DEPARTMENT OF HUMAN SERVICES

Acute Care Transitions Advisory Council February 29, 2024

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Hospital Decompression versus Acute care transitions

Hospital Decompression

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

Acute Care Transitions

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

System Challenges

- Unknown number of people statewide (children and adults)
- Multiple and varied efforts across Minnesota (and the country)
  - Usually based on population (e.g. children with behavioral support needs, adults with disabilities)
  - No centralized entity to coordinate and align efforts
- Short term solutions are elusive but pressure to find them is extreme
- Recognition that systemic change is needed but accompanying sense of urgency to find short term solutions
- Effective solutions must take regional capacity/regional gaps into account

Complex Transitions Referral Form

- Process begins with hospital submitting the Complex Transitions Referral Form
  - Search internet for MN DHS and Complex Transitions

Partners and providers

- Program overviews
- Policies and procedures
- Enroll with MHCP
- eDocs library of forms and documents
- News, initiatives, reports, work groups
- Training and conferences
- Contact us
- Grants and RFPs
- Licensing
- IT systems and supports

Complex Transitions Team

The Complex Transitions Team supports people who might benefit from DHS technical assistance to move from hospital and institutional settings back into the community. The team connects with subject matter experts across departments and divisions within the state to be a single point of contact for people who need to navigate the supports available through DHS.

The Complex Transitions Team technical assistance is not a substitute or waiver of requirements, nor a substitute for regular communication channels and processes. The hospital must continue to collaborate with the lead agency and the support team working with the person. If you have an exceptional circumstance that may require DHS consultation, please contact us through the referral form under the How to get help tab below.

How to get help | Resources | Contact us

How to get help

Before submitting a Complex Transitions Referral Form, the hospital must reach out to the lead agency that serves the person. Lead agencies are the first point of contact for human services supports. You can find a list of lead agencies here: County and tribal nation offices.

If a Plan is in Place: What Can We do to Expedite/Help?

- Options include:
  - Help with rate exceptions
  - Information or assistance needed from other parts of DHS (licensing, provider enrollment, etc.)
  - Flexible use of state grant dollars
  - Connection to clinical consultation and enhanced training
  - What else could we do to help?

If No Plan is in Place

- Provide referral options from DHS provider network for potential matches
    - DHS needs to expand this pool of providers, different provider types, and provide ways for that network to further develop capacity

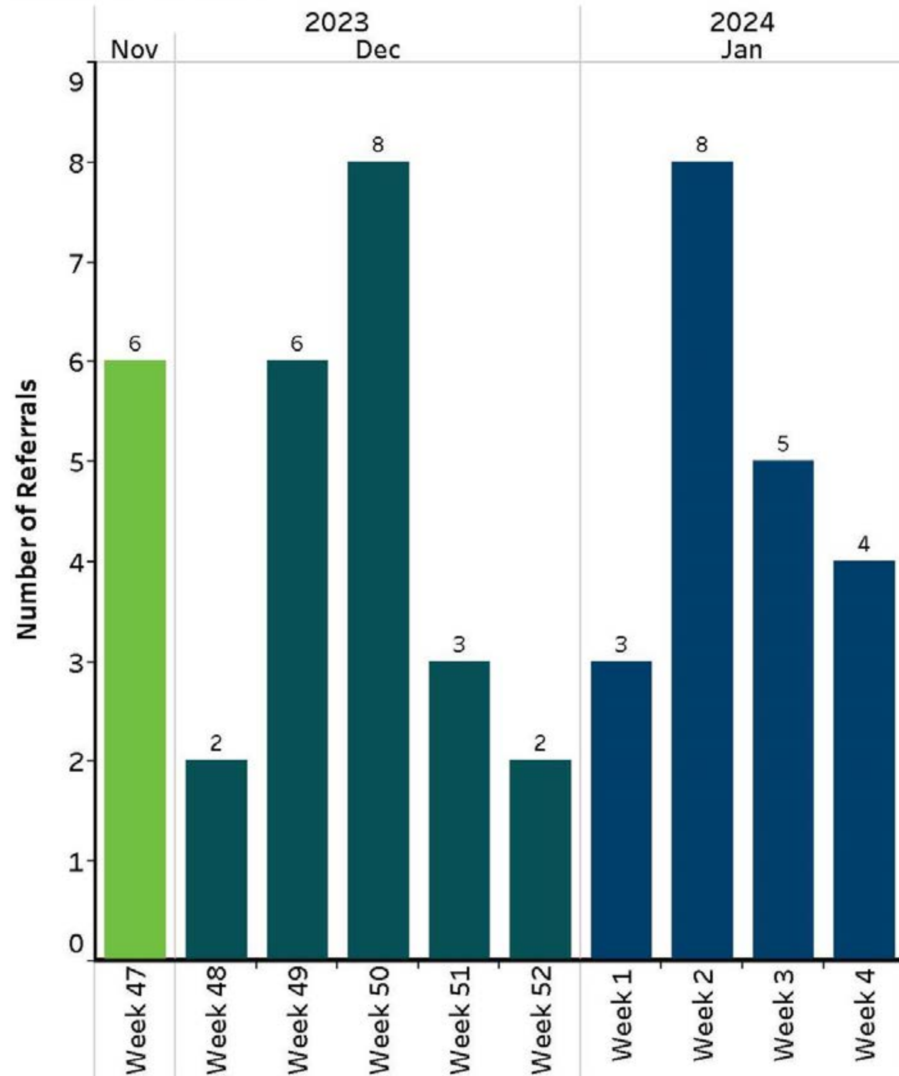
- Discusses what else is needed to identify good supports for the person?
    - Person-centered planning (full plan or one page description)
    - Additional funding through WIT or similar
    - Crisis options

