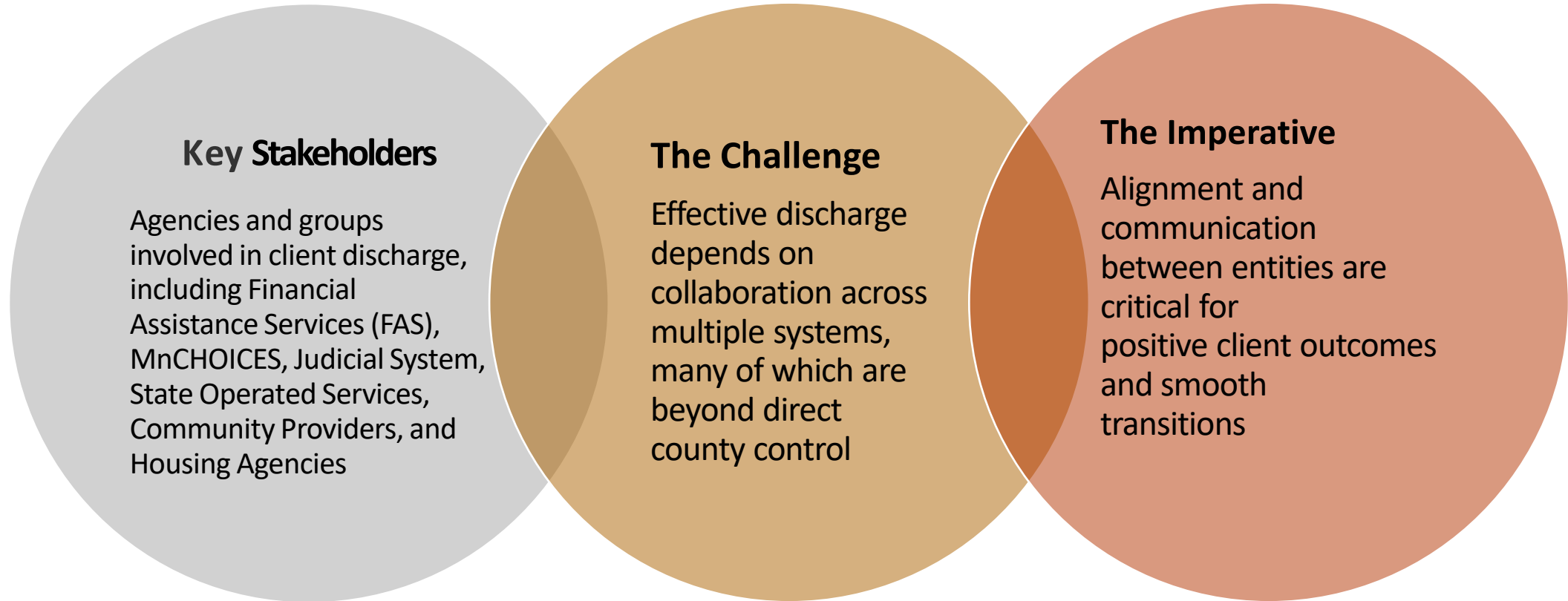
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Section #4

# Barriers to Discharge

# Multiple Systems Must Align

Seamless Coordination for Successful Client Discharge



Successful client discharge is a complex, multi-system endeavor requiring seamless coordination

# Primary Barriers Driving Delays

## Obstacles in the State Hospital Discharge Process



### Scarcity of Step-Down Placements

Limited availability of suitable residential care, assisted living, or specialized facilities



### High Provider Refusal Rates

Community providers may decline accepting patients due to perceived risk or resource limitations



### Persistent Housing Limitations

A critical shortage of affordable, stable, and appropriate housing options



### Critical Workforce Shortages

Insufficient mental health professionals, case managers, and support staff in the community



### Delays in Activating Support Services

Bureaucratic hurdles in securing insurance, benefits, and essential community support systems

These interconnected barriers necessitate strategic interventions to improve patient outcomes and alleviate strain on state hospital resources

## Key Takeaways from AM Session

- Summary of AM discussion
- Preview of PM session and guest speakers