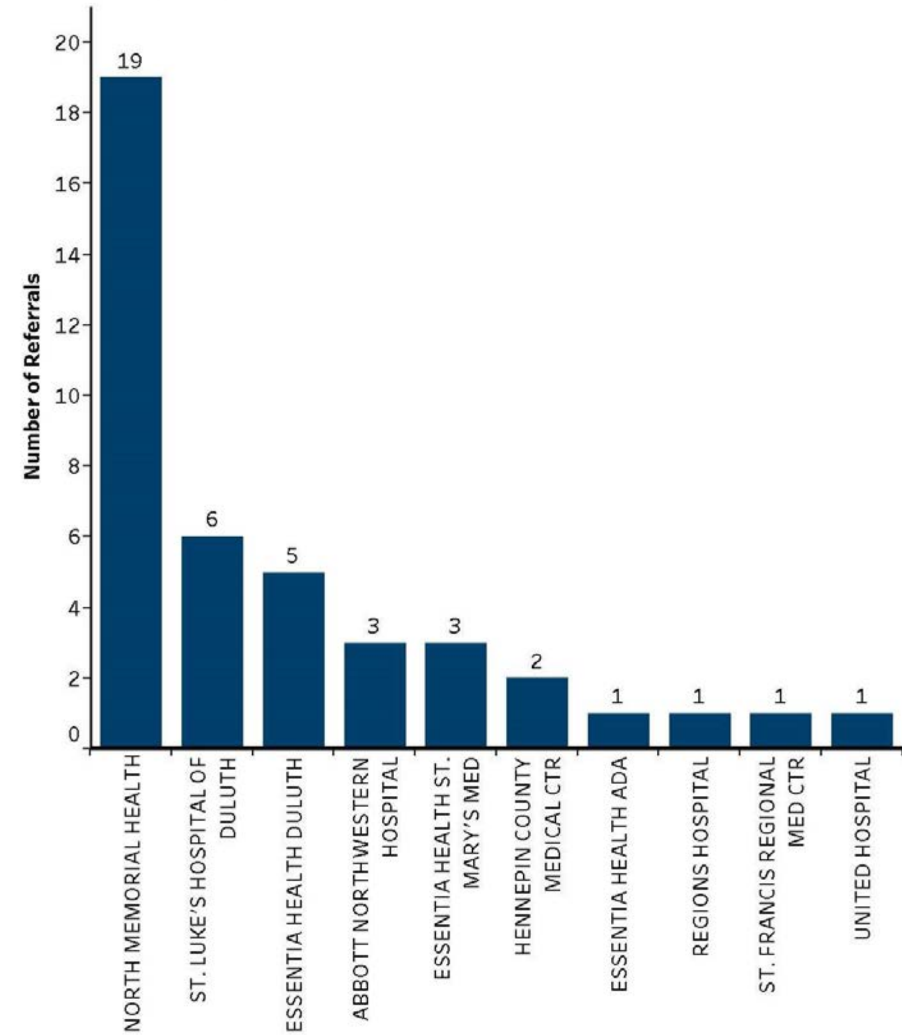
Who is getting stuck?

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

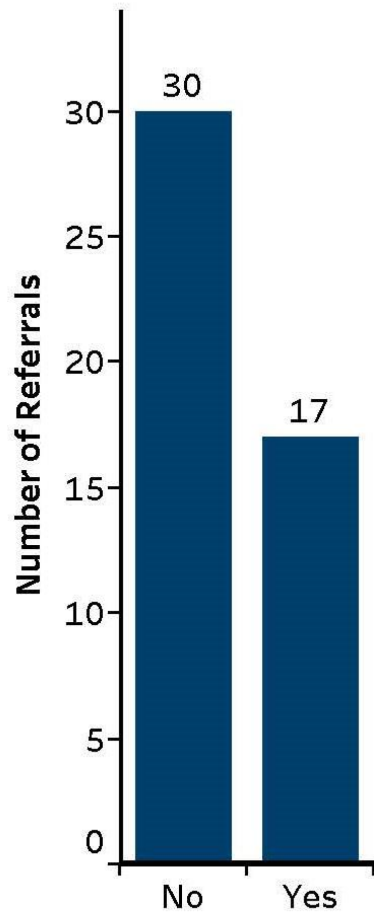
- Individuals with acute aggression who injure parents or caregivers
- Trauma present
- Reputation with providers as being hard to serve – burned bridges
- Under serviced – receiving only PCA – this applies a lot to the BIPOC community
- Non-verbal
- Dual MH and IDD diagnosis

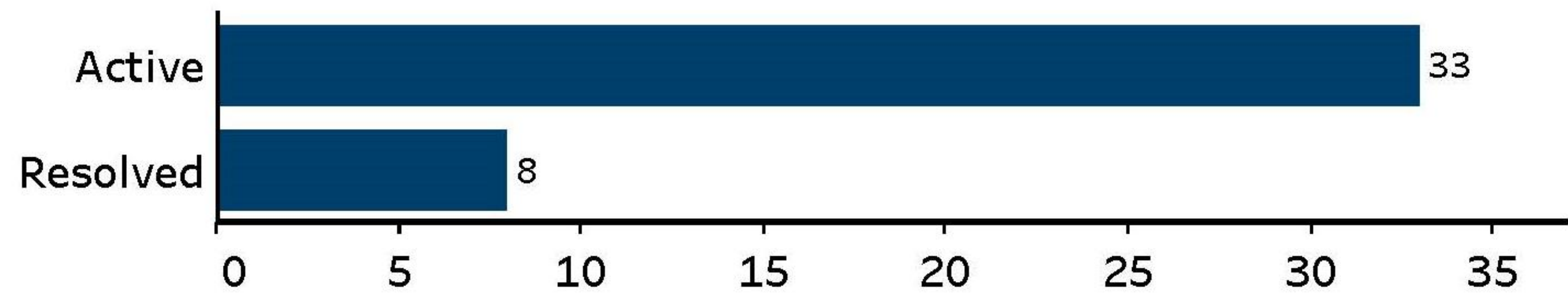
Complex Transitions Referral Data



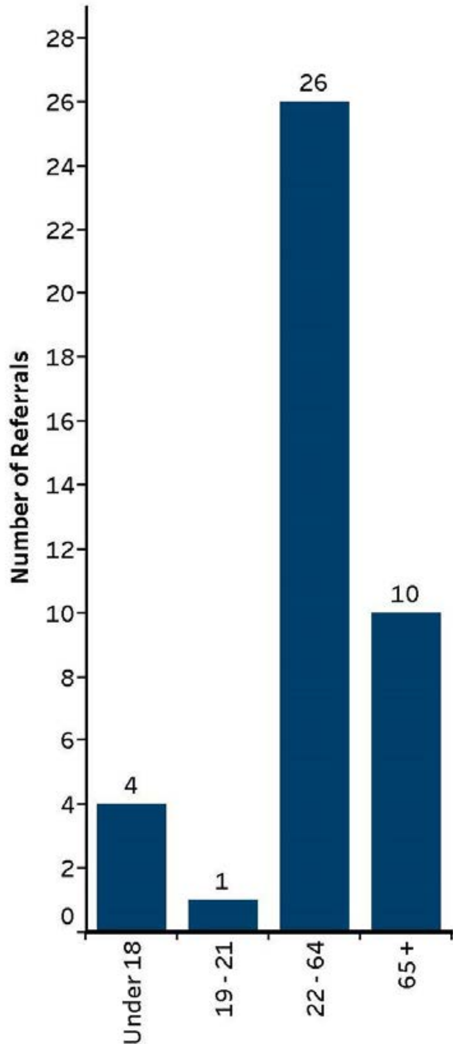


Complex Transitions Discharge Data





Complex Transitions Referral Data continued



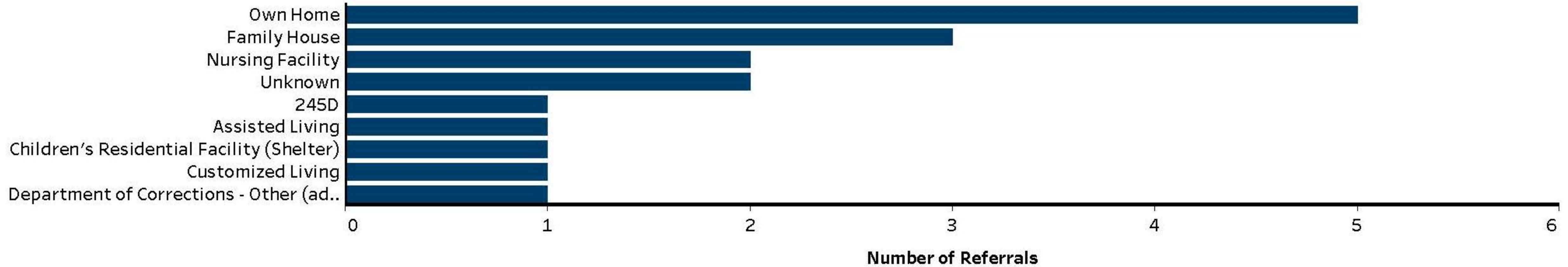
Reason Presented to ER

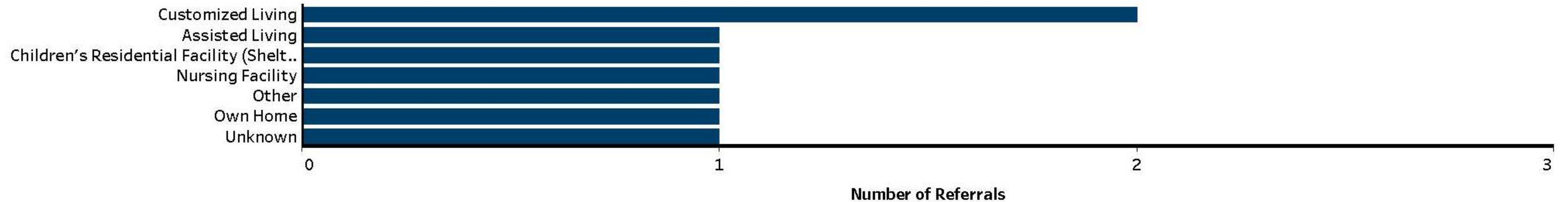
Reason	Number of Referrals
Illness or Injury	14
Physical Aggression	11
Self Harm Behaviors	8
Psychotic or MI Symptoms	8
Self Neglect	7
Suicidal Ideation	5
Criminal Behavior	5
Sexualized Behaviors	3
Suicide Attempt	2
Readmission 72 hours	2
Property destruction	1

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Number of Referrals

Complex Transitions Location Data





Transition Services

- Relocation Service Coordination
- Moving Home Minnesota
- Housing Stabilization Services
- (Waiver) Transitional Services

**Search internet for: Comparison of MHM, RSC-TCM and HSS*

Eligibility criteria	MHM	RSC-TCM	HSS
Be on MA	Yes	Yes	Yes
Age	No requirement	No requirement	Age 18 or older
Resides in a hospital	Yes, for 60 or more days	Yes, and there is no requirement for length of stay	Yes, and there is no requirement for length of stay
Resides in a nursing facility	Yes, for 60 or more days	Yes, and there is no requirement for length of stay	Yes, and there is no requirement for length of stay

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Thank You!

